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Public and Private Actions to Counter Perpetuation of Inequality: Lessons from Southeast Asia and Beyond

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Introduction

This paper aims to identify some of the central issues in the engagement by and partnership between state and non-state actors in addressing inequality, with a particular focus on interventions designed to break or mitigate intra-generational continuation and/or intergenerational transmission of deprivations and disadvantages that perpetuate inequality in various domains of life. Discussion will be informed by the conceptual/ analytical frameworks and working hypotheses on service provision developed in Yanagihara (2016).

Inequality has many faces, some visible and some hidden. It is income and/or wealth inequality that is most prevalent in academic and policy discussion. There are, however, common phenomena called "socioeconomic gradients" in many areas of human and developmental concern, ranging from nutrition, health, education, to water and sanitation, housing and living environment, and, most fundamentally, to entitlements and capabilities. On the conceptual level, there is an important distinction between *inequality of outcomes* and *inequality of opportunities*.

Note need be taken of the diversity among private actors, cutting across formal and informal, as well as for-profit and not-for-profit, divides. In fact, in many cases, the most important private actors may be service users themselves.

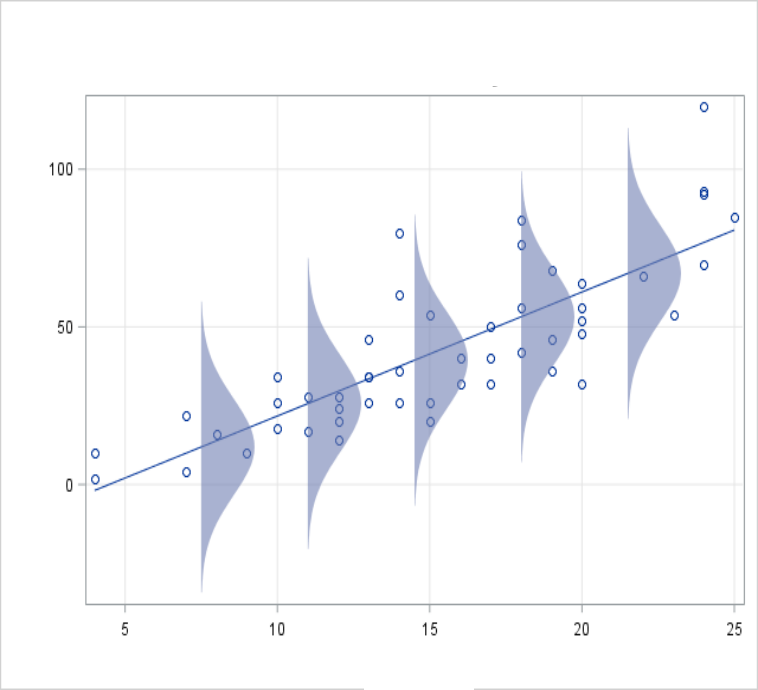
The empirical part of the paper aims to draw generalizable lessons for practice and research based on a selective review of evaluation documents on important public and private interventions in social sectors in Southeast Asia, with particular attention to Indonesia and Vietnam. Additional documents are drawn from other parts of the world to illustrate some approaches not well established in the region. Information is obtained from World Bank, ADB, UNICEF, JICA, Oxfam, Plan International, and Save the Children

1. Conceptual and analytical frameworks

1.1 "Gradient" and "deviance"

In addressing the above-mentioned questions, we will apply two alternative perspectives to pattern recognition and approaches to policy formulation. One is the "gradient" perspective/approach, and the other the "deviance" perspective/approach. (Figure1)

Figure1. "Gradient" and "deviance"



The "gradient" summarizes the tendency found in correlation between the determining variable (on the horizontal axis) and the outcome variable (on the vertical axis). In contrast, the "deviance" shows the spread around that tendency.

The "gradient" perspective seeks to summarize the observed relationship between the level of the determining variable and the *average* level of the outcome variable; higher the determining variable, higher the outcome variable *on average* in Figure 1. The "deviance" perspective, by contrast, pays attention to divergences of individual observations of the outcome variable from the *conditional average* given the level of the determining variable.

Based on these alternative perspectives, two alternative approaches are derived for the formulation of policies/programs aimed at raising the level of the outcome variable: The "gradient" approach advocates that action be taken so that the

level of the determining variable be heightened; alternatively, the "deviance" approach proposes that secrets behind above-average performers be discovered and transferred to below-average performers.

It seems that the "gradient" perspective is dominant in pattern recognition of inequalities, while the "deviance" approach, if anything, is more common in the design of interventions. We will see how these two approaches have been applied for fact finding and policy/program design.

1.2 Modes of service transactions[1]

Interventions take place on the ground level in the real world and involve personal contacts and transactions between first-line service providers and service users. Oftentimes effectiveness and efficiency of interventions critically rely on the quantity and quality of services produced and utilized through the transactional process of interactions between providers and users.

Interventions to counter perpetuation of inequalities, and especially those informed by the "deviance" approach, involve provision of services to targeted population groups. Modes of service transactions, starting from an outreach, then to initiation of relationship, and further to continued interactions, between providers and users are a critical determining factor in the success or failure of interventions. Here we will present and discuss different modes of service transactions and associated characteristics.

In this section, we will first present an analytical framework for service transactions, followed by articulation and elaboration of key concepts employed to classify services into four distinct types. Particular attention will be paid to "practice"-type services, and conjectures will be put forth regarding possible failures in the provision of that type of services. Secondly, we will propose another set of conceptual-analytical schemes for the understanding of the place and role of agency on the part of service users in the transaction and utilization of services.

Analytical framework on service supply-uptake links

The links between public expenditure and outcomes (in terms of increased well-being) are stylized as follows:

1) Public expenditure → 2) Generation of services → 3) Uptake of services → 4) Well-being outcomes,

The first link (i.e., components 1 and 2 as well as the arrow connecting them) represents supply-side factors and processes, including policy decisions and administrative realities of organizations involved. Availability of resources, resource allocation and deployment decisions, and governance of administrative behavior are important elements on the supply side.

The second link (components 2 and 3 and the arrow connecting them) incorporates behaviors of, and interactions between, front-line service providers and users in specific contexts of service transaction. Here, capacities, constraints, attitudes and motivations on the part of providers and users, as well as incentives faced by them, are important determining factors of how services are delivered and received.

The third and final link (components 3 and 4 and the arrow connecting them) represents user-side factors and processes and is importantly affected by conditions, attitudes and behaviors of service users in the context of their daily life. This link has traditionally received much less attention than the first two.

The present paper will address some of the important factors impinging on service delivery and uptake from micro and system analytic angles, building on foundational contributions by Lant Pritchett and Michael Woolcock: first, conceptual articulation based on a two-way classification of types of services according to degrees of discretion and transaction-intensity[2]; and secondly, hypotheses for mechanisms of systemic and persistent implementation failures[3]. We will pay much attention to the second and third links above, highlighting the importance of user-side factors and conditions for effective uptake and utilization of services.

Conceptual articulation and classification of services

Services may be classified into four types based on a two-by-two framework according to degrees of discretion and transaction-intensity. Labels and characteristics of those four types are as follows (Table 1) (Pritchett and Woolcock 2004, 194-5). Illustration in education and health fields of the four types of services is also provided (Table2).

Table 1: Classification of natures of service

	Discretionary	Non-discretionary
Transaction-intensive	"Practice"	"Program"
Non-transaction-intensive	"Policy"	"Rule/Procedure"

Source: Pritchett and Woolcock (2004), pp.194-5.

1 This section draws on Yanagihara (2016).

2 Pritchett and Woolcock (2004)

3 Pritchett, Woolcock and Andrews (2010)

Table 2: Illustration of the four types of services

Type ＼Sector	Education	Health
"Policy"	Criteria for teacher certification	Criteria for drug certification
"Program"	Standardized examination	Vaccination
"Practice"	Classroom teaching	Clinical consultation
"Rule/Procedure"	Class registration	Clinical registration

Source: Author.

"Transaction intensity" refers to the extent to which the delivery of a service (or an element of a service) requires purposive actions on the part of service providers, oftentimes involving some face-to-face contact. Services are "discretionary" to the extent that their delivery requires decisions by providers to be made on the basis of information that is inherently imperfectly specified and incomplete, thereby rendering them unable to be standardized. As such, these decisions usually entail professional (gained via training and/or experience) or informal context-specific knowledge. Discretionary decisions are taken in the process of service provision; the right decision depends on conditions that are difficult to assess (*ex ante* or *ex post*), and hence it is very difficult to monitor and determine whether or not the right decision was taken.

It is important to distinguish clearly these different modes of services and understand their distinctive characteristics and challenges for effective delivery: "policies" are primarily technocratic; "programs" are primarily bureaucratic; and "practices" are primarily idiosyncratic. The primary challenges for "programs" are technical (finding an effective and least-cost solution) and logistical (carrying out the mandated actions reliably). In contrast, the provision of those elements of services which are discretionary and transaction-intensive –"practices"– poses inherent difficulties for public administration, because they are intrinsically incompatible with the logic and mechanism of large-scale, routinized, administrative control. Large organizations, by nature and design, are essentially constrained to operate exclusively in terms of "policies" and/or "programs," and not apt to manage "practices."

We accept and adopt the definition and characterization of the distinctive natures of the four types of services proposed by Pritchett and Woolcock (P-W). We find it necessary to apply a number of comments for further articulation of their definition and characterization, however. Our comments relate to both "transaction intensity" and "discretion":

(P-W) Transaction intensity refers to the extent to which the delivery of a service requires interactive transactions, nearly always involving some face-to-face contact.
Comment #1:
There are distinct differences in required degrees of interaction in service transactions between "practice" and "program."
Comment #2:
Interactive transactions entail ability and willingness to engage on the part of both providers and users of services.

(P-W) Discretionary decisions are taken in the process of service delivery and uptake; the right decision depends on conditions that are difficult to observe or assess (*ex ante* or *ex post*), and hence it is very difficult to monitor and determine whether or not the right decision was taken."
Comment #3
There is room for front-line service providers to reduce "interactive transactions" by standardizing and routinizing transactions (i.e., turning "practice" into "program") in an attempt to minimize transaction intensity (and thus levels of time/psychic costs entailed).
Comment #4:
There is room for service users to reduce "transaction intensity" in the interactive process of service transactions. Users also could use discretion in utilization of services proffered (as in failure to adhere to instructions and prescriptions).

1.3 Conjectures on two types of failures in service provision

Discretionary and transaction-intensive services have the character of being interactive, collaborative and co-productive, and these features apply not only to service providers but to users as well; not only teachers (clinicians) but also students (patients) need to be meaningfully engaged in the transactions for the quality of services, and well-being outcomes, to be achieved. There are two types of failures related to the generation and uptake of discretionary and transaction-intensive services:

Type1: opportunistic behaviors on the part of front-line service providers and service users toward minimization of transaction-intensity
Type2: idealistic pursuit of the maximization of transaction-intensity on the part of policymakers/ aid agencies

Failure Type1 in "practices" takes the form of the minimization of transaction intensity. Front-line service providers (teachers and clinicians) may not be able (or willing) to achieve the stipulated modes and levels of transaction-intensity, with consequent deterioration in the quality of service, as discretionary nature of the engagement may allow them to disregard required standards. This is observed in education as in monotonous lecturing, and in health as in routinized diagnosis and prescription. Similarly, service users may not be able (or willing) to achieve the stipulated modes and levels of transaction-intensity; they may not be sufficiently attentive or responsive in classrooms or clinics.

Failure Type 2 in "practices" may possibly arise from idealistic pursuits of the maximization of transaction-intensity. Trying to realize stipulated engagement from the users may excessively heighten the demand for transaction-intensity on the part of service providers, resulting in persistent implementation failures. This concern seems to be particularly pertinent in the assessment of feasibility and effectiveness of the user-centered approach.

In parallel with the above-stated failures in service transactions, there may also be failure (on the part of service users) in self-management in the utilization of services proffered, as mentioned in Comment #4 above

1.4 Definition and articulation of agency and motivation

In discussing the effectiveness of interventions, it will be essential that one has systematic understanding of the subjective and objective conditions of the (potential) users of services. Among the subjective conditions are importantly included agency and motivation of the user with regard to the transaction and utilization of services. Here we propose the working definitions of two terms, agency and motivation, their conceptual clarification and articulation, and an analytical framework for the understanding of the relationship between them.

In this paper, agency is defined as "disposition and capacity inherent in an individual for self-determination and self-management." It is postulated as a latent potentiality and something generic with possibilities of application in a wide range of contexts and activities. In contrast, motivation is defined to be "a factor or process by which agency is activated in a specific context or activity."

It is important to distinguish between "agency in existence (AE)" and "agency activated (AA)." We postulate that AE, which is latent, is activated and realized up to the level of AA to the extent that the individual is "motivated" to direct and exert AE to carry out a specific activity. The level of AA exhibited in a certain activity thus is a function of the level of AE and the intensity of motivation for the activity in question. The level of AE at any point in time, on the other hand, may be stipulated to be determined by the following three factors: the initial level of AE, the level of AA over time, and external influences affecting the level of AE.[4]

1.5 Typology of user-provider relations and user agency in service transaction and utilization

In the context of service transaction and utilization, both the level of the existing stock of agency (AE) and the intensity of motivation for its activation in the specific context or activity of the service in question are relevant. For the immediate action what matters is the intensity of motivation as the level of the existing stock of agency is given and unalterable at a point in time. Over time, however, the level of the stock of agency can be augmented.

In discussing the role of agency in service transaction and utilization, an additional scheme of classification of services will be in order. Unlike the previous classification scheme, this one places direct focus on different modes of interactions between the user and provider of service, with particular attention to the subjective condition of the service user. We propose a four-way classification of the user-provider relationship: "(user-driven) service delivery," "consulting" service, "counseling" service, and "pre-counseling" service (or "outreach") (Table 3).

Table 3 Typology of user-provider relationship in service transactions

Type 1	"(User-driven) service delivery"
User side	Desire and sufficient ability to self-determine "solutions" and express them as wants
Provider side	Supply of services to meet user's wants on demand
Type 2	"Consulting service"
User side	Desire but insufficient ability to self-determine "solutions" or express them as wants
Provider side	Consultation and supply of ideas for "solutions" to user's desire
Type 3	"Counseling service"
User side	Vague desire and lack of ability to identify "solutions" or express them as wants
Provider side	Counseling and clarification of recipient's desire (through interactive process of communication)
Type 4	"Pre-Counseling service - Outreach"
User side	Lack of desire and/or willingness to engage in communication or activity
Provider side	Proactive attempts at establishing communication with and providing support to potential users

Source: Author.

[4] The conceptualization of latent and activated agency, as well as the stipulation of functional relationship between them, may be viewed as something analogous to that of potential and actual power generated by an engine. Engines are built to generate a certain maximum level of power. But the actual power generated by an engine will be determined by the rate at which fuel is supplied to it. In the extreme case of no fuel supply, the actual level of power generation will be zero. Similarly, the function tracing the trajectory of the level of latent agency can also be understood in analogy with the case of an engine. There may be decay in capacity with a passage of time, wear and tear from use, and restorative effects of tune-ups. Interestingly, in the case of agency, there might not be any decay of AE with a passage of time, and its use as expressed as AA might exert positive effect on AE if, as is imaginable, exercise of agency leads to an enhanced state of agency rather than a depleted state. For the third term, influences and supports provided from outside will be functional equivalents of tune-ups in the case of an engine.

In some cases the user clearly identifies what service she wants and is capable of conveying it to the provider as "demand." The provider responds to the demand and deliver. These cases may be classified as "(user-driven) service delivery." In some other cases, the user has broad idea as to what she wants but will need to consult with the provider as to appropriate specification of the service to be provided to meet the user's desire. In such cases provision of service will contain elements of "(technical) consulting" in the process of reaching an "informed decision." In yet other cases, the user may desire to change the situation but may not be clear as to what service they want. In such cases, the service will take on the nature of "(psychosocial) counseling", consisting of clarifying the situation, identifying possible solutions, accompanying in the process of mental and behavioral changes, and providing moral support throughout the process. In all cases above, the service user has ability and willingness to engage in service transactions. In some cases, that might not be the case and the provider side might operate proactive "outreach" activities so that potential users of the service be contacted and brought into service transactions, oftentimes of the counseling type.

It is to be recalled that user-provider relations are characterized not only by differing levels of transaction intensity but also by varied degrees of discretion on both sides. Transaction intensity entails sustained attention, judgment and communication, all of which demand exercise of cognitive resources. When services are discretionary, there is room for reduced intensity in transaction and/or self-management, thus undermining the quality and outcome of the service. Focusing our attention on the user side, the ability and willingness on the part of (potential) users to engage in service transactions are determined by the activated level of agency. In the short term, with the level of potential agency given, it is a matter of motivation; in the long term, however, it is a matter of agency development, or a change in the level of potential agency. The same considerations on potential and activated agency apply to self-management in the utilization of services on the part of the service user.

These different types of user-provider relations are associated with varying degrees of transaction intensity and discretion on the part of both front-line service providers and service users (Table 4).

Table 4 Types of User-Provider Relations and Degrees of Transaction Intensity and Discretion

Type 1 "(User-driven) Service delivery"
Λ
Type 2 "Consulting service"
Λ
Type 3 "Counseling service"
Λ(?)
Type 4 "Pre-Counseling service - Outreach"

Source: Author.
Note: The sign Λ indicates presumed ascending degrees of transaction intensity and discretion between the four types of user-provider relations.

In the case of "(user-driven) service delivery" interactions between service users and providers tend to be highly standardized and pre-programed involving low levels of transaction intensity and discretion. Both "consulting" and "counseling" services constitute instances of service co-production insofar as they involve the user and the provider in close communication and collaboration. As well, they also have aspects of self-management on the part of the service user to the extent co-produced services need to be implemented and internalized into the user's routine activities. There seems, however, to be a difference in degree between "consulting" and "counseling" in the levels of transaction intensity and discretion on the part of both service user and provider.

While in "consulting service" the nature of communication and decision is technical and functional, in "counseling service" it is psycho-social and involves personal relationship between the service user (client) and provider (counselor) as essential constituent of interactions between them; as such, "counseling service" almost inevitably involves emotions and subconscious factors. That, it is presumed, makes "counseling service" more transaction-intensive and discretionary than "counseling service." Discretion on the part of the client seems to be of particular significance for "counseling services"; in some extreme cases, the client may not show up for an appointment and when she does she may not engage in conversation with the counselor.

In fact such is precisely the condition that characterizes the attitude and behavior of potential service users in the state of "self-exclusion" from communication and activity. In such cases, for counseling processes to be initiated, the provider side needs to engage in outreach in a proactive mode. It would typically involve sustained attempts at contact and communication on the part of the front-line service providers like social workers or health workers. To that extent and in that manner the "pre-counseling outreach" will be transaction-intensive on the part of the provider, if not on the potential user's part. It might also be discretionary when and as there is no meaningful feedback from the potential user.

Effective interventions entail certain level of activated agency on the part of service users in the context of service transactions. Activation of agency is mediated by motivation for the engagement in question. In some cases, this prerequisite may not be met in the short term and there might be need for preceding, preparatory process of agency development.

2 Early childhood development

Perpetuation of inequalities can be conceived of the combination of that of advantages/disadvantages across different socioeconomic subsections of the population. Here we will mostly pay attention to the perpetuation of disadvantages both within

one generation and from one generation to the next. One particular focus which relates to both types of perpetuation of inequalities is early childhood development (ECD). ECD is a dominant determining factor of the life chances and wellbeing over the life course of an individual, with implications for intergenerational transmission of advantages and disadvantages.

ECD is a fundamental equity concern, directly connected to basic premises of social justice. Disparities in ECD relate both to *inequality of opportunities* and *inequality of outcomes;* they are typically outcomes of existing inequalities in opportunities for children in the form of family and social conditions surrounding the birth and daily life of children Once formed, disparities in ECD continue to generate inequalities in opportunities and outcomes in a cumulative manner. ECD is a mixed message, emphasizing as it does accumulation of positive or negative effects on health and wellbeing over an individual's life course. There are hopes for new born babies, if and only if they are provided with proper care by parents and/or other caregivers; if not, once beyond the ECD period, certain irreparable damages will last for the rest of an individual's life.

There are three aspects to ECD: physical, mental, and psychosocial (broadly corresponding to the WHO definition of health as the state of physical, mental, and social well-being.) Corresponding to these three, there are three interrelated aspects of home life that could impact significantly upon ECD: nutrition and health, and mental and psychosocial environment. In what follows we will take up each of these aspects.

Among these three aspects, the last one has traditionally been least well understood or attended. Recently, however, it has come to receive academic and practical attention it merits. It is now believed that psychosocial capacity underlies the other two, i.e., physical and mental capacities. Empirical knowledge generated by progresses in neuroscience on the development of human brain during early childhood provided a powerful evidence base for the predominance of psychosocial capacity and effects of psychosocial conditions on children's development. The most salient determining factor of a human being is the size and functionality of the "human" part of the brain, its outer layer, or cortex. ECD in brain capacities represents one of the most fundamental determinants of human security and human development throughout the life course.

Of particular importance in this new scientific light is emotional security in those early years of life; it is a critical necessary condition for openness and learning, i.e., development. Conversely, its absence, or emotional insecurity, constitutes disempowerment and a hindrance to development.
Equity, being grounded on some theory of justice, is a more fundamental concern than equality, which is an empirical observation. One pays attention to equality from the perspective of a certain equity concern.

2.1 **Early childhood malnutrition**

The general nutritional level of a population is primarily a socioeconomic matter that permits high or low access to adequate amounts of food (the "gradient" perspective). This is especially prominent among poor subsections of a population, whether defined in economic, ethnic, occupational, or geographic terms. When there is a defined, deprived subgroup, it is by definition somewhat homogeneous, particularly in its subnormal health and nutritional status. Nevertheless, some members of the group may be clearly in good health and nutritional status (the "deviance" perspective).

The Positive Deviance (PD) Inquiry is a methodology for doing nutrition surveys among deprived population subgroups of homogeneous socioeconomic status so as to identify those families in which a young child (between age six months and five years) exhibits a better than average physical condition (height and/or weight). These families are labeled as "Positive Deviants" from the undernutrition that prevails in those population subgroups. They are then observed and studied to uncover any practices related to food sources, storage, preparation, consumption, and content. The information would be used in designing food supplementation or other nutritional promotion in the population at large on the assumption that the observed "favorable" practices, although atypical, are feasible and culturally acceptable because they are indigenously rather than extraneously derived.

The usual approach for establishing a food supplementation program in a community is to assess the nature of the prevailing dietary deficit, identify the categories of persons most in need, and introduce the needed nutrients in whatever form and from whatever source is economically and logistically available. The PD approach is somewhat opposite. The objective is to identify the unusually well-nourished members of the community and find out how they have managed to be such "Positive Deviants". If successful in finding an answer, beneficial foodstuffs or food practices uncovered would be introduced to the rest of the community. Those would be more likely to be feasible and culturally acceptable because they already exist in the community, and not derived from outside.

PD approach intervention in Vietnam[5]

In December 1991, Jerry Sternin arrived in Vietnam, accompanied by his wife, Monique, to take up the role of Save the Children US Country Director. The country had seriously high levels of child malnutrition, affecting 65 per cent of all under fives. Supplementary feeding programs delivered by international agencies were expensive and the benefits were seldom sustained beyond their lifetime. He had six months to demonstrate impact, or his visa would not be renewed.

5 This section draws on Green (2013) and Mackintosh *et al.* (2002).

Sternin remembered a Tufts University colleague, Marian Zeitlin, who was supported by UNICEF and WHO to examine the phenomenon of "positive deviance": the off-the-chart performance— in health, growth, and development—of certain children in a community compared with others. The Sternins used the principles of positive deviance as the basis for their approach. Monique Sternin told that one of their key goals was to make the positive deviance approach operational, with the community taking the lead, referring to Zeitlin's work for scientific justification.

After numerous negotiations, the Sternins finally obtained a mandate to work in four rural communities with 2,000 under-three year olds, 63 per cent of whom were malnourished. The Sternins told the heads of the major village committees that the approach was going to be about finding solutions that were already in the community, which would have to take responsibility for their identification and application. To their considerable surprise, the villagers were very keen on the idea. They had previously experienced only short-term aid projects after which they had watched their children's health gains deteriorate again. This sounded different and more beneficial.

After the children were weighed and ranked according to their family's economic status, volunteer groups then identified the positive deviants. The guiding question was: 'Is it possible for a child to be very poor and still well fed?' And the answer was 'yes.' And it turned out that much of what was being done differently in the positive deviant families was tacit and unconscious: the individuals in question weren't even aware they were doing anything different.

Teams of volunteers undertook observations in their homes and found some intriguing things, some of which were common to all the positive deviant families. The two standout practices related to the content of the diet and the way food was administered. In every positive deviant family, the mother or father was collecting a number of tiny shrimps, crabs, or snails—making for a portion 'the size of one joint of one finger'—from the rice paddies and adding these to the child's diet. Although readily available and free for the taking, the conventional wisdom held these foods to be inappropriate, or even dangerous, for young children.

Families also varied the frequency and method of feeding. Other families fed young children only twice a day, before parents headed to the rice fields early in the morning and in the late afternoon after returning from a working day. Because these children had small stomachs, they could only eat a small amount of the available food at each sitting. The positive deviant families, however, instructed the home babysitter (an older sibling, a grandparent, or a neighbor) to feed the child regularly, four or even five times a day. Using exactly the same amount of rice, their children were getting twice the amount of calories as their neighbors who had access to exactly the same resource. Other key factors included atypically high levels of hand hygiene in positive deviant families.

At this point, the Sternins decided the key would be to give community members the opportunity to share and learn directly from each other, with a focus on fostering and facilitating the exchange of practices. At its core, this meant turning a conventional approach to behavioral change—that of Knowledge–Attitude–Practice (KAP)—on its head reversing the process, to work on Practice–Attitude–Knowledge (PAK). 'You start by enabling people to change their practice, which then changes their attitude, and ultimately they internalize new knowledge.' This beguilingly simple idea would become the basis of the positive deviance mantra, and go on to inform thousands of applications around the world over the next two decades: 'It's easier to act your way into a new way of thinking than to think your way into a new way of acting.'

The progress was shared on a board in the town hall, and the charts quickly became a focus of attention and buzz. A few short weeks later, district health staff assessed progress to date. The findings were remarkable: some 40 per cent of the children had already been fully rehabilitated, and a further 20 per cent were well on the way. Granted another six-month visa for their efforts, the Sternins continued their work. By the end of the first year, half the children had participated and 80 per cent were rehabilitated.

The model was taken on and applied by the Vietnamese National Institute of Nutrition, and after this by the government, which scaled it nationally. Over time, the positive deviance approach saw a sustained reduction in malnutrition rates of 65–80 per cent, and reached a population of 2.2 million in Vietnam. As of 2009, the PD approach had been applied to tackle malnutrition in 41 countries.

Save the Children's (SC) program in Viet Nam using PD approach over the first half of the 1990s produced improvements that were sustained after SC's departure. Cross-sectional surveys were administered to 46 randomly selected households in four communes that had previously participated in the program and 25 households in a neighboring comparison community in 1998 and 1999. Two children per household, an older child who had participated in the program and a younger sibling who had not, were measured (total n =142 children), and their mothers were interviewed. Older SC children tended to be better nourished than their counterparts. Their younger siblings were significantly better nourished than those in the comparison group. SC mothers reported feeding the younger siblings more than their counterparts did and washing their hands "often" more than comparison mothers. Growth-promoting behaviors identified through PD studies and practiced through neighborhood-based rehabilitation sessions persisted years after program completion. These sustained behaviors contributed to better growth of younger siblings never exposed to the program.

PD approach intervention in Indonesia[6]

During 2003-2008, USAID funded five international NGOs to implement "PD/Hearth," called *pos gizi* in Indonesia, as a part of food security programs. Here "PD" refers to the nature of the inquiry for the identification of superior performers and their behaviors, while "Hearth " to group sessions for trying out those behaviors thus identified. The PD/Hearth methodology had been introduced to Indonesia earlier and was concurrently being implemented by various other NGOs, but this was the first relatively large-scale effort. All five NGOs --- CARE, Catholic Relief Services (CRS), Mercy Corps (MC), Save the Children US (SC), and World Vision International (WVI) --- standardized their basic implementation and monitoring systems, making it possible to assess the efficacy of the methodology in ameliorating child malnutrition in various contexts in Indonesia and thus to draw lessons from their collective experiences that would be useful to the government or others who wish to expand use of PD/Hearth.

The overall results of the assessment showed the potential for application of PD/Hearth as a components of the MOH nutrition strategy, which was then shifting to a behavior change approach from a traditional food-based approach. PD/Hearth would serve well as one component of the MOH strategy, particularly to improve infant and young child feeding practices among families who already had malnourished children less than two years of age.

Of the nearly 5,000 children who participated and on whom there were records for another weighing at one month, 45% gained 400 grams or more in one month, which was one of the accepted international standards for graduation for the program. The District Health Offices and NGOs all had about the same rate of success. This showed the potential for PD/Hearth, with some improvements in implementation, to substantially contribute to reducing malnutrition in Indonesia.

The NGOs were particularly successful in raising awareness of community officials about malnutrition and motivating them to make concrete contributions. They used PD/Hearth as a means of strengthening the knowledge and skills of the *kader*s to improve the *posandus*, which are the basic unit of health and nutrition service delivery at the community level. They wanted the PD/Hearth experience to serve to shift the health center (*puskesmas)* staff members from a supplemental food-based mentality to promoting behavior changes to prevent malnutrition. They succeeded in assisting *puskesmas* staff and *kader*s to become actively involved and to take on additional responsibility, and in building their capacity to address malnutrition from a behavioral perspective.

The assessment offered a number of conjectures on what factors made PD/Hearth most effective. These included:
- level of community participation,
- level of volunteers' (*kader*s') understanding of the key concepts,
- level of support they received from the NGO or health center (*puskesmas*),
- frequency of home visits to the participating families, and
- quality of the menus.

At the same time, it also identified some aspects of implementation to be improved in order to further enhance the effectiveness of PD/Hearth. Two stood out:
- Volunteers(*Kader*s) needed to learn to help mothers discover strategies for changing behaviors and not just give them information on best practices.
- De-worming all children prior to enrollment and providing a thorough health check-up would improve weight gain. Detection and treatment of children with tuberculosis was critical.

The first of the two points above referred to an important characteristic of interventions aimed at promoting behavior change: for behavior changes to be effective in producing results and be sustained, what is required is not merely learning to imitate what others do but acquiring an attitude and skills for exploring for better alternatives. Such type of change could only be realized through close relationships with the mothers in the provision of "practice"-type facilitative services on the part of the Volunteers(*Kader*s). This casts doubt to the efficacy of applying a standardized, bureaucratic "program" approach to the replication and scaling-up of the PD/Hearth methodology.

The second of the two points above relates to the need for coordination between different sectoral interventions. Whether sensible ideas for coordination could be translated into changes in regulatory and procedural routines in bureaucratic reality is never a sure thing.

2.2 Sanitation and hygiene

UNICEF + Government + Local actors for Community Led Total Sanitation (CLTS)[7]

Inadequate sanitation and hygiene remain significant problems in the East Asia and Pacific region, with several countries having fallen short of their MDG sanitation targets. SDG6 on Water and Sanitation does not specifically mention children. Insofar as sanitation and hygiene are significant factors in infant and child mortality and morbidity, however, there is need to pay attention to their consequences in health and development of children. Here we will review the experiences of Community Led Total

6 This section draws on McNulty and Pambudi (n.d.)

7 This section draws on UNICEF/EAPRO (2016).

Sanitation (CLTS) promoted by UNICEF. CLTS is an approach used by 7 countries in Southeast Asia (Viet Nam, Lao PDR, Cambodia, Myanmar, the Philippines, Indonesia, Timor-Leste). CLTS plays an important role in achieving reduction in open defecation and the uptake of sanitation in the region, but accurately quantifying that contribution is difficult. Indonesia has a functioning monitoring system and it is estimated that the 3,140 villages that achieved open defecation free (ODF) status between 2012 and 2015, using CLTS as part of a broader government rural sanitation program. CLTS contributes to village-wide sanitation coverage, which, from a growing number of studies, contributes to the protection against "*environmental enteropathy"* or "leaky gut syndrome" among young children. Environmental enteropathy appears to be a significant cause of infant and child malnutrition – far more serious than diarrhea. CLTS is a particularly appropriate sanitation approach because it aims for village-wide elimination of open defecation – a requirement for combating environmental enteropathy.

Government support has been notable in some countries. Here we look at the cases of Indonesia and Vietnam.

- Indonesia has incorporated CLTS as government program and has initiated it in 25,000 communities. The 2008 National Strategy for Community-Led Total Sanitation (STBM strategy) provided a definition for an improved latrine – an effective sanitary facility to break the transmission of disease – and stated that subsidies should not be provided for household sanitary facilities. The 2010-2014 National Mid-Term Development Plan (RPJM-N) set the target of 100 % ODF villages nationally by 2014. The current RPJMN-3 2015-2019 has the goal of universal access by 2019, however the interpretation of this is unclear.

- In Viet Nam, Rural Water Supply and Sanitation National Target Program III Phase 2012-2015 Decision 366 described toilets as a household responsibility. The program focus was on sanitation targets, particularly household latrines with priority to low-cost models and preferential credit to improve the access of the poor, and sanitation promotion for behavior change. The MoH 2013 National Guideline for Planning and Implementation on Rural Sanitation included "creation of collective demand for rural sanitation, using community approaches such as CLTS." The targets set were 85 per cent of hygienic toilets by 2020, with the draft five year sanitation plan 2016-2020 including annual targets and roadmaps for ODF by 2025.

It has long been confirmed that the quality of facilitators is one of the critical factors in delivering effective triggering as a precursor to sustainable sanitation. In this connection it is important to assure the consistency and quality of facilitator training, and whether training is institutionalized or even professionalized, including the quality control of the triggering by facilitators. Across the 12 countries implementing CLTS, there exists a full spectrum of facilitator 'quality'. Even in those countries with standardized training, on the job monitoring and follow-up receive the least attention.

- Indonesia has been institutionalizing facilitator skill development since 2013 through the MoH with support from the World Bank, and its approach is somewhat of a model for other countries to consider. Institutionalization of capacity building of STBM human resources has three distinct target groups: (i) current STBM implementers (in-service); (ii) environmental health students at health polytechnic schools who will be future sanitarians (pre-service); and (iii) those interested in STBM and other members of the general public as a secondary audience. To reach these target groups, three instruments were developed: (i) accredited training for STBM implementers; (ii) integrating STBM into environmental health curriculums at health polytechnics; and (iii) e-learning for both groups and for the general public. Distance learning aims to increase the outreach of learning opportunities and resolve geographical and financial challenges around face-to-face training. Indonesia has standardized and accredited its curricula and modules to not only improve the quality of delivery but also to motivate trainees through formal recognition, as well as linking the completion of training to the MoH incentive system for career development opportunities for civil servants and enhanced training opportunities for non-civil servants.

- In Vietnam, a standard CLTS training manual and supporting materials have been developed by MoH and is used by implementers for training. The College of Agriculture and Rural Development is a center for CLTS master training and a database of CLTS master trainers is maintained.

Local actors are importantly involved in all stages of the CLTS process. Their roles range from influencing, empowering, supporting, helping, monitoring, following up and reporting on CLTS activities in a community. They are indispensable aides to the facilitator and field staff, and can follow up after triggering and keep the community on track after the facilitator has departed. Key local actors are village leaders, teachers, women (including women's associations and unions), youth, medical staff, and religious leaders (Christian, Islam, Buddhist). Experiences show that local actors should be brought into the CLTS process as early as possible – from first triggering, if not before. They should be invited to actively participate in triggering sessions. The benefit from involving local actors is that they can directly influence village plans, but also influence behavior change through their regular interactions with the community.

Private business initiative and partnership for a sustainable BOP business model in toilet systems[8]

A growing number of companies are turning their attention to low-income or "bottom of the pyramid" consumers in developing countries. With their extensive knowledge and skills, these companies seek innovative and inexpensive solutions for societies that lack access to sanitation, water, education and technology. LIXIL, a Japan-based internationally renowned manufacturer of water and sanitation facilities, with annual sales of more than $15 billion and more than 80,000 employees around the globe, is one of them.

A member of the Global Compact Japan Network, LIXIL is committed to promoting and enabling access to safe and hygienic sanitation practices, especially for women and girls, while preventing the harmful transmission of diseases for children. LIXIL has pledged to provide better sanitation to 100 million people by 2020. In addition to committing its own substantial corporate resources to this goal, the company is at the forefront of public-private partnership, teaming with such organizations as UNICEF, the Japan International Cooperation Agency (JICA) and WaterAid. It is also a member of the Toilet Board Coalition, a wide-ranging global alliance that aims to develop sustainable, scalable measures to tackle the problem of inadequate water and sanitation around the world and achieve universal access to sanitation by 2030. LIXIL is at the forefront of addressing this pressing global problem in the pursuit of a number of product lines.

Through their common membership in the Toilet Board Coalition, the leadership at both LIXIL and the Water and Sanitation for the Urban Poor (WSUP) network realized that they shared a common vision and had complementary needs and assets. WSUP is a multi-sector partnership between leading names in both for-profit and not-for-profit sectors, such as Unilever, Care, and WaterAid, with mission of extending access to clean water and sanitation services to poor urban communities in financially and environmentally sustainable ways. WSUP had good relations with project donors and access to low income markets but needed a well-designed portable toilet for residents of informal settlements; LIXIL had technical and technological expertise on toilet design and was looking for opportunities to innovate and explore new markets. WSUP raised and provided the grant funding for implementing the joint pilot project in Ghana.

One solution that has already been commercialized is the affordable plastic SATO (Safe Toilet) series. First developed with the support of the Bill & Melinda Gates Foundation, SATO products are designed to cover open pit latrines and feature a counterweighted trapdoor that allows waste to flow through, while sealing shut to keep out flies, other insects and odors. This helps prevent the spread of disease, as well as improve both the safety and user experience of open pit latrines. Widely known as frugal innovation, the adopted design approach aims at searching for affordable, simple and sustainable solutions. During dozens of iterations, the core team of 10 people experimented with the shape of the trapdoor and the flush mechanism. They analyzed computational fluid dynamics to ensure good water flow. Many prototypes later, the SATO was successfully field-tested in Bangladesh in late 2012. In 2015, SATO won a "Patents for Humanity" award from the U.S. Department of Commerce.

LIXIL has been scaling up its SATO business and fast-tracking commercial sales at a viable price point for low-income consumers, through licensing arrangements with local businesses for manufacturing and distribution in developing countries. In 2016 it received a third grant from the Bill & Melinda Gates Foundation to support this acceleration. As of March 2017, more than 1.2 million SATO units have been installed in over 14 countries, including Bangladesh, India, Nepal, Indonesia and the Philippines, improving sanitation for 6 million people. Of these, some 500,000 SATO toilets were donated to NGOs for installation in homes and schools in Bangladesh, and another 300,000 have been sold in Bangladesh for as little as $2 each.

2.3 "Nurturing care"

From conception to five years of age, early childhood is an extremely important period for cognitive and psychosocial development. Children's high levels of brain plasticity and neurogenesis make them especially receptive to external stimuli. Young children's minds are still learning how to learn, and simple play activities that stimulate the brain through all the senses can help improve their ability to think, communicate, and connect with others. Research from around the world suggests that guaranteeing such early childhood stimulation is critical.

Children in developing countries may have the most to gain from interventions that promote early childhood stimulation. Poverty can limit parents' ability to spend time and money to play with, feed, and educate their children, resulting in a less stimulating home environment. Children in poor households may thus start life at a disadvantage and can fall further behind their more advantaged peers throughout life. Millions of children under the age of five are at risk of not reaching their full developmental potential, with most living in extreme poverty.

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8 This section draws on Acumen and Skoll Centre for Social Entrepreneurship (2016), information in the web site of LIXIL Corporation at http://www.lixil.com/en/stories/stories_02/ (updated 161213, accessed 171012) and http://www.lixil.com/en/sustainability/activities/sanitation.html (accessed 171012), and private communications with Mr. Kensuke Tomita, Managing Director, LIXIL Group Corporation (171010 and 171016).

The 2016 *Lancet* Early Childhood Development Series[9]

The 2016 *Lancet* Early Childhood Development Series highlighted early childhood development (ECD) at a time when it had been universally endorsed in the 2030 Sustainable Development Goals (SDGs). This Series considered new scientific evidence for interventions, building on the findings and recommendations of previous *Lancet* Series on child development (2007, 2011), and proposed pathways for implementation of ECD at scale. The Series emphasized 'nurturing care,' especially of children below three years of age, — care which ensures health, nutrition, responsive caregiving, safety and security, and early learning."

Main messages included the following:

- The burden and cost of inaction is high. A staggering 43 percent of children under five years of age—an estimated 250 million—living in low- and middle-income countries are at risk of suboptimal development due to poverty and malnutrition. The burden is currently underestimated because risks to health and wellbeing go beyond these two factors. A poor start in life can lead to poor health, nutrition, and inadequate learning, resulting in low adult earnings as well as social tensions. Negative consequences impact not only present but also future generations. Because of this poor start, affected individuals are estimated to suffer a loss of about a quarter of average adult income per year while countries may forfeit up to twice their current GDP expenditures on health and education.

- Young children need nurturing care from the start. Development begins at conception. Scientific evidence indicates that early childhood is not only a period of special sensitivity to risk factors, but also a critical time when the benefits of early interventions are amplified and the negative effects of risk can be reduced. The most formative experiences of young children come from nurturing care received from parents, other family members, caregivers, and community-based services. Nurturing Care is characterized by a stable environment that promotes children's health and nutrition, protects children from threats, and gives them opportunities for early learning, through affectionate interactions and relationships. Benefits of such care are life-long, and include improved health, wellbeing, and ability to learn and earn. Families need support to provide nurturing care for young children, including material and financial resources, national policies such as paid parental leave, and provision of population-based services in a range of sectors, including health, nutrition, education, and child and social protection.

- Interventions—including support for families to provide nurturing care and solving difficulties when they occur—target multiple risks to development, and can be integrated into existing maternal and child health services. Services should be two-pronged, considering the needs of the child as well as the primary caregiver, and include both care for child development as well as maternal and family health and wellbeing. Essential in this context are nutrition, to support growth and health; child protection, for violence prevention and family support; social protection, for family financial stability and capacity to access services; and education, for quality early learning opportunities.

- It is possible to scale up projects to nationwide programs that are effective and sustainable, as indicated by country case studies in diverse world regions. However, government leadership and political prioritization are prerequisites. Governments may choose different pathways for achieving ECD goals and targets, from introducing transformative government-wide initiatives to progressively enhancing existing services. Services and interventions to support ECD are essential to ensuring that everyone reaches their potential over the life course and into the next generation—the vision that is core to SDGs.

Intervention Study in Jamaica[10]

UNICEF estimates that approximately seventy countries have implemented early childhood development programs. These interventions vary substantially in design, effectiveness, cost, and scalability. A growing body of randomized evaluations has rigorously evaluated stimulation and nutrition interventions, and tested their separate and combined impacts. One study, in particular, provides actionable lessons for early childhood stimulation programs. Long-term findings from a small and carefully designed intervention in Jamaica provided a proof of effectiveness of this approach.

In the mid-1980s, in low-income neighborhoods in Kingston, Jamaica, researchers conducted a house-to-house census and recruited all identified stunted children. Stunting is an easily observed valid indicator of chronic malnutrition, which is strongly associated with significant and persistent cognitive, socioemotional, and behavioral issues. In total, 129 stunted children aged 9–24 months were selected as program participants. The participants were randomly assigned to one of four groups:

- Stimulation intervention only
- Nutrition intervention only
- Combination of stimulation and nutrition interventions
- No intervention (control group)

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[9] Lancet (2016) "Advancing Early Childhood Development: from Science to Scale" *The Lancet* (October 4, 2016) Available at http://www.thelancet.com/series/ECD2016 (accessed 170825)

[10] This section draws on Gertler *et al.*(2014), Grantham-McGregor and Smith (2016), and J-PAL Policy Bulletin (2016)

This design allowed researchers to gauge the relative and combined effects of stimulation and nutrition interventions on early childhood development.

The intervened households received weekly one-hour home visits by trained health aides over a two year period. During these visits, health aides conducted play demonstrations with low-cost or homemade toys and practiced language learning with books and songs, while interacting directly with both mothers and children and delivering positive feedback to mothers throughout the sessions. To encourage mothers to engage with their children between visits, they also left toys and books behind, exchanging them weekly with new ones. Households that received the nutrition intervention were given one kilogram of baby formula per week.

The research team followed participants through their lives, conducting surveys at the time children were initially enrolled in the study, at the end of the intervention (ages 33–48 months) and follow-up rounds at average sample ages of 7, 11, 17, and 22 years. In these follow-up studies, researchers measured additional outcomes such as academic achievement and labor force participation. A sample of non-stunted children identified in the initial house-to-house census was also included in the Jamaica study to measure whether stunted children in the intervention groups "caught up" to their non-stunted counterparts (comparison group).

The research results show that early childhood stimulation had large and lasting impacts on the cognitive ability and socioemotional development of children, and ultimately contributed to improved academic and employment outcomes. Some of the salient findings are as follows:

- Weekly home visits promoting psychosocial stimulation changed the way parents interacted with their children and shaped their home environments.
- Children exhibited, on average, immediate and sustained increase in cognitive ability.
- Children in the stimulation group improved their reading abilities, were half as likely to drop out, and ultimately attended more years of school.
- As they entered into full-time jobs, 22-year-old stimulation group members earned around 25 percent more than those in the comparison group.
- Psychosocial stimulation may result in less depression and social inhibition up to 20 years later in participants' lives.

It is interesting to note that the nutrition intervention alone showed no long-term effects on any measured outcomes including employment and earnings. And, there were no statistically significant differences in effects between the stimulation-only and stimulation-nutrition groups, although the latter group had somewhat stronger outcomes.[11] Findings in this study point to the importance of "nurturing care" --- psychosocial stimulation and parental engagement --- in human development in early childhood and beyond..

2.4 Agency development for high-risk young mothers

It is oftentimes necessary to provide service for agency development of (potential) service users as a preparatory stage for social services to produce desired outcomes. Those preparatory services are typically in the nature of "counselling" or "pre-counselling (outreach)." Either way they are essentially "practice"-type services involving high degrees of transaction intensity and discretion on the parts of both providers and users. Here we review the experiences of two of the most systematic interventions of this nature.

Nurse-Family Partnership[12]

The Nurse-Family Partnership (NFP) program constitutes an important case of agency development and self-management on the part of service users. The program was developed in the United States, where it has been rigorously tested over the course of 35 years

In NFP, trained nurses visit first-time young mothers 64 times over a 30-month period covering six months of pregnancy before the birth of a child and the first two years of the child's life. The program focuses on low-income, first-time mothers—a vulnerable population segment that sometimes has limited access to good parenting information or role-models. When a young woman becomes pregnant before she is ready to take care of a child, the risk factors for the entire family escalate—often resulting in dysfunctional family life. The transition to motherhood can be particularly challenging for many low-income, first-time mothers. Many are socially isolated or are experiencing severe adversity. An early intervention during pregnancy will allow for any critical behavioral changes needed to improve the health and welfare of the mother and child.

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11 The nutrition supplement for the child was often shared with the family, so it may not have been sufficient to produce better outcomes. Other studies have shown cognitive benefits from nutritional supplementation in the first 24 months. This section draws on Gertler et al.(2014), Grantham-McGregor and Smith (2016), and J-PAL Policy Bulletin (2016).

12 This section draws on information provided on the homepage of the Nurse-Family Partnership (NFP). http://www.nursefamilypartnership.org/ (accessed 141104).

The NFP program is informed by the following four philosophical standpoints:

- **Client-Centered**: the nurse is constantly adapting to ensure the visit and materials are relevant and valued by the parent. The goals and aspirations of the nurse and family are aligned and a sense of responsibility is established in the client with clear structure and understanding of what the program entails.

- **Relational**: the relationship between the nurse and the client is the fundamental basis for learning and growth in each family served, with intimacy and continuity building trust. The nurse provides care and guidance for mothers and family members to deal with stress and anxiety.

- **Strengths-Based**: the intervention is based on an adult learning and behavior change theory. Adults and adolescents make changes most successfully when they are building on their own knowledge, strengths and successes. Building on the person's strengths and previous successes leads to improved self-efficacy

- **Multi-Dimensional** : the life of each program participant is viewed holistically, and what the program offers is tied to multiple aspects of personal and family functioning: personal and environmental health, parenting, life course development, relationships with family and friends, and community connections

In accordance with the above-mentioned philosophical perspectives, the NFP model is expressed in 18 elements of principles and operational guidelines. Among them the following are of particular interest (underlines added):

- Client participates voluntarily in the Nurse-Family Partnership program (Element 1).
- Client is visited one-to-one, one nurse home visitor to one first-time mother or family (Element 5).
- Client is visited in her home (Element 6).
- Nurse home visitors, using professional knowledge, judgment, and skill, apply the Nurse-Family Partnership visit guidelines, individualizing them to the strengths and challenges of each family and apportioning time across defined program domains (Element 10).
- Nurse home visitors apply the theoretical framework that underpins the program, emphasizing self-efficacy, human ecology, and attachment theories, through current clinical methods (Element 11).
- A full-time nurse home visitor carries a caseload of no more than 25 active clients (Element 12).
- A full-time nurse supervisor provides supervision to no more than eight individual nurse home visitors (Element 13).
- Nurse supervisors provide nurse home visitors clinical supervision with reflection, demonstrate integration of the theories, and facilitate professional development essential to the nurse home visitor role through specific supervisory activities including one-to-one clinical supervision, case conferences, team meetings, and field supervision (Element 14).

NFP is designed to achieve the following three goals by means of home-visitor nurses offering a combination of technical advice and practical support (on breastfeeding, child development and childhood illnesses), coaching in life skills, and addressing psychological issues:

- Improve pregnancy outcomes by helping mothers engage in good preventive health and prenatal practices, including getting appropriate prenatal care from healthcare providers, improving their diet, and reducing their use of cigarettes, alcohol, and illegal substances. Nurses also help the mother prepare emotionally for the arrival of the baby by educating her on the birth process and the immediate challenges of the first few weeks after delivery (e.g., breastfeeding and potential postpartum depression).
- Improve child health and development by providing individualized parent education and coaching aimed at increasing awareness of specific child development milestones and behaviors, and encouraging parents to use praise and other nonviolent techniques.
- Improve the economic self-sufficiency of the family through life coaching, i.e., helping parents develop a vision for their own future, plan future pregnancies, continue their education, and find work

Effectiveness of the NFP interventions is rigorously demonstrated[13]. Three well-conducted randomized controlled trials were carried out, each in a different population and setting. The specific effects that were replicated, with no countervailing findings, in two or more of the trials – and thus are the most likely to be reproducible in a program replication – are: (i) reduction in measures of child abuse and neglect (including injuries and accidents); (ii) reduction in mothers' subsequent births during their late teens and early twenties; (iii) reduction in prenatal smoking among mothers who smoked at the start of the study; and (iv) improvement in cognitive and/or academic outcomes for children born to mothers with low psychological resources (i.e., intelligence, mental health, self-confidence). It is important to recall that the three trials all found the program to produce sizable, sustained effects on important mother and child outcomes, which provides confidence that this program would be effective if faithfully replicated in other, similar populations and settings.

[13] The Top Tier Initiative's Expert Panel has identified NFP intervention as *Top Tier*, meeting the Congressional Top Tier Evidence standard, defined as: *Interventions shown in well-designed and implemented randomized controlled trials, preferably conducted in typical community settings, to produce sizable, sustained benefits to participants and/or society.* See Coalition for Evidence Based Policy homepage. http://toptierevidence.org/programs-reviewed/interventions-for-children-age-0-6/nurse-family-partnership (accessed140924).

Agency development in NFP

First of all, it is important to recall that the Nurse-Family Partnership (NFP) program is designed to have sufficient intensity and duration (64 visits over a 30-month period) for a trustful, committed relationship to be formed between the nurse and the mother. Another important consideration is the level of workload for nurses (no more than 25 active clients) and for supervisors (no more than eight individual nurse home visitors). These stipulations help secure sufficient intensity of interactions between the nurse and the mother and between the supervisor and the nurse.

It is interesting to note that the impact of the program was more pronounced among children born to mothers with limited psychological resources to manage well the care of their children while living in concentrated social disadvantage (limited psychological resources manifest themselves in higher levels of depression, anxiety, and lower levels of intellectual functioning and sense of mastery over their lives). This was demonstrated in lower incidence of injuries and in higher school readiness (i.e., better language development and ability to control impulses) compared with their control-group counterparts. In contrast, there were no benefits of the program for these types of outcomes among children born to mothers with relatively high psychological resources (those with greater wherewithal to manage caring for their children while living in poverty). This contrast seems to imply the existence of a certain threshold level in the mother's psychological resources needed to attain sufficient level of agency and to exercise self-control and provide adequate care to their children.

To achieve the third goal of the program, i.e., to improve the economic self-sufficiency of the family, nurses offer life coaching, helping mothers develop a vision for their own future, plan future pregnancies, continue their education, and find work. While working with their nurse home visitor, many of the young mothers in the Nurse-Family Partnership program set goals for themselves for the very first time. Research shows that NFP does, indeed, improve maternal life course. Apparently, nurses help the mother to feel empowered to make sound choices about education, workplace participation, partner relationships, and the timing of subsequent pregnancies that enable her to take better care of herself and her child.

Based on these pieces of evidence, it may be reasonable to conclude that the NFP program has succeeded in the augmentation of agency among participating young mothers with particularly significant impacts on those of them with less favorable initial conditions. As stated as Element 1 in Section 3.2, the NFP program works with mothers who voluntarily participate. To that extent it presupposes clients' agency to engage. The nature of user-provider relations is a combination of consulting and counseling, initially relatively more in the nature of counseling and subsequently and gradually relative importance of consulting increasing over the course of the program. This represents a cumulative process of activation and development of agency on the part of the client, with disposition and capacity for self-determination and self-management strengthened through repeated actions and continued support.

Chile Solidario[14]

The *Chile Solidario* (CHS) program consists of four components:

1. An intensive phase of psycho-social support (Puente Program) implemented through the outreach activities by a local social worker to homes of target families. During these visits, the social worker works with the family to identify its main problems, and the steps they need to take to solve them; raise awareness of available social services and stimulate their uptake. It lasts for 24 months, with decreasing intensity, conducting 21 sessions on average. The multidimensional aspect of deprivation is operationalized in terms of defining a set of minimal critical conditions, which aim at measuring a minimally acceptable level of well-being along different dimensions (identification/legal documentation, family dynamics, education, health, housing, employment, and income). Each family signs a contract with the social worker as indication of its commitment to put its effort in meeting those unmet priority conditions. The essence of this contract lies in the understanding of mutual obligations: the government takes responsibility for supplying services and resources and that the family commits to overcome problematic aspects of their lives, using the opportunities offered by the government.

2. Cash transfer conditional on the family meeting the contract (in principle; in practice, given to every family).The transfer lasts for 24 months and amount declines over time. The transfer is uniform across families, and it is meant to be a compensation for the transaction costs that households incur when connecting to the supply side of services within its municipality (learning about eligibility and program rules of various programs and the processing costs associated with the application process).

3. Guaranteed Subsidies. Families are guaranteed all subsidies they are entitled to. Until September 2004, families applying for subsidies through CHS were allocated to vacancies assigned to the municipality, competing with non-CHS families. Over time, the constraint on the vacancies on these cash subsidies has been relaxed, so that all eligible families that apply for the subsidy are automatically enrolled as recipients.

4. Preferential access to social services. Even with a given local supply of services, the program has made them available to the CHS population with preferential access, in the sense of providing priority access to the existing supply, should they chose to activate their demand for the services. The concept of preferential access is crucial in the logic of the program, as the target population is made 'visible' to the local municipalities. The supply side component aims at ensuring coordination among different

[14] This section draws heavily on Carneiro *et al.* (2009)

social programs and public services at the national and municipal level. Public programs and services were previously available for eligible households only upon demand. CHS works directly with municipalities, which are the local providers of public services, and with national programs to make sure that the supply side is adequately organized to attend the needs of specific target populations and meet the newly identified demand. These supply-side efforts aim at making sure that the services are pertinent to the needs of these families, which could go as far as inducing changes in design, outreach strategies, or even the organization of new types of programs.

The main result of the CHS program is that the program increased the uptake of subsidies and of the employment programs. The main channel driving significant effects in employment, income, and indigence comes from the activation of the labor force of the spouse in bi-parental families. This result is noteworthy in a country with an exceptionally low female labor force participation. The spouse employment effects (and with them the income and poverty alleviation effects) are concentrated among rural households, and in families with lower educational attainment of the head. There is suggestive evidence that the same subgroups which have received the employment programs are more likely to show a positive employment effect.

Families established access to the public service system and received public services assisted and supported by the social workers. Insofar as the experience of dealing with officials and receiving responses is positive, families will be motivated to repeat the service transactions. This will be particularly the case when they perceive that they receive preferential treatment from the government.

The impacts of CHS vary across families with different characteristics and located in different municipalities. For example, the impact of the program on the uptake of subsidies is larger in municipalities with a better network of social services, for families served by social workers with relatively low caseloads, and in male-headed families. Similarly, the impact of the program on employment of the spouse is larger in rural areas and for families served by social workers with relatively low caseload. Social workers are instrumental in bringing families into contact with public services. Their roles involve not only provision of information but psychological support through encouragement and accompaniment (Carneiro et al. 2009, 82).

Agency development in CHS

Intervention by social workers in the Chile Solidario (CHS) program consists of "counseling" (psycho-social support through accompaniment and encouragement) and "consulting" (technical support through education and advice), both tailored to the conditions of the families. The counseling function addresses psychological matters related to perceptions, feelings and emotions such as self-esteem, self-control, self-efficacy and motivation for achievement. The central task is to promote and develop positive elements in perceptions, feelings and emotions and enhance expectations for positive change in life (MIDEPLAN 2009a 18).

As stated in Section 3.2, the central objective of the Puente Program is to initiate and promote a process of empowerment of target families with an adult education approach. The learning on the part of families is geared to the acquisition of capacity for self-management and autonomous resolution of problems, encompassing such competencies as recognition of opportunities, management and resolution of problems, determination of alternative courses of actions, establishment and utilization of relationships with providers of services. Such learning during the program is expected, as the program is completed in two years' time, to have enabled the formation of capacity to formulate projects and courses of action for their realization. In the Final Note at the time of the termination of the Puente Program, each participating family expresses their views and evaluations of their experiences with the program and also proposes a project for improvement of family life.

The central "empowerment" objective of the Puente Program is closely related to the task of rehabilitating sound personal relations within the family and reestablishing it as source of mutual support and positive contributor to the resolution of problems. This is clearly indicated in the Final Note of many of the families as indicated in the "area of most significant learning" during the program:

Of those who mentioned "Family" as the area of most significant learning, a half of them mentioned "self-respect and positive attitude" and a quarter "intra-family relations" as the most significant subcategory, far exceeding those mentioning learning of more technical nature such as "household management" and "development of abilities."

Area of most significant learning:

Family	52.5%
Institutions	31.8%
Community	4.4%
Others	11.4%

Source: MIDEPLAN (2009b), Grafico 2.1, p.71.

Subcategory of most significant learning under "Family":

Self-respect and positive attitude	50.4%
Intra-family relations	24.5%
Household management	12.0%
Development of abilities	8.0%
Development of values	8.0%

Source: MIDEPLAN (2009b), Tabla 2.1, p.73.

Some interviewees state that they recognize the importance of having developed better capacity to express and verbalize their emotions and that such capacity were enhanced during the conversations with social workers about events and difficulties. They say that such capacity not only contributes to the improvement of intra-family relations but also to increased sense of security, self-efficacy and positive attitude, contributing to the enhancement of agency.

Area of most significant functioning

Family	20.9 %	Work	6.5 %
Housing	14.9 %	Health	4.1 %
Income	14.1 %	Education	3.4 %
Positive attitude	10.5 %	Registration	1.4 %
Public services	8.8 %	Others	15.6 %

Note: In the table above "Income" refers to the receipt of cash transfer and subsidies, and newly acquired practice of saving.
Source: MIDEPLAN (2009b), Grafico 2.2, p.80

The process of changes in mentality and attitude on the part of family members is closely associated with the relationship established between them and the social worker. Such processes of personal change are closely intertwined with changes in intra-family relationships. The social worker works within the families to help them restore their basic socio-emotional capabilities, and foster behaviors conducive to improved family welfare and labor market success, and engage them in a process to identify a family strategy to exit extreme poverty. The critical role of social workers as change agent is to promote improvements in attitude and behavior toward each other within a family as basis for more positive and constructive attitude toward oneself and life in general (MIDEPLAN 2009b, 80 and Carneiro et al. 2009, 28-29).

Social workers are also instrumental in bringing families in contact with public services. This involved not only provision of information but psychological support through encouragement and accompaniment. (MIDEPLAN 2009b, 82) As stated above, families in the CHS program established access to the public service system and received public subsidies and services, accompanied, assisted and supported by social workers. Insofar as the experience of dealing with officials and receiving responses is positive, families will be motivated to repeat the service transactions. This will be particularly the case when they perceive that they receive preferential treatment from the government. Such positive experiences and perceptions ("not being left out" and "the state being concerned with the extreme poor like them") lead to increased sense of security and self-efficacy, in turn increasing agency and strengthening the motivation to engage with the public system.

As stated above, the impacts of the CHS vary across families with different characteristics and located in different municipalities. For example, the impact of the program on the uptake of subsidies is larger in municipalities with a better network of social services, for families served by social workers with relatively low caseloads, and in male-headed families. Similarly, the impact of the program on employment of the spouse is larger in rural areas and for families served by social workers with relatively low caseload. It seems that it takes sufficient intensity and duration of psychosocial support, only possible when workload of social workers are relatively low, for an increase in uptake of these services to take place. These findings on the workload of social workers seem to indicate a type of threshold in either technical advice (consulting) or psychosocial support (counseling), or possibly in both of them.

It seems that psychosocial support (counseling) is a necessary precondition for effectiveness of information and technical advice (consulting). The feeling of intimacy and affection between the family and the social worker is necessary for the family to be able to overcome insecurity and low self-esteem and acquire a positive outlook on life. This being the case, care is needed so that emotional attachment will not create psychological dependence and instead that the family strengthen their independent planning and managing capacities (MIDEPLAN 2009b, 88-89).

In this context, the requirement of the declaration of a project at the conclusion of the program serves as an important instrument to gauge the degree of self-determination and self-management capacity in the family. A project is to consist of goals set by the family and courses of action to realize them. These projects constitute the starting point for the trajectory of family life they make efforts to realize through a series of actions independent of the assistance of the social worker (MIDEPLAN 2009b, 90).

The degree of success in achieving self-determination and self-management capacity varies across families. There seems to have emerged contrasting patterns of virtuous and vicious circles. Virtuous and vicious circles involve three elements: the condition of family life, attitude toward government offices, and the relationship with the social worker (MIDEPLAN 2009b, 94).

We need to understand the variability in the degree of success at three stages --- i.e., pre-program, in-program and post-program. Families with relatively favorable initial psycho-social conditions benefited more from the program and prepared themselves for the realization of their life goals, while less favorably situated families benefited less from the program and failed to change outlook on their life prospects. In some cases of high attainment during the program, with increased sense of self-efficacy, self-confidence and optimism, goals set for the project reflect future-oriented aspirations in pursuit of higher standing in society---stable work, higher income, home ownership, and higher education for children. (MIDEPLAN 2009b, 111) By contrast, there are cases of virtually no attainment during the program among the families with unfavorable initial conditions, typically characterized by alcoholism, drug use, and domestic violence.

It has been found that there are variations in the performance of social workers: some of them made more frequent and longer visits than others. Those families visited by less attentive social workers tended to have poor results in learning, low utilization of the program offerings, and low evaluation of the program. Similar negative sentiments were generated when there were frequent changes in social workers, as families felt abandoned and insecure about their relationship with the program. They need to establish expectations of sustained benefits on the basis of correct understanding of the program if their connection with government offices should continue beyond the period of accompaniment and psycho-social support by social workers. For that to happen intimate and

trustful relationship with a social worker is indispensable, as family members need to feel safe in discussing most private family matters openly. (MIDEPLAN 2009b, 86-87)

It is to be remembered that, unlike in the Nurse-Family Partnership (NFP) program where nurses with a predetermined workload work with mothers who voluntarily participate, the Chile Solidario (CHS) is an outreach program with the policy design of covering all the eligible families. It seems that this situation has inevitably spawned difficult cases of the lack of preparedness on the part of families and the excessively demanding workload on the social workers.

Concluding remarks

The effectiveness and scalability of "practice"-type services needs to be examined against the realities of public services at question, from the viewpoints of transaction intensity and discretion on the parts of both providers and users of services, and also with the conjectures on service system failures in mind. These services entail high intensities of transactions thus demanding heavy use of psychic and cognitive resources from both sides of service transactions. Especially for service users, it involves qualitatively different role of taking charge of their own affairs in partnership with service providers and through self-management. To discharge such a role, they have to pay active attention, interact with others, and make decisions and act on them, all demanding individual efforts in the utilization of psychic and cognitive resources, or activation of agency, and causing psychic costs. As a matter of human nature, transaction intensity tends to bring about discretionary response toward averting such costs and thus avoiding the activation of agency. And, more often than not, there are existing competing demands on the use of these resources. This is and will likely remain a fundamental constraint on the scalability of preparatory services for the purpose of agency development. This recognition will carry a significant implication for the pledge of "leaving no one behind" and "reaching the furthest behind first."

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