Governing for Better Health
A Targeted Literature Review

May 2012
Prepared by the USAID Leadership, Management, and Governance Project

Inspired leadership, sound management, transparent governance
About the Leadership, Management, and Governance Project (LMG)

As the U.S. government enters a new era in international development through initiatives such as the Global Health Initiative and PEPFAR II, there is a strong emphasis on sustainability and country ownership within the health system strengthening framework. Development practitioners increasingly agree that improving the leadership, management and governance capacity of policy makers, health care providers, and program managers allows them to better implement quality health services, and meet local citizens’ health needs. Funded by USAID, the Leadership, Management and Governance Project (2011-2016) collaborates with health leaders at all levels to improve leadership, management and governance practices to create stronger health systems and improve health for all, including vulnerable populations worldwide.

The LMG Project seeks to do the following:

- Promote enhanced performance improvement processes driven by country leadership for individuals and teams through South-to-South dialogue and collaborative learning modules designed to increase organizational capacity
- Develop senior leadership and governance capabilities using participatory processes and gender-aware approaches that enable health leaders and policy-makers to address their own challenges, and achieve results
- Build and use evidence-based approaches by generating and disseminating evidence that shows how improved leadership, management, and governance contribute to health gains

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Acknowledgments

This report was prepared for the United States Agency for International Development (USAID) by the Leadership, Management, and Governance (LMG) Project. The LMG project team thanks the USAID Global Health Bureau, Office of Population and Reproductive Health for their generous support and technical guidance—in particular, Brenda Doe, the LMG project’s Agreement Officer’s Representative (AOR), for her constant encouragement and support.

Mahesh Shukla, MD, MPA, and Karen Johnson Lassner, MPH, MA, are the authors of this study. James A. Rice, PhD, reviewed the report, and Laura Lartigue, MIS, MA, edited the report. The authors wish to thank colleagues within the LMG project, as well as many staff members within the broader Management Sciences for Health (MSH) family—without their support the study and the report would not have been possible. Credit is also due to the LMG partners: African Medical and Research Foundation (AMREF), International Planned Parenthood Federation (IPPF), Johns Hopkins University (JHU), MedicMobile, and the Yale Global Health Institute (GHLI) for their contributions during different stages of the study.

Finally, the LMG Project team thanks the 500 leaders, managers, and those who govern in the health sector and within health institutions in low- and middle-income countries, all of whom spent substantial time in taking the survey or doing the key informant interviews that informed the organizing framework for this targeted literature review. We wish them success in their efforts toward strengthening health systems in their respective countries, regions, and jurisdictions, and we hope that this report will be useful to them as well as to others charged with carrying out similar responsibilities in resource-scarce and difficult-to-govern environments.
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Introduction
This literature review, carried out by the USAID Leadership, Management, and Governance (LMG) project, was conducted to help identify key concepts and practices that inform the development and use of technical assistance and leadership development training of those who govern in the health sectors of low- and middle-income countries (LMICs). Insights have been distilled from the extensive studies of health sector governance by the WHO, the World Bank, the OECD, BoardSource, and the Governance Institute. These insights are intended to guide studies among LMIC health sector leaders around key governance principles and practices that might shape the design of USAID strategies for health system strengthening, country ownership, inform interventions carried out by the LMG project, and ultimately improve health outcomes in LMIC health sectors.

This is a work in process. The research agenda is to extend throughout the next four years of the LMG project.

What constitutes governance?
The word governance derives from the Greek verb κυβερνάω [kubernáo] [French: kubernân] which means to steer. The word was used in a metaphorical sense by the Greek philosopher Plato to describe the act of governing men. He mentioned governing in his dialogue about philosopher kings. The word governing appears thus in Plato’s Republic:

“Governing refers to the head (rulers or philosopher kings) — those who are intelligent, rational, self-controlled, in love with wisdom, well suited to make decisions for the community. These correspond to the “reason” part of the soul and are very few.”

The term and the concept of governance in the past two decades has been extensively studied in the realms of public administration, political science, international relations, economics, business, sociology, and environmental sciences. Robichau (2011) has reviewed definitions, theories, and debates on public governance. She states that governance scholarship is reaching a critical point and advocates cohesion among and within academic domains. She describes key definitional differences as follows:

“The broad application of governance meanings and analyzes have rendered it “fashionable . . . imprecise, [and] wooly” (Fredrickson, 2005, p. 289), “shapeless” (Lynn, 2010a), and both ubiquitous and contested (Bevir, 2010) . . . Fifty separate governance concepts are described by Bevir (2009) who concludes there are many obstacles for researchers (Bevir, 2009, 2010). Many theorists reason that governance describes something broader than government (Bevir, 2010; Denhardt & Denhardt, 2007; Jordan, 2008; Kjær, 2004; Milward & Provan, 2000).”

“In paraphrasing dictionary meanings, Lynn (2010c) defines governance as “the action or manner of governing—that is, of directing, guiding, or regulating individuals, organizations, or nations in conduct or actions” (p. 671). Hughes (2010) combines the Latin word gubernare and dictionary meanings into a working definition where governance is “about running organizations, about steering as in the original derivation, how to organize, and how to set procedures for an organization to be run” (p. 88). These definitions provide a map for navigating governance meanings, but there are other useful phrases that provide insight of what governance is about including: “ordered rule” and “collective action or decision making” (e.g., Ansell & Gash, 2008; Löffler, 2009; Milward & Provan, 2000; Stoker, 1998, 2004), “all patterns of rule” whether formal or informal (e.g., Bevir, 2009, 2010; Imperial, 2005; Löffler, 2009), and “exercise of authority” (Denhardt & Denhardt, 2007; Stivers, 2008).”

1 From Plato’s The Republic, 473c-d.
Corporate Governance

The first documented use of the word “corporate governance” is by Richard Eells (1960, pg. 108) to denote “the structure and functioning of the corporate polity.” Theoretical exploration of corporate governance is relatively new though the practice is ancient. The phrase “corporate governance” appeared as a title of a paper in Perspectives in Management in 1983 and in 1984, and a report of the American Law Institute was titled principles of Corporate Governance.

Governance failure in the corporations attracted attention of the media and the public. Following the raft of governance failures in the United Kingdom in the 1990’s, Sir Adrian Cadbury chaired a committee (The Committee on the Financial Aspects of Corporate Governance) whose aims were to investigate the British corporate governance system and suggest improvements that would restore investor confidence in the system. The Cadbury Report, which unleashed the modern international flood of corporate governance reform, defined corporate governance and its values as follows:

“Corporate governance is the system by which companies are directed and controlled. Boards of directors are responsible for the governance of their companies. The shareholders’ role in governance is to appoint the directors and the auditors and to satisfy themselves that an appropriate governance structure is in place. The responsibilities of the board include setting the company’s strategic aims, providing the leadership to put them into effect, supervising the management of the business and reporting to shareholders on their stewardship. The board’s actions are subject to laws, regulations and the shareholders in general meeting.”

“The principles on which the Code is based are those of openness, integrity and accountability. They go together. Openness on the part of companies, within the limits set by their competitive position, is the basis for the confidence which needs to exist between business and all those who have a stake in its success. An open approach to the disclosure of information contributes to the efficient working of the market economy, prompts boards to take effective action and allows shareholders and others to scrutinize companies more thoroughly.”

“Integrity means both straight forward dealing and completeness. What is required of financial reporting is that it should be honest and that it should present a balanced picture of the state of the company’s affairs. The integrity of reports depends on the integrity of those who prepare and present them.”

“Boards of directors are accountable to their shareholders and both have to play their part in making that accountability effective. Boards of directors need to do so through the quality of the information which they provide to shareholders, and shareholders through their willingness to exercise their responsibilities as owners.”

Contemporary discussions of corporate governance tend to refer to principles raised in three documents released since 1990: The Cadbury Report (Cadbury, 1992), the 1998 and 2004 OECD Principles of Corporate Governance,1 and the Sarbanes-Oxley Act of 2002. The Cadbury and OECD reports present general principles around which businesses are expected to operate to ensure proper governance. The Sarbanes-Oxley Act operationalizes several of the principles recommended in the Cadbury and OECD reports. The most salient principles are:

- **Rights and equitable treatment of shareholders:** Organizations should respect the rights of shareholders and help shareholders to exercise those rights. They can help shareholders exercise their rights by openly and effectively communicating information and by encouraging shareholders to participate in general meetings.
■ **Interests of other stakeholders**: Organizations should recognize that they have legal, contractual, social, and market driven obligations to non-shareholder stakeholders, including employees, investors, creditors, suppliers, local communities, customers, and policy makers.

■ **Role and responsibilities of the board**: The board needs sufficient relevant skills and understanding to review and challenge management performance. It also needs adequate size and appropriate levels of independence and commitment.

■ **Integrity and ethical behavior**: Integrity should be a fundamental requirement in choosing corporate officers and board members. Organizations should develop a code of conduct for their directors and executives that promotes ethical and responsible decision making.

■ **Disclosure and transparency**: Organizations should clarify and make publicly known the roles and responsibilities of board and management to provide stakeholders with a level of accountability. They should also implement procedures to independently verify and safeguard the integrity of the company’s financial reporting. Disclosure of material matters concerning the organization should be timely and balanced to ensure that all investors have access to clear, factual information.

### Nonprofit governance

BoardSource in its Handbook of Nonprofit Governance describes major features of nonprofit governance:

> “Governance is the board’s legal authority to exercise power and authority over an organization on behalf of the community it serves. The board is authorized to establish policies and make decisions that will affect the life and work of the organization. Governance is a group action. Individual board members do not govern the organization. An organization’s articles of incorporation specify how its board is to be constituted and organized.”

> “Government laws assign overall responsibility and liability to the governing board. The board collectively and its individual members are bound by legal obligations. The board functions in part to assure the public and other stakeholders that the organization is in good hands. It assumes responsibility for the organization’s achievements. The board acts as the agent for the organization’s constituents and the board members are expected to place the interests of the organization above any other considerations. Oversight is the prime duty for all boards. They work closely with management to ensure that goals are met and ethical practices guide all activities.”

> “All actions taken by the board are held to three legal standards: duty of care, duty of loyalty, and duty of obedience. These three collective duties require the active participation of all the individual board members. These duties set the guidelines for the board to act as a fiduciary and steward of the organization.

■ **Duty of care** is a standard of care that can be expected of all prudent individuals under similar circumstances. Each board member is to act in good faith and actively participate in governance.

■ **Duty of loyalty** is a standard of faithfulness for the organizations’ priorities. Board members put the interest of the organization ahead of their own professional and personal interest.

■ **Duty of obedience** is a standard of faithfulness to the organization’s mission and purpose. It requires that the board members comply with the applicable laws and the organization’s bylaws; and remain guardians of the mission. Nonprofits are mission driven, mission focused and values based organizations.”
BoardSource distinguishes between responsible boards and exceptional boards. Exceptional boards are characterized by: a frank and open relationship with the chief executive; being intentional (thoughtful, self-aware and proactive); and being engaged (motivated, committed and having an appetite for change).

Carver (2010), the creator of the Policy Governance Model, believes that governance exists to translate the wishes of informed “owners” or “stakeholders” into organizational performance. The theory positions governance as an owner-representative or stakeholder-representative function rather than a management function; provides for resolute board action despite diversity of views among owners and even among directors; balances over-control and under-control through a policy design that enables boards to control what they need to control while safely leaving to the CEO what they do not need to control; avoids both rubber stamping and micromanaging; optimizes the values of CEO empowerment and board control; moves directors from advising on management’s job to defining management’s job; forces the practice of group authority by allowing no way to elude it; ensures that committees are aligned with dominant board accountability; positions the topmost of a two-tier board arrangement as the owner-representative (“governing” board), and eliminates any practice or structure that detracts from total board allegiance to agency responsibility (such as executive/inside directors and chair-CEO duality).

Public sector governance

Governance has gained increasing eminence in the discussions in the realm of the public sector in the past two decades when the nature and role of the state changed due to public sector reforms in the 1980s and 1990s. These reforms sought to shift the balance from a hierarchical bureaucracy toward greater use of markets, quasi-markets and networks; especially in the delivery of public services (Bevir, 2009). Governance in this sense meant that the state increasingly depended upon other organizations (private, nonprofit and civil society) to secure its intentions and deliver its policies. In this view, governing is done in the public sector (public governance), private sector (corporate governance) and not-for-profit sector (governance of nonprofits and civil society organizations). Governing is also done at various levels: institutional, local, state, national and global. This creates a certain degree of complexity and also heterogeneity in the way the concept of governance or governing is used. Networks, rules, steering, order, control, new, good, governing, and authority are some of the words used in discourse on public governance.

International institutions (UN, World Bank, IMF, and EU) began using the concept of public sector governance in the early 1990s to distinguish governance and government, or promote a mode of governance which they defined as good based on their values.

Osborne (2010) has reviewed the evolution of public governance in his essay:

“Public governance has evolved in three stages. The longer, pre-eminent stage was of Public Administration (PA), from the late nineteenth century through to the late 1970s/early 1980s. The second stage of the New Public Management (NPM) lasted through to the start of the twenty-first century. The third stage of the New Public Governance (NPG) is emerging since then. Elements of each stage can often coexist with each other or overlap. Both PA and NPM contain strong though differentiated elements of hierarchy (Klijn 2002).”

“The key elements of PA (Hood, 1991) can be defined as:
The dominance of the “rule of law;”
A focus on administering set rules and guidelines;
A central role for the bureaucracy in policy making and implementation;
The ‘politics – administration split within public organizations;
A commitment to incremental budgeting; and
The hegemony of the professional in the service delivery system.”

“The spread of the NPM from the late 1970s onward saw the growth of a new discourse of public policy implementation and public services delivery. In its most extreme form, this asserted the
superiority of private-sector managerial techniques over those of PA with the assumption that the application of such techniques to public services would automatically lead to improvements in the efficiency and effectiveness of these services (Thatcher 1995).”

“The key elements of the NPM can be summarized as: attention to lessons from private-sector management; growth both of hands-on ‘management’ – in its own right and not as offshoot of professionalism – and of “arm’s length” organizations where policy implementation is organizationally distanced from the policy makers (as opposed to the ‘inter-personal’ distancing of the policy – administration split within pa); focus upon entrepreneurial leadership within public service organizations; emphasis on inputs and output control and evaluation as well as performance management and audit; disaggregation of public services to their most basic units and a focus on their cost management; and growth of use of markets, competition and contracts for resource allocation and service delivery within public services.”

“The NPM has been criticized most devastatingly for its intra-governmental focus in an increasingly plural world and for its adherence to the application of outdated private sector techniques to PAM, and in the face of evidence about their inapplicability (Metcalfe and Richards 1991).”

“In contrast to both of the above, the New Public Governance (NPG) is rooted firmly within organizational sociology and network theory and acknowledges the increasingly fragmented and uncertain nature of public management in the twenty-first century (Haveri 2006). It draws much from the influential work of Ouchi (1979) and Powell (1990) on networks and from the substantial organizational social capital literature within organizational strategy (such as Tsai 2000). Thus it has the potential to tap into a more contemporary stream of management theory, concerned with the ‘relational organization’, than does the output and intra-organizational focus of the NPM. It posits both a plural state, where multiple inter-dependent actors contribute to the delivery of public services and a pluralist state, where multiple processes inform the policy making system. As a consequence of these two forms of plurality, its focus is very much upon inter-organizational relationships and the governance of processes, and it stresses service effectiveness and outcomes. Further, it lays emphasis on the design and evaluation of enduring inter-organizational relationships, where trust, relational capital and relational contracts act as the core governance mechanisms (Bovaird 2006; Teicher et al. 2006).”
<table>
<thead>
<tr>
<th>Paradigm/Key Elements</th>
<th>Theoretical roots</th>
<th>Nature of the state</th>
<th>Focus</th>
<th>Emphasis</th>
<th>Relationship to external (non-public) organizational partners</th>
<th>Governance mechanism</th>
<th>Value base</th>
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<tr>
<td>Public Administration</td>
<td>Political science and public policy</td>
<td>Unitary</td>
<td>The policy system</td>
<td>Policy implementation</td>
<td>Potential elements of the policy system</td>
<td>Hierarchy</td>
<td>Public sector ethos</td>
</tr>
<tr>
<td>New Public Management</td>
<td>Rational/public choice theory and management studies</td>
<td>Disaggregated</td>
<td>Intra-organizational management</td>
<td>Service inputs and outputs</td>
<td>Independent contractors within a competitive market-place</td>
<td>The market and classical or neo-classical contracts</td>
<td>Efficacy of competition and the market-place</td>
</tr>
<tr>
<td>New Public Governance</td>
<td>Organizational sociology and network theory</td>
<td>Plural and pluralist</td>
<td>Inter-organizational governance</td>
<td>Service processes and outcomes</td>
<td>Preferred suppliers, and often inter-dependent agents within ongoing relationships</td>
<td>Trust or relational contracts</td>
<td>Neo-corporatist</td>
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Frederickson (2005) reviewed and evaluated the evolution of governance in public administration. He notes:

“It was Harlan Cleveland who first used the word “governance” as an alternative to the phrase public administration. In the mid-1970s, one of the themes in Cleveland’s particularly thoughtful and provocative speeches, papers, and books went something like this: “What the people want is less government and more governance” (1972).”

“Peters uses an expansive definition of governance as “institutions designed to exercise collective control and influence” (1995, p. 3). Peters, and Peters with Pierre (2000), settle on the “steering” characteristics of governance as distinct from government. .....Public institutions continue to bear the primary responsibility for steering the economy and society. Government may, however, be able to discharge that fundamental responsibility through means other than direct imposition of authority, or use other instruments not requiring directly government involvement in the social processes being influenced. Governance, in the words of Walter Kikert (1997), is “steering at a distance.” “This style of steering is more palatable politically in an era in which there is significant public resistance to the state and its more intrusive forms of intervention’ (Peters 1995, p. 86).”

“Governance reform, particularly as seen in Great Britain, New Zealand, Australia, and the United States is modeled on various contributions of four different approaches to public administration – markets and competition, participative administration, greater flexibility, and deregulation. Peters provides an excellent summation of the characteristics of these four governance models.”
Table 2: Major Features of Four Models of Governance as Public Administration

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<tbody>
<tr>
<td>Principal diagnosis</td>
<td>Monopoly</td>
<td>Hierarchy</td>
<td>Permanence</td>
<td>Internal regulation</td>
</tr>
<tr>
<td>Structure</td>
<td>Decentralization</td>
<td>Flatter organizations</td>
<td>“Virtual organizations”</td>
<td>No particular recommendation</td>
</tr>
<tr>
<td>Management</td>
<td>Pay for performance; other private-sector techniques</td>
<td>TQM; teams</td>
<td>Managing temporary personnel</td>
<td>Greater managerial freedom</td>
</tr>
<tr>
<td>Policymaking</td>
<td>Internal markets; market incentives</td>
<td>Consultation; negotiation</td>
<td>Experimentation</td>
<td>Entrepreneurial government</td>
</tr>
<tr>
<td>Public Interest</td>
<td>Low cost</td>
<td>Involvement; consultation</td>
<td>Low cost; coordination</td>
<td>Creativity; activism</td>
</tr>
</tbody>
</table>


Rhodes (1996) records six uses of the term governance:

- The minimal state;
- Corporate governance;
- The new public management;
- ‘Good governance’;
- Socio-cybernetic systems; and
- Self-organizing networks.

Kooiman (1993, 2003) looks at governance from sociological and network perspective. He perceives governance as “all activities of social, political and administrative actors that can be seen as purposeful efforts to guide, steer, control or manage societies.” The sociological approach enables Kooiman to describe the basic elements, modes and orders of modern governance and assess their relevance and significance for improving the social and political governability of modern society. He discusses the concept of interaction in relation to the increasing complexity, dynamics and diversity of modern society. These things contribute to the growing interplay between state, market and civil society. Three fundamental kinds of governance are clarified in Kooiman (2003): self-governance, co-governance and hierarchical governance. Self-governance is seen as a governance mode embedded in interferential interaction around primary societal processes, having a special capacity for dealing with societal diversity and dynamics. Co-governance signifies that the parties involved have something in common, and that in some way autonomy and identity are at stake. It concerns utilizing organized forms of interactions for governing purposes and implies the absence of a central “governator” dominating communication, collaboration, cooperation and co-management. Co-governance is viewed as the most obvious response to governance failure on the part of hierarchical governance. Hierarchical governance is portrayed as a vertical or top-down mode of governance. Hierarchical governance is embedded in interactions that are based on interventions.

Yanacopulos (2005) draws on Kooiman’s work and extends it to national and international non-governmental organizations (NGOs) and international cooperation. In the context of global governance, the concept of continual interaction is the main thesis of Yanacopulos’ work as she attempts to explain the “quality of these relations.” In the conclusion of her literature review on governance she outlines the mechanisms of governance as an activity including pre-decision making, the framing of problems and setting the agenda; the attempt by actors to steer issues and influence decision maker’s choices, and the norm-setting process (the process of creating shared beliefs). She perceives the concept of governance as a purposive activity “where organizations attempt to influence other political actors by ways in which they frame and steer issues.”
Collaborative governance

Ansell and Gash (2008) define collaborative governance as a type of governance in which public and private actors work collectively in distinctive ways, using particular processes, to establish laws and rules for the provision of public goods. It is a new form of governance that has emerged to replace adversarial and managerial modes of policymaking and implementation. Collaborative governance brings public and private stakeholders together in collective forums with public agencies to engage in consensus-oriented decision-making.

Ansell and Gash conducted a meta-analytical study of the existing literature on collaborative governance with the goal of elaborating a contingency model of collaborative governance. After reviewing 137 cases of collaborative governance across a range of policy sectors they identified critical variables that influence whether or not this mode of governance produces successful collaboration. These variables include the prior history of conflict or cooperation, the incentives for stakeholders to participate, power and resources imbalances, leadership, and institutional design. They also identify a series of factors that are crucial within the collaborative process itself. These factors include face-to-face dialogue, trust-building, and the development of commitment and shared understanding. Ansell and Gash found that a virtuous cycle of collaboration tends to develop when collaborative forums focus on “small wins” that deepen trust, commitment, and shared understanding.

Emerson, Nabatchi and Balogh (2011) define collaborative governance broadly as the processes and structures of public policy decision-making and management that engage people constructively across the boundaries of public agencies, levels of government, and/or the public, private and civic spheres in order to carry out a public purpose that could not otherwise be accomplished. Their definition of collaborative governance captures a broader range of emergent forms of cross-boundary governance, extending beyond the conventional focus on the public manager or the formal public sector. It can be used to inform participatory governance and civic engagement. Kettl (2006) describes “the collaboration imperative” as cross-boundary.

Figure 1: The Integrative Framework for Collaborative Governance

Emerson, Nabatchi and Balogh’s integrative framework for collaborative governance is depicted in Figure 1 as three nested dimensions shown as boxes representing the general system context, the collaborative governance regime (CGR), and its collaborative dynamics and actions. The outermost box, depicted by solid lines, represents the surrounding system context or the host of political, legal, socioeconomic, environmental and other influences that affect and are affected by the CGR. This system context generates opportunities and constraints and influences the dynamics of the collaboration at the outset and over time. From this system context emerge drivers, including leadership, consequential incentives, interdependence, and uncertainty, which help initiate and set the direction for a CGR.

Collaborative dynamics, represented by the innermost box with dotted lines, consist of three interactive components: principled engagement, shared motivation, and capacity for joint action. The three components of collaborative dynamics work together in an interactive and iterative way to produce collaborative actions or the steps taken in order to implement the shared purpose of the CGR. The actions of the CGR can lead to outcomes both within and external to the regime; arrows extend from the action box to demonstrate impacts (i.e., the results on the ground), and potential adaptation (the transformation of a complex situation or issue) both within the system context and the CGR itself. Emerson, Nabatchi and Balogh (2011) present 10 general propositions about how these dimensions, components, and elements interact.

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These propositions set forth general preliminary working assumptions about what factors lead to collaboration, how the components work together to produce desired states, what leads to the success and effectiveness of collaborative governance, and how a CGR may achieve adaptation).

1) One or more of the drivers of leadership, consequential incentives, interdependence, or uncertainty are necessary for a collaborative governance regime to begin. The more drivers present and recognized by participants, the more likely a collaborative governance regime will be initiated.

2) Principled engagement is generated and sustained by the interactive processes of discovery, definition, deliberation, and determination. The effectiveness of principled engagement is determined, in part, by the quality of these interactive processes.

3) Repeated, quality interactions through principled engagement will help foster trust, mutual understanding, internal legitimacy, and shared commitment, thereby generating and sustaining shared motivation.

4) Once generated, shared motivation will enhance and help sustain principled engagement and vice versa in a “virtuous cycle.”

5) Principled engagement and shared motivation will stimulate the development of institutional arrangements, leadership, knowledge, and resources, thereby generating and sustaining capacity for joint action.

6) The necessary levels for the four elements of capacity for joint action are determined by the collaborative governance regime’s purpose, shared theory of action, and targeted outcomes.

7) The quality and extent of collaborative dynamics depends on the productive and self-reinforcing interactions among principled engagement, shared motivation, and the capacity for joint action.

8) Collaborative actions are more likely to be implemented if 1) a shared theory of action is identified explicitly among the collaboration partners and 2) the collaborative dynamics function to generate the needed capacity for joint action.

9) The impacts resulting from collaborative action are likely to be closer to the targeted outcomes with fewer unintended negative consequences when they are specified and derived from a shared theory of action during collaborative dynamics.

10) Collaborative governance regimes will be more sustainable over time when they adapt to the nature and level of impacts resulting from their joint actions.
Policy Consensus Initiative (PCI)

Policy Consensus Initiative (PCI), a non-profit organization, has developed a collaborative governance process in working with the National Policy Consensus Center (NPCC). This process works when its key principles are followed: transparency; equity and inclusiveness; effectiveness and efficiency; responsiveness; accountability; forum neutrality; and consensus-based decision-making.

Figure 2: PCI Collaborative Governance Process

Principles of a Collaborative Process

**Transparency and Accountability:** Decisions take place in the public eye.

**Equity and Inclusiveness:** All interests who are needed and willing contribute to solution.

**Effectiveness and Efficiency:** Solutions are tested to make sure they make practical sense.

**Responsiveness:** Public concerns are authentically addressed.

**Forum Neutrality:** Different perspectives are welcome; the process itself has no bias.

**Consensus-Based:** Decisions are made through consensus rather than majority rule

Four Elements of a Collaborative Process

Collaborative processes have four key elements:

1. **The Assessment:** An assessment is critical to defining a problem or opportunity and determining whether and what kind of collaborative approach is appropriate to the context. What kinds of policy situations lend themselves to collaborative strategies? Are there particular situations where structural problems or gaps in the system make these processes most valuable?

2. **The Convening Role:** Leaders have the power to convene people and to keep them at the table. How, why, and when should leaders use their convening authority? How does that power need to be deployed to address the kinds of problems states face? How can convening be used most effectively at the state level?

3. **The Collaborative Process:** Collaborative processes must be both effective and efficient. “Effective” means productive, and “efficient” means a minimum of expenditure. What has been learned about methods and practices that lead to more effective and efficient collaborative processes?

4. **The Agreement:** The rationale for engaging in collaboration is to arrive at decisions on difficult issues that reflect the interests of a greater number of citizen stakeholders, and that are more easily implementable. Policy makers and others need to know when collaborative strategies will produce better outcomes. What has been learned about creating durable, measurable, and sustainable agreements? What contributes to better monitoring, implementation, and accountability with regard to outcomes?

*Leaders engaging with all sectors—public, private, non-profit, citizens, and others—to develop effective, lasting solutions to public problems that go beyond what any sector could achieve on its own.*

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3 The National Policy Consensus Center (NPCC) is a national applied research and development center in collaborative governance that serves Oregon and state and local leaders in the United States. This Center is a partnership between Portland State University and the Policy Consensus Initiative (PCI), a national non-profit. PCI and NPCC are governed by a joint Board of Directors—a nationally recognized group of state leaders and elected officials. Policy Consensus Initiative (PCI) builds and supports networks that provide states in the US with leadership and capacity to achieve more collaborative governance. National Policy Consensus Center (NPCC) develops collaborative governance systems that enable leaders to achieve better solutions to public issues.
What results does it produce?

The best public solutions come from people working together on issues. Collaborative governance takes as its starting point the idea that working together creates more lasting, effective solutions.

Lasting: Solutions developed through collaborative governance won’t simply be undone in the next year or legislative session.

Effective: The collaborative governance approach ensures that the realities of the situation are considered and discussed; decisions are not made in a vacuum.

More buy-in: From the outset, all with a stake are involved in authentic ways; all have a role in the final agreement.

Why is it needed?

Accelerating change
Overlapping institutions and jurisdictions
Increasing complexity
A need to integrate policies and resources

How is this different from “government?”

“Governance” is the process by which public ends and means are identified, agreed upon, and pursued. This is different than “government,” which relates to the specific jurisdiction in which authority is exercised. “Governance” is a broader term and encompasses both formal and informal systems of relationships and networks for decision making and problem solving.

What does it take?

Collaborative governance requires the following elements:

Sponsor: An agency, foundation, civic organization, public-private coalition, etc. to initiate and provide support

Convener/Leader: A governor, legislator, local official, respected civic leader, etc. with power to bring diverse people together to work on common problems

Neutral Forum: An impartial organization or venue, etc. to provide and ensure skilled process management

Participants: All sectors (public, private, civic, etc.) are involved to ensure representation of all interests and points of view.

How does it work?

The System integrates the principles and network to assure an effective collaborative governance process:

Sponsors identify and raise an issue
Assessment is made on the feasibility for collaboration and who needs to be involved
Leader(s) convene all needed participants
Participants adopt this framework for addressing the issue
Conveners and participants frame (or reframe) the issue for deliberation
Neutral forum/facilitator designs and conducts a process to negotiate interests and integrate resources
Written agreement establishes accountability
Sponsors identify and raise an issue or opportunity that calls for a collaborative response

Source: Policy Consensus Initiative (PCI) and the National Policy Consensus Center (NPCC)
What constitutes effective governance?

United Nations

UNDP

The United Nations Development Program (UNDP) in its 1997 policy document entitled, “Governance for sustainable human development” has enunciated a set of principles that define good governance. From the UNDP perspective, governance and human development are indivisible. Human development cannot be sustained without good governance. Governance cannot be sound unless it sustains human development. Good governance, according to UNDP principles is participatory, transparent and accountable. It is effective in making the best use of resources, is equitable, and promotes the rule of law. Governance includes the state but transcends it by including the private sector and civil society.

Table 3: UNDP Principles of Good Governance

<table>
<thead>
<tr>
<th>Principles</th>
<th>UNDP definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Legitimacy and Voice</td>
<td>Participation – All men and women should have a voice in decision-making, either directly or through legitimate intermediate institutions that represent their intention. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Consensus orientation – Good governance mediates differing interests to reach a broad consensus on what is in the best interest of the group and, where possible, on policies and procedures.</td>
</tr>
<tr>
<td>2. Direction</td>
<td>Strategic vision – Leaders and the public have a broad and long-term perspective on good governance and human development, along with a sense of what is needed for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded.</td>
</tr>
<tr>
<td>3. Performance</td>
<td>Responsiveness – Institutions and processes try to serve all stakeholders. Effectiveness and efficiency – Processes and institutions produce results that meet needs while making the best use of resources.</td>
</tr>
<tr>
<td>4. Accountability</td>
<td>Accountability – Decision-makers in government, the private sector and civil society organizations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organizations and whether the decision is internal or external. Transparency – Transparency is built on the free flow of information. Processes, institutions and information are directly accessible to those concerned with them, and enough information is provided to understand and monitor them.</td>
</tr>
<tr>
<td>5. Fairness</td>
<td>Equity – All men and women have opportunities to improve or maintain their wellbeing. Rule of Law – Legal frameworks should be fair and enforced impartially, particularly the laws on human rights.</td>
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</tbody>
</table>


UNESCAP

According to the UNESCAP model, good governance has eight major characteristics: it is participatory, consensus oriented, accountable, transparent, responsive, effective and efficient, equitable and inclusive and follows the rule of law. It assures that corruption is minimized; the views of minorities are taken into account; and the voices of the most vulnerable in society are heard in decision-making. It is also responsive to the present and future needs of society.
The International Monetary Fund (IMF) and the World Bank

The IMF

The IMF believes in the significance of good governance for economic efficiency and growth. The IMF’s role in these issues has been evolving and it has learned more about the contribution that greater attention to governance issues could make to macroeconomic stability and sustainable growth. The IMF’s involvement in governance is limited to its economic aspects. IMF Managing Director Michel Camdessus’s said in his address to the United Nations Economic and Social Council on July 2, 1997:

“Good governance is important for countries at all stages of development. . . . Our approach is to concentrate on those aspects of good governance that are most closely related to our surveillance over macroeconomic policies—namely, the transparency of government accounts, the effectiveness of public resource management, and the stability and transparency of the economic and regulatory environment for private sector activity.”

IMF’s contribution to good governance (including the avoidance of corrupt practices) through its policy advice and, where relevant, technical assistance, arises principally in two spheres:

- Improving the management of public resources through reforms covering public sector institutions (e.g., the treasury, central bank, public enterprises, civil service, and the official statistics function), including administrative procedures (e.g., expenditure control, budget management, and revenue collection); and

- Supporting the development and maintenance of a transparent and stable economic and regulatory environment conducive to efficient private sector activities (e.g., price systems, exchange and trade regimes, and banking systems and their related regulations).

The World Bank

In a 1989 study carried out by the World Bank, the term “governance” was first used to describe the need for institutional reform and a better and more efficient public sector in Sub-Saharan countries. The concept of governance was further developed in the Bank’s 1992 publication “Governance and Development.” In this publication, governance was defined as “the manner in which power is exercised in the management of a country’s economic and social resources for development.” Two years later in 1994, the Bank came up with this definition:

“Governance is epitomized by predictable, open, and enlightened policymaking (that is, transparent processes); a bureaucracy imbued with a professional ethos; an executive arm of government accountable for its actions; and a strong civil society participating in public affairs; and all behaving under the rule of law.”

4 Available at http://www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp
The World Bank Institute defines its approach to governance as follows:

“We define governance as the traditions and institutions by which authority in a country is exercised for the common good. This includes (i) the process by which those in authority are selected, monitored and replaced, (ii) the capacity of the government to effectively manage its resources and implement sound policies, and (iii) the respect of citizens and the state for the institutions that govern economic and social interactions among them.”

These definitions represent the basis of the Bank’s perception of good governance and reflect its work in the areas of public sector management, accountability, rule of law, transparency and information, anti-corruption, and participation.

The bank has done considerable work on measuring governance. The Worldwide Governance Indicators project of the Bank defines governance as the set of traditions and institutions by which authority in a country is exercised. The political, economic, and institutional dimensions of governance are captured by six aggregate indicators:

- **Voice and accountability**: The extent to which a country’s citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media.

- **Political stability and absence of violence**: Perceptions of the likelihood that the government will be destabilized or overthrown by unconstitutional or violent means, including domestic violence and terrorism.

- **Government effectiveness**: The quality of public services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government’s commitment to such policies.

- **Regulatory quality**: The ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development.

- **Rule of law**: The extent to which agents have confidence in and abide by the rules of society, and in particular the quality of contract enforcement, the police, and the courts, as well as the likelihood of crime and violence.

- **Control of corruption**: The extent to which public power is exercised for private gain, including both petty and grand forms of corruption, as well as “capture” of the state by elites and private interests.

**The European Union (EU)**

The EU defines “Governance” as rules, processes and behavior that affect the way in which powers are exercised at the European level, in particular with regard to openness, participation, accountability, effectiveness and coherence. These five principles underpin good governance from the EU perspective. Each principle promotes democratic governance. They underpin democracy and the rule of law within Member States, but they also apply to all levels of government—global, European, national, regional and local:

- **Openness**: The Institutions should work in an open manner. Together with the Member States, they should actively communicate about what the EU does and the decisions it takes. They should use language that is accessible and understandable for the general public. This is of particular importance in order to improve the confidence in complex decisions.
---

**Participation:** The quality, relevance and effectiveness of EU policies depend upon ensuring wide participation throughout the policy chain from conception to implementation. Improved participation is likely to create more confidence in the end result and in institutions that deliver policies. Participation crucially depends upon central governments following an inclusive approach when developing and implementing EU policies.

**Accountability:** Roles in the legislative and executive processes need to be clear. Each of the EU Institutions must explain and take responsibility for what it does in Europe. But there is also a need for greater clarity and responsibility from Member States and all those involved in developing and implementing EU policy at whatever level.

**Effectiveness:** Policies must be effective and timely, delivering what is needed on the basis of clear objectives, an evaluation of future impact and, where available, of past experience. Effectiveness also depends on implementing EU policies in a proportionate manner and on taking decisions at the most appropriate level.

**Coherence:** Policies and action must be coherent and easily understood. Coherence requires political leadership and a strong responsibility on the part of institutions to ensure a consistent approach within a complex system.

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**What constitutes effective governance in the context of health?**

**WHO governance frameworks**

**Stewardship**

World Health Organization introduced the concept of stewardship in the context of health. WHO's World Health Report 2000, defined stewardship as “the effective trusteeship of national health.” Richard B. Saltman and Odile Ferroussier-Davis (2000) have reviewed the concept of stewardship in the context of WHO's World Health Report (2000). The following are excerpts from this review:

“The concept of stewardship has religious origins. According to the Old Testament, a steward is a selfless servant, who manages assets without owning them, anticipates future trends and devises grand plans. The New Testament extends it. According to New Testament, when entrusted with something of value one has an obligation to improve it. Christian and Jewish faiths thus define the notion of stewardship as a responsibility for protecting and developing one's resources. The concept of ecological stewardship has emerged in northern Europe and North America out of this religious tradition.”

“WHO had felt that the configuration and the application of state authority in the health sector should be realigned in the interest of achieving agreed policy objectives. The expectation was good governance would emerge and serve the public interest. Stewardship as a concept, it was felt, had a potential for encouraging state decision-making that is both normatively based and economically efficient. The World Health Report 2000 proposed that stewardship – which in its traditional definition points to the ethical use of common resources in pursuit of financially efficient outcomes – is the appropriate basis on which to reconfigure the governing role of the state in the health sector.”

“The most basic definition of stewardship is ‘the disinterested performance of a duty by government and/or its agents on behalf of a superior’. Kass believes that the notions of trust, ethical behavior and good decision-making are inherent in the concept of stewardship. Armstrong takes a similar ethical as well as an efficiency-oriented view of stewardship. He defines it in a broader and more inclusive way:
“Stewardship is ... the willingness to be accountable for the well-being of the larger organization by operating in service rather than in control of those around us.” Kass and Armstrong both understand stewardship as being capable of bringing together efficiency of organizational operation and ethical, trust-based representation. The notion of stewardship can be viewed as an ethically informed or “good” form of governance. Stewardship is a sociological and psychological approach to governance.”

“Stewardship can infuse normative, content-oriented values into a set of largely technical, process-oriented institutions. The pursuit of policy-making that is both ethical and efficient distinguishes stewardship from other concepts. The positive dimensions of stewardship are predominantly tied to its potential for improving policy outcomes. The core contention is that while focusing the policy process on traditional principal–agent relationships can create an efficient state, it is possible to create a state that is not only efficient but good by emphasizing normative, ethically oriented expectations of stewardship. Stewardship is potentially a model of governance which can infuse state policy-making and regulatory functions with an explicitly normative dimension.”

The most important challenge to those who visualize the potential advantages of a stewardship approach is to implement it in the real world of governance. At present, no country presents a satisfactory operating example of the principles that stewardship implies. The concept may be alien to many cultures and many languages. A language may not have an equivalent word to describe the concept.

Recently, Veillard and colleagues have reviewed the concept of stewardship and proposed an operational framework for assessing the completeness and consistency of the stewardship function of national health ministries. They carried out a purposive and multidisciplinary review of the literature and derived an operational framework through iterative discussions and participatory methods. Their operational framework describes six functions of stewardship:

1. To define the vision for health and strategy to achieve better health;
2. To exert influence across all sectors for better health;
3. To govern the health system in a way that is consistent with prevailing values;
4. To ensure that system design is aligned with health system goals;
5. To better leverage available legal and regulatory instruments; and
6. To compile, disseminate and apply intelligence.

Table 4: Stewardship

<table>
<thead>
<tr>
<th>Domain</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Strategy formulation and policy development</td>
<td>Define the vision for health and strategies and policies to achieve better health</td>
</tr>
<tr>
<td>2 Intersectoral collaboration and action</td>
<td>Exert influence across all sectors and advocate for better health</td>
</tr>
<tr>
<td>3 Health system governance and accountability</td>
<td>Ensure good governance supporting the achievement of health system goals</td>
</tr>
<tr>
<td>4 Attention to system design</td>
<td>Ensure the alignment of system design with health system goals</td>
</tr>
<tr>
<td>5 Health system regulation</td>
<td>Make use of legal, regulatory and policy instruments to steer health system performance</td>
</tr>
<tr>
<td>6 Intelligence (data and analysis) generation</td>
<td>Compile, disseminate and apply appropriate health information and research evidence</td>
</tr>
</tbody>
</table>
Veillard and colleagues point out that the stewardship concept is difficult to grasp and risky to implement; its boundaries are unclear; the term stewardship itself does not translate well to other languages than the English language; and it has been challenging for countries to implement. Indeed, stewardship involves a wide range of issues that have been addressed by scholars in numerous disciplines, in particular in philosophy (the relationship between the individual and the state), political science (the role of government), law (the role of legislation), organizational theory (inter-sectoral action), management science (stewardship theory of management) and other disciplines such as complexity theory. The authors have identified a number of common characteristics from the different definitions of stewardship:

1. It is a function of governments – specifically health ministries – responsible for the well-being of the population and for protecting the public interest.
2. It takes place within an overall framework of agreed norms and values.
3. It is ethically driven, in turn implying an element of trust on behalf of the population.
4. It involves a focus on health system outcomes and on the well-being of the population.
5. It requires effective decision-making based on accountability and transparency.
6. It implies giving due attention to system design.

Figure 4: Boundaries of the health system stewardship function of national health ministries.


Other World Health Organization (WHO) frameworks

Good Governance in Medicines

The WHO program on good governance in medicines was launched in 2004 to raise awareness of abuse in the public pharmaceutical sector, and to promote good governance. Its aim is to ensure that pharmaceutical spending is not misappropriated, and essential medicines reach people. The WHO’s framework for good governance in the pharmaceutical sector has two basic strategies: a discipline approach based on the legislative and administrative reforms necessary to establish transparent systems, and a values approach, building institutional integrity through the promotion of moral values and ethical principles. The first
strategy is by nature top-down, whereas the latter tends to be a bottom-up approach (WHO, 2006). Central to this program is the application of new administrative procedures for increased transparency/accountability and the development of leadership capabilities.

Figure 5: Good Governance in Medicines

Source: WHO (2009). Good Governance in Medicines Model Framework

The basic components of the framework of good governance in medicines (WHO, 2009) are:

**Values approach**

1. A system of moral values and ethical principles (See Appendix A)
2. A code of conduct
3. A programme for the systematic socialization of the moral values, ethical principles and code of conduct
4. Promotion of moral leadership

**Disciplinary approach**

- Outside the pharmaceutical sector
  - Established anti-corruption legislation
  - Mechanisms for whistle-blowing (ombudsman)
  - Sanctions on reprehensible acts based on anti-corruption legislation
- Within the pharmaceutical sector
  - Established management procedures, including internal and external financial audits
  - Collaboration between anti-corruption agencies, civil society organizations and the private sector
  - Management, coordination and evaluation of the good governance programme

**Siddiqi et al.’s framework**

Siddiqi et al. (2009), have considered four existing frameworks (See Table 5): the World Health Organization’s (WHO) domains of stewardship; the Pan American Health Organization’s (PAHO) essential public health functions; the World Bank’s six basic aspects of governance; and the United Nations Development Programme (UNDP) principles of good governance. They propose their Health System Governance (HSG) assessment framework that has 10 principles (See Table 6). Their analytical framework poses questions and items for each principle at three levels: the national level; the health policy formulation level; and the policy implementation level. They ask altogether 63 broad questions across the 10 governance principles ranging from contextual and descriptive to process-related and outcome-related questions.
## Table 5: Possible frameworks for assessing health system governance

<table>
<thead>
<tr>
<th>WHO’s domains of stewardship</th>
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<tbody>
<tr>
<td>Generation of intelligence</td>
</tr>
<tr>
<td>Formulating strategic policy direction</td>
</tr>
<tr>
<td>Ensuring tools for implementation: powers, incentives and sanctions</td>
</tr>
<tr>
<td>Building coalition/building partnership</td>
</tr>
<tr>
<td>Ensuring a fit between policy objectives and organizational structure and culture</td>
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<tr>
<td>Ensuring accountability</td>
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<table>
<thead>
<tr>
<th>PAHO’s essential public health functions</th>
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</thead>
<tbody>
<tr>
<td>EPHF 1: Monitoring evaluation and analysis of the health situation of the population</td>
</tr>
<tr>
<td>EPHF 2: Public health surveillance, research and control of risks</td>
</tr>
<tr>
<td>EPHF 3: Health promotion</td>
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<tr>
<td>EPHF 4: Social participation in health</td>
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<tr>
<td>EPHF 5: Development of policies and institutional capacity for planning and management in public health</td>
</tr>
<tr>
<td>EPHF 6: Strengthening the institutional capacity for regulation and enforcement in public health</td>
</tr>
<tr>
<td>EPHF 7: Evaluation and promotion of equitable access to necessary health services</td>
</tr>
<tr>
<td>EPHF 8: Human resource development and training in public health</td>
</tr>
<tr>
<td>EPHF 9: Quality assurance in personal and population-based health services</td>
</tr>
<tr>
<td>EPHF 10: Research in public health</td>
</tr>
<tr>
<td>EPHF 11: Reducing the impact of emergencies and disasters on health (prevention, mitigation, preparedness, response and rehabilitation)</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>World Bank’s governance indicators—three clusters and six basic aspects of governance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process by which those in authority are selected and replaced:</td>
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<tr>
<td>Voice and accountability, Political instability and violence</td>
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<tr>
<td>Ability of the government to formulate and implement sound policies:</td>
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<tr>
<td>Government effectiveness, Regulatory burden</td>
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<tr>
<td>Respect of citizens and the state for institutions which govern their interaction:</td>
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<tr>
<td>Rule of law, Graft (control of corruption)</td>
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<thead>
<tr>
<th>UNDP</th>
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<tbody>
<tr>
<td><strong>Principles</strong></td>
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<tr>
<td>Legitimacy and voice</td>
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<td>Direction</td>
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<td>Performance</td>
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<td>Accountability</td>
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<td>Fairness</td>
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## Table 6: Health system governance principles

<table>
<thead>
<tr>
<th>Governance principle</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic vision</td>
<td>Leaders have a broad and long-term perspective on health and human development, along with a sense of strategic directions for such development. There is also an understanding of the historical, cultural and social complexities in which that perspective is grounded</td>
</tr>
<tr>
<td>Participation and consensus orientation</td>
<td>All men and women should have a voice in decision-making for health, either directly or through legitimate intermediate institutions that represent their interests. Such broad participation is built on freedom of association and speech, as well as capacities to participate constructively. Good governance of the health system mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on health policies and procedures</td>
</tr>
<tr>
<td>Rule of law</td>
<td>Legal frameworks pertaining to health should be fair and enforced impartially, particularly the laws on human rights related to health</td>
</tr>
<tr>
<td>Transparency</td>
<td>Transparency is built on the free flow of information for all health matters. Processes, institutions and information should be directly accessible to those concerned with them, and enough information is provided to understand and monitor health matters</td>
</tr>
</tbody>
</table>
Governance principle | Explanation
--- | ---
Responsiveness | Institutions and processes should try to serve all stakeholders to ensure that the policies and programs are responsive to the health and non-health needs of its users
Equity and inclusiveness | All men and women should have opportunities to improve or maintain their health and well-being
Effectiveness and efficiency | Processes and institutions should produce results that meet population needs and influence health outcomes while making the best use of resources
Accountability | Decision-makers in government, the private sector and civil society organizations involved in health are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organization and whether the decision is internal or external to an organization
Intelligence and information | Intelligence and information are essential for a good understanding of health system, without which it is not possible to provide evidence for informed decisions that influences the behavior of different interest groups that support, or at least do not conflict with, the strategic vision for health
Ethics | The commonly accepted principles of health care ethics include respect for autonomy, nonmaleficence, beneficence and justice. Health care ethics, which includes ethics in health research, is important to safeguard the interest and the rights of the patients


WHO Regional Office for Europe

Ilona Kickbusch and David Gleicher (2011), in their study conducted for the WHO Regional Office for Europe have discussed governance for health in the 21st century in European context. They define smart governance for health in terms of how governments approach governance for health challenges strategically in five dimensions, by:

1. Governing through collaboration (how the state and society co-govern in the 21st century);
2. Governing through citizen engagement;
3. Governing by a mix of regulation and persuasion;
4. Governing through independent agencies and expert bodies; and
5. Governing by adaptive policies, resilient structures and foresight.

Figure 6: Governance for health in the 21st century


Kirigia and Kirigia (2011) recommend a broader health development governance framework as other sectors that assure human rights to education, employment, food, housing, political participation, and security, and that combine these elements to have
greater impact on health development than health systems alone. They recommend a broader concept of “governance in health development” applicable to the WHO African Region context. They propose a health development governance index with 10 functions and 42 sub-functions to facilitate inter-country comparisons and suggest potential sources of data for estimating the index. They argue that the governance indices for individual sub-functions can aid policymakers to establish the sources of weak health governance and subsequently develop appropriate interventions for improving the situation.

USAID

The U.S. Agency for International Development (USAID) has described effective health governance as the process of “competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people.” For health care interventions to work, countries need effective policy making, transparent rules, open information, and active participation by all stakeholders in the health sector.” (USAID 2006)

Health Systems 20/20, a USAID Project, in its *Health Systems Assessment Approach: A How-To Manual* (Islam, M., ed. 2007), considers the following five dimensions of governance in the health sector:

1. **Information/Assessment Capacity**: information available to decision makers and a broad range of stakeholders on trends in health and health system performance and on possible policy options. Available information is used for planning and decision making.

2. **Policy Formulation and Planning**: appropriate processes in place to develop, debate, pass, and monitor legislation and regulations on health issues. The government planning process is functioning. There is consistency and coherence between health sector laws or plans and actual implementation.

3. **Social Participation and System Responsiveness**: involvement of a broad range of stakeholders (nongovernmental and representatives of various public sector actors) in understanding health issues and in planning, budgeting, and monitoring health sector actions as well as the health system’s responsiveness to the input of these stakeholders.

4. **Accountability**: existence of rules on publishing information about the health sector (e.g., plans, health data including health statistics, fee schedules); a functioning free popular and scientific press; functioning watchdog organizations; and consumer protection from medical malpractice; and

5. **Regulation**: capacity for oversight of safety, efficacy, and quality of health services and pharmaceuticals; enforcement capacity for guidelines and standards and regulations; and perception of the burden imposed by excessive regulation.

**Brinkerhoff and Bossert Model**

Brinkerhoff and Bossert (2008) have created a framework that defines the roles, rules and responsibilities, and institutions that shape the interactions among three main sets of actors — citizens, service users, government and health service providers. These interactions include how governments respond to citizen demands, how providers and citizens engage to improve service quality, and how citizen and provider groups advocate and report on health concerns.
The governance relationships from state actors to providers are encapsulated in the arrow labeled “compact.” This term seeks to capture the notion of a contract-like connection in which policymakers specify objectives, procedures, and standards; provide resources and support; and exercise oversight relative to providers. In exchange for the resources, providers carry out the agreed upon desires and directives of the policymakers. In essence, the compact is the sum of the rules that determine the roles and responsibilities of the various parties to the agreement; these in turn establish incentives for the actors involved. Health system reforms that separate payment from provision of services have introduced major changes in the role of state actors relative to providers. These changes have concentrated significant attention on the accountability dimension of health governance.

From providers to state actors, key governance relationships revolve around reporting: that is, the provision of information for purposes of monitoring and in fulfillment of the three types of accountability (political, performance, and financial). The particular features of provider payment schemes, for example, influence the nature of reporting relationships between providers and payers, and the incentives created for providers. Pay-for-performance arrangements join financial and performance accountability, and increasing numbers of developing countries are experimenting with them. Besides accountability, another important function of the governance link between providers and state actors is to furnish data for policymaking. If health policymakers are to pursue evidence-based policy formulation, then providers have a critical role as the source of evidence.

The relationships between service users and providers are the heart of health systems. In principle, clients/citizens convey their needs and demands for services – and their level of satisfaction – directly to providers, who in turn offer a mix of quality services that satisfy needs and demands. Yet from a governance perspective, the links from clients/citizens to providers and from providers to clients/
citizens are fraught with power and information asymmetries, capacity gaps, accountability failures, and inequities. The compact between health policymakers and providers cannot specify all the relevant factors for quality service delivery, and an effective client provider link is necessary for system functioning, quality of services, and service utilization; but the problems listed often weaken this leg of the governance triad substantially. As with the governance link from clients/citizens to the state, the connection to providers can be strengthened through collective action, for example, civil society organizations that exercise voice on behalf of beneficiaries, or village health associations that participate with health providers in needs assessments and community mobilization. Reforms that create health service markets and introduce competition among providers can enhance client power and increase provider accountability to service users, who have the ability to choose among providers, and/or whose views are incorporated into provider performance assessments that inform funding decisions, for example, through service delivery surveys. Measures to reinforce the purchasing power of particular societal groups – such as subsidies for the poor, elderly, or HIV/AIDS affected – are another example of offsetting imbalances between providers and service users.”

Brinkerhoff and Bossert (2008) define Good Health Governance in terms of Roles and responsibilities and relationships that are governed by:

- Responsiveness to public health needs and beneficiaries’/citizens’ preferences while managing divergences between them;
- Responsible leadership to address public health priorities;
- The legitimate exercise of beneficiaries’/citizens’ voice;
- Institutional checks and balances;
- Clear and enforceable accountability;
- Transparency in policymaking, resource allocation, and performance;
- Evidence-based policymaking; and
- Efficient and effective service provision arrangements, regulatory frameworks, and management systems.

Other Frameworks

Mikkelsen-Lopez, Wyss and de Savigny (2011) have proposed a framework for addressing governance from a health system framework perspective based upon a systems thinking approach. They provide an example of how this approach could be applied to illuminate areas of governance weaknesses that can be addressed by targeted interventions and policies. This approach is problem-driven and considers the major health system building blocks at various levels in order to ensure a complete assessment of a governance issue rather than a simple input-output approach. It seeks to facilitate a more comprehensive assessment of governance in health systems leading to the development of governance interventions to strengthen system performance and improve health.
Kruk and Freedman (2008) have reviewed the literature on indicators currently used to measure performance of a health system in the international health setting. They propose indicators in the three categories: effectiveness, equity, and efficiency. Measures of health system effectiveness are improvement in health status, access to and quality of care, and patient satisfaction. Measures of equity include access and quality of care for disadvantaged groups together with fair financing, risk protection, and accountability. Measures of efficiency are appropriate levels of funding, the cost-effectiveness of interventions, and effective administration. This framework can be used to assess the effect of governance enhancement on health outputs, outcomes and impact in developing countries using an appropriate research design.
Countdown to 2015 Working Group on Health Policy and Health Systems (2008) has identified the adoption of the International Code of Marketing of Breastmilk Substitutes (1981) and the ratification of the International Labour Organisation (ILO)'s Maternity Protection Convention 2000 (number 183) as two indicators of government leadership, governance and inter-sectoral action that are critical for the health of pregnant and lactating women and their infants. The group has proposed these indicators for monitoring country-level progress in achieving high and equitable coverage with interventions effective in reducing mortality of mothers, newborn infants, and children up to 5 years of age.

Strengthening Pharmaceutical Systems (SPS), a USAID project, has described the importance of good governance in the context of the pharmaceuticals sector. It uses use a systems-orientated approach to organize interventions that support adherence to one or more principles of good governance. This approach focuses on establishing:

- Policies and legislation supported by rule of law;
- Organizational structures able to exercise appropriate decision making, authority, and oversight;
- Systems and processes that are transparent, ethical, accountable, and grounded in well-formed policies and legislation; and
- Human resource management systems that promote effective performance and ethical practices.
Diack et al. (2010) in their assessment of governance of the pharmaceuticals sector in eight LMICs found: a dominant role of the private sector; pervasive weaknesses in regulation; inefficient public sector logistics systems; poor availability of essential drugs in the public sector; lack of consumer power; and market failures influencing consumption patterns.

What are the enablers of effective governance for health?

Ethics

Rakhal et al. (2010) review the evidence on the effect of corruption in the health sector:

“The effects of corruption in the health sector have been described in a number of different ways and at different levels. These include general effects, effects on the healthcare system, and effects on health outcomes.”

“General systemic effects: Corruption tends to produce more unequal distribution of income (Li 2000). Corruption also inhibits the improvement of services and the ability of reform in improving a range of services (Ensor 2004). Corruption increases the cost of key public services and limits the access for those least able to pay (Falkingham 2004; Rose-Ackerman 2004; Szende 2006).”

“Health system effects: Within the health sector, corruption tends to favour the construction of hospitals and purchase of expensive, high technology equipment over primary healthcare programs such as immunization and family planning (U4 2006). As resources are drained from health budgets through embezzlement and procurement fraud, less funding is available to pay salaries and fund operations and maintenance, leading to demotivated staff, lower quality of care and reduced service availability and use (Lindelow 2006). Corruption in the form of informal payments for care reduces access to services, especially for the poor, and causes delays in care-seeking behavior (Lewis 2000).”
“Health outcomes: Corruption has been associated with lower immunization rates, delays in vaccination and failures to treat patients, less use of public health clinics, reduced satisfaction with care and increased waiting times (Azfar 2004; Azfar 2005). Corruption has been found to be negatively associated with health indicators such as infant and child mortality (estimated to be almost twice as high in countries with high corruption than in countries with low corruption), after adjusting for income, female education, health spending and level of urbanization (Gupta 2002). These effects are based on associations found in studies using regression analyses on cross-sectional data sets. Given possible confounding and the fact that causation cannot be confidently attributed, the effects of corruption and the magnitude of these effects are uncertain. However, it is likely that large-scale corruption has important impacts on access to and the quality of health services and that that these in turn affect health outcomes.”

“A wide range of strategies to reduce corruption has been described in the literature, but these have uncertain impacts, may have adverse effects, and may require substantial investments of resources. These include
1. Dissemination of information (information campaigns aimed at changing knowledge, attitudes or beliefs about corruption; or skills to address corruption),
2. Reduced monopolies (increasing the ability to choose from different providers of a service or product),
3. Reduced incentives (removing or reducing incentives or factors that motivate corrupt behaviors),
4. Increased transparency and accountability (increasing transparency and accountability in decision-making processes; e.g. by increasing stakeholder participation or mandatory documentation of decisions that is open to access),
5. Decreased discretion (decreasing discretion of those who have power),
6. Improved detection and enforcement (improving detection and punishment of corruption), and
7. Establishment of an independent agency (establishing an anti-corruption agency to coordinate anti-corruption activity).”

Vian (2008) has created a comprehensive framework and proposed a set of methodologies for describing and measuring how opportunities, pressures and rationalizations influence corruption in the health sector. She discusses implications for intervention, and presents examples of how theory has been applied in research and practice. She has also addressed challenges of tailor-
ing anti-corruption strategies to particular contexts (Annex B).

### Table 7: Ethics

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Finding</th>
</tr>
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<tbody>
<tr>
<td>McPake, Asiimwe and Mwesigye (1999)</td>
<td>Health Economic and Financing Programme, London School of Hygiene and Tropical Medicine, London Makerere Institute of Social Research, Kampala, Uganda Uganda Ministry of Health Royal Tropical Institute, Amsterdam, Netherlands</td>
<td>The paper reported the results of a study in Uganda of the ‘informal’ economic activities of health workers, defined as those which earn incomes but fall outside official duties and earnings. The study was carried out in 10 sub-hospital health facilities of varying size and intended role and used a variety of quantitative and qualitative methods. Few of the drugs supplied to health units were prescribed and issued in those sites. Most health workers who have the opportunity to do so, levied informal charges. Where formal charges were collected, high levels of leakage occurred both at the point of collection and at higher levels of the system. Drugs available after leakage were sufficient to cover less than half of those attending in most facilities.</td>
</tr>
<tr>
<td>Azfar, et al. (2001)</td>
<td>IRIS Center, University of Maryland. The World Bank</td>
<td>Corruption is negatively associated with the quality of health services as proxied by the health staff’s knowledge on required immunizations. Corruption has an insignificant negative effect on both household satisfaction with health services and waiting time in health units, but a marginally significant effect on the composite index based on both satisfaction and waiting time. Results also indicate that corruption has a marginally significant effect on retarding increases in immunization. Corruption also appears to have an effect on health outcomes through the knowledge of required immunizations by health officials.</td>
</tr>
<tr>
<td>Lindelow and Serneels (2006)</td>
<td>The World Bank &amp; Center for the Study of African Economies, University of Oxford, UK</td>
<td>Corruption in the health sector has a direct negative effect on access and quality of patient care. As resources are drained from health budgets through embezzlement and procurement fraud, less funding is available to pay salaries and fund operations and maintenance, leading to demotivated staff, lower quality of care, and reduced service availability and use.</td>
</tr>
<tr>
<td>Delavallade (2006)</td>
<td>Centre Economie Sorbonne, University of Paris</td>
<td>Corruption in financial management has a direct negative effect on access and quality of care. A study of 64 countries found that corruption lowered public spending on education, health and social protection. In Chad, the regions only received a third of the centrally allocated resources; in Cambodia 5-10% of the health budget was lost at the central level alone; in Tanzania, local or district councils diverted up to 41% of centrally disbursed funds; in Uganda, up to two thirds of official user-fees were pocketed by health staff.</td>
</tr>
<tr>
<td>Gupta, Davoodi and Tiongson (2000)</td>
<td>International Monetary Fund</td>
<td>The authors show that levels of corruption are clearly related to child mortality and other health outcomes. A two-point improvement in the integrity of government would reduce child mortality by 20%.</td>
</tr>
<tr>
<td>Swaroop and Rajkumar (2002)</td>
<td>The World Bank</td>
<td>Controlling for several variables including female education, income, urbanization, and distance from the equator they show that public health spending has a greater effect on child and infant mortality the higher is the quality of government –measured both as the absence of corruption and the quality of the bureaucracy.</td>
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<tr>
<td>Citation</td>
<td>Affiliation</td>
<td>Finding</td>
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<tr>
<td>Azfar, Kähkönen and Meagher (2001), Azfar and Gurgur (2001)</td>
<td>IRIS Center, University of Maryland, The World Bank</td>
<td>Controlling for income, voting, media exposure, and other variables the authors find that corruption is significantly related to knowledge of required immunizations and that knowledge of required immunizations is strongly related to immunizations and disease incidence.</td>
</tr>
<tr>
<td>Anti-Corruption Resource Centre U4 Norway</td>
<td>U4</td>
<td>A review of research in Eastern Europe and Central Asia found evidence that corruption in the form of informal payments for care reduces access to services, especially for the poor, and causes delays in care-seeking behaviour (Lewis 2000). However, where the payments are cost contributions, they can enhance efficiency because more people can be treated at relatively low additional cost. But generally there are better ways to enhance efficiency, and we find that secret payments are more open to abuse. In Azerbaijan, studies have shown that about 35% of births in rural areas take place at home, in part because of high charges for care in facilities where care was supposed to be free (World Bank 2005). In many countries, families are forced to sell livestock or assets, or borrow money from extended family and community members, in order to make the necessary informal payments to receive care. Besides informal payments, other types of corruption which clearly affect health outcomes are bribes to avoid government regulation of drugs and medicines, which resulted in the dilution of vaccines in Uganda and has contributed to the rising problem of counterfeit drugs in the world. Unregulated medicines which are of sub-therapeutic value can contribute to the development of drug resistant organisms, increase the threat of pandemic disease spread, and severely damage patients’ health as counterfeit drugs might have the wrong ingredients or include no active ingredients at all and undermine public trust in important medicines according to WHO IMPACT (2006). Bribes to avoid government regulation of drugs have contributed to the rising problem of counterfeit drugs which can lead to increased disease resistance and death. Globally 10% of all drugs are believed to be fake, while in some African countries the figure can amount to 50%. An estimated 10-25% of public procurement costs for drugs are lost to corruption. Unethical drug promotion and conflict of interest among physicians can have negative effects on health outcomes as well. As documented by Jerome Kassirer, promotional activities and other interactions between pharmaceutical companies and physicians, if not tightly regulated, can influence physicians to engage in unethical practices (Kassirer, 2006). Studies have shown that these interactions can lead to non-rational prescribing (Wazana, 2000), and increased costs with little or no additional health benefit. Patients’ health can be endangered as some doctors enrol unqualified patients in trials or prescribe unnecessary or potentially harmful treatments, in order to maximise profit (Kassirer, 2005).</td>
</tr>
<tr>
<td>Lewis (2007)</td>
<td>The World Bank</td>
<td>The range of frequency of informal payments is enormous: from 3 percent in Peru to 96 percent in Pakistan. Regionally, South Asia stands out for its heavy reliance on informal payments. East Asian experience is split between Thailand and Indonesia, with low levels, and the former Communist countries, with Cambodia at 55 percent and a dated estimate for Vietnam at 81 percent. The proportions for Latin America and Eastern Europe have a wide distribution, with low levels in some countries and among the highest in others, which makes generalizations problematic. Recent evidence from smaller samples in Africa suggests that informal payments of various kinds are common in Uganda, Mozambique, and Ethiopia. In all three, patients pay public providers directly for consultations and drugs over and above any formal charges.</td>
</tr>
<tr>
<td>Rose (2006)</td>
<td>Transparency International</td>
<td>Corruption is a pervasive problem affecting the health sector. At the level of individuals and households, there is mounting evidence of the negative effects of corruption on the health and welfare of citizens.</td>
</tr>
<tr>
<td>Ombaka (2009)</td>
<td>Ecumenical Pharmaceutical Network, Nairobi, Kenya</td>
<td>It is estimated that in some countries, up to two thirds of all hospital medicines are “lost” through poor procurement practices, including corruption and fraud.</td>
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</table>
Transparency

A range of interventions enhancing transparency in the health sector or the health institutions has been attempted and these interventions appear to work. These interventions may or may not involve public reporting of the information. Many of these studies are in the nature of pre-post studies. We cannot ascribe a casual attribution to the interventions in the absence of a control group. We highlight some of the studies that indicate that health systems are vulnerable to corruption.

Table 8: Openness and Transparency

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tbody>
<tr>
<td>Schargrodsky, Mera, &amp; Weinschelbaum (2001)</td>
<td>Inter-American Development Bank</td>
<td>Examples of transparency initiatives in Argentina, Morocco and Uganda show the range of interventions possible. The Ministry of Health in Argentina created a price monitoring system that tracked prices paid by 33 public hospitals for common drugs, sharing this data with the reporting hospitals. The effect of the transparency policy was that purchase prices fell immediately by an average of 12%, and stayed below the baseline for over a year.</td>
</tr>
<tr>
<td>Reinikka &amp; Svensson (2002)</td>
<td>World Bank</td>
<td>In Uganda, an information strategy was used to reduce leakage of central government education grants to local governments (a problem first identified through a Public Expenditure Tracking Survey). Before the grant transfer amounts were publicized in newspapers and posted in schools, only 13% of grant allocations reached the schools; after the reforms, 80–90% of grant funds were reaching recipients.</td>
</tr>
<tr>
<td>Transparency International (2006)</td>
<td>Transparency International</td>
<td>In Croatia, regulations have been proposed which will require hospitals to make waiting lists public, to reduce the practice of patients bribing doctors to jump ahead of the queue.</td>
</tr>
<tr>
<td>Garuba et al., 2009</td>
<td>University of Toronto</td>
<td>The overall score for Nigeria’s pharmaceutical system was 7.4 out of 10, indicating a system that is marginally vulnerable to corruption. The weakest links were the areas of drug registration and inspection of ports. Analysis of the qualitative results revealed that the perceived level of corruption did not always match the qualitative evidence. The study findings suggest that facets of the pharmaceutical system in Nigeria remain fairly vulnerable to corruption.</td>
</tr>
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Accountability

Six years ago, two researchers – Martina Bjorkman and Jakob Svensson - did a randomized field experiment in fifty rural communities of Uganda to see if community monitoring of providers improves health outcomes. A community on average had 2,500 households living around a public dispensary. Half the communities were randomly assigned to the treatment group and the remaining half to the control group. In the treatment group, a community, with the help of a local community-based organization, monitored primary health care providers of the public dispensary for a year using a citizen report card. The control communities did not. At the end of one year, the researchers found that community monitoring had increased the quality and quantity of primary health care. The treatment communities became more engaged in their care and had begun to monitor the dispensary performance more extensively. Utilization of out-patient services was 20 percent higher in treatment communi-
ties. Treatment practices, examination procedures, and immunization coverage all improved. Most importantly, there was a significant increase in weight of infants and a significant as much as 33 percent reduction in under-5 mortality in the treatment communities as opposed to the control communities.

Björkman and Svensson’s (2009) study shows that overall, there were improvements in a variety of outcomes, both in the quantity and quality of health service provision. This research is an example how improvement in accountability of the providers can lead to better health outcomes. It is one of the most frequently cited pieces of evidence in the research on the effects of governance interventions as it comes from a randomized controlled trial, a gold standard in causal studies.
Table 9: Accountability

<table>
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<th>Citation</th>
<th>Main finding</th>
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<tr>
<td>Björkman and Svensson (2009)</td>
<td>Overall, there were improvements in a variety of outcomes, both in the quantity and quality of health service provision. <strong>1.) New or stronger practices and processes.</strong> During the citizen report card project, a typical village had, on average, six meetings in 2005. In those meetings 89 percent of the villages discussed specific issues concerning the project health facility and the action plan. The mismanaged Health Unit Management Committees (HUMCs) were dissolved. The community also monitored health facility staff during health visits to the clinic, questioning issues in the action plan that had (or had not) been addressed. In addition, tools such as suggestion boxes (for comments on changes supposed to have taken place), numbered waiting cards (to ensure first-come-first-serve), and duty rosters were placed in several treatment facilities. Treatment facilities were more likely to have suggestion boxes, duty rosters, and numbered waiting cards. The facilities posted more information about free services and patient's rights and obligations. And they held more discussions about their own performance in village meetings. <strong>2.) Better treatment practices.</strong> The treatment practices and staff behavior improved. One measure is <em>examination procedures.</em> On this indicator, about half of the patients in the treatment community reported that equipment (such as thermometer or blood pressure equipment) was used during the examination. But in the control communities, only 41 percent reported that equipment was used the last time the respondent (or respondent’s child) visited the project clinic. A second measure is <em>patient waiting time,</em> defined as the difference between the time the user left the facility and the time the user arrived at the facility minus the examination time. On average, the waiting time was 119 minutes in the treatment facilities, a marked improved over the 131 minutes in the control facilities. A third measure is <em>staff absenteeism.</em> On average, the absence rate—defined as the ratio of workers not physically present at the time of the post-intervention survey to the number of workers employed—was 13 percentage points lower in the treatment facilities (to be compared to the 47 percent absenteeism rate in the control facilities). A fourth measure is <em>information sharing.</em> For this indicator, households in the treatment communities were better informed about various aspects of service provision following the intervention. For example, a significantly larger number of households received information about the dangers of self-treatment and the importance of visiting a health clinic for medical treatment and family planning. A final measure is <em>immunization coverage.</em> The treatment communities were significantly better off than the control communities for all four vaccines. For example, in the treatment group, twice as many newborns received vitamin A supplements, and for BCG and polio, the difference was positive (46 and 42 percent respectively) and significant in the youngest age group. But the differences were not significant in all age groups. <strong>3.) Better use of services.</strong> The study shows improved use in all of the service areas for the treatment group. One year into the program, use (for general outpatient services) was 20 percent higher in the treatment facilities. The difference in the number of deliveries at the facility was up 58 percent (albeit from a low level). And the number of patients seeking antenatal care (19 percent) and family planning (22 percent) also rose, and these estimates are jointly significantly different from zero. A similar pattern of better use of services is evident from the household data. Households in the treatment communities switched from traditional healers and self-treatment to the project facility in response to the intervention. <strong>4.) Better health outcomes.</strong> In the ex-post evaluation survey, data were collected on whether the household suffered from the death of a child (under five years old) in 2005, the first year of the community monitoring project. The average under-five mortality rate in the treatment community was 97 per 1,000, markedly lower (about 33 percent) than the average rate of 144 in the control community. With about 55,000 households residing in the treatment communities, the treatment effect corresponds to 550 averted under-five deaths following the intervention—with children younger than two-years-old driving this reduction in under-five mortality. As for infant weight, the study focused on weight-for-age z scores for all infants (under 18 months) and children (18–36 months). The difference in mean z scores is 0.14, which corresponds to a reduction in average risk of mortality of about 7 percent.</td>
</tr>
</tbody>
</table>
Reinikka and Svensson (2004) 
Institute for International Economic Studies, Stockholm University, Development Research Group, the World Bank 

According to official statistics, 20 percent of Uganda’s total public expenditure was spent on education in the mid-1990s, most of it on primary education. One of the large public programs was a capitation grant to cover schools’ nonwage expenditures. Using panel data from a unique survey of primary schools, we assess the extent to which the grant actually reached the intended end-user (schools). The survey data reveal that during 1991–1995, the schools, on average, received only 13 percent of the grants. Most schools received nothing. The bulk of the school grant was captured by local officials (and politicians). The data also reveal considerable variation in grants received across schools, suggesting that rather than being passive recipients of flows from the government, schools use their bargaining power to secure greater shares of funding. The authors found that schools in better-off communities managed to claim a higher share of their entitlements. As a result, actual education spending, in contrast to budget allocations, was regressive. Similar surveys in other African countries confirmed that Uganda was not a special case.

Atkins and Dunn (2007) 

Accountability is essential if policies to fight the arsenic crisis in Bangladesh are to avoid problems of local power, patronage and clientelism.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tbody>
<tr>
<td>Kegler et al. (2009)</td>
<td>Rollins School of Public Health Public Health Institute, Sacramento, CA University of North Carolina at Greensboro University of Oklahoma</td>
<td>Authors evaluated resident involvement, broad representation and civic engagement beyond the local initiative. Findings suggest that the Healthy Cities and Communities model can be successful in facilitating community participation.</td>
</tr>
<tr>
<td>Gray-Molina et al. (2001)</td>
<td>IDB</td>
<td>Using a survey of clients, doctors and nurses, this study examines the scope and determinants of corruption in Bolivia’s public health sector. The authors find that ‘voice’ mechanisms such as citizen activism and oversight are significant in exposing bribery and deterring the overpricing of medical supplies. Hierarchical controls, such as administrative regulations and procedures, seem to have little impact on hospital corruption. In Bolivia, citizen health board activism was an important deterrent of informal payments and was associated with lower prices in government procurement of essential supplies.</td>
</tr>
<tr>
<td>Lee et al. (2009)</td>
<td>Department of International Health, Johns Hopkins Bloomberg School of Public Health</td>
<td>There is moderate quality evidence that community mobilization with high levels of community engagement can increase institutional births and significantly reduce perinatal and early neonatal mortality. Meta-analysis showed a doubling of skilled birth attendance and a 36% reduction in early neonatal mortality.</td>
</tr>
</tbody>
</table>

Participation

We cite a model successful in facilitating community participation that was used in the California Healthy Cities and Communities (CHCC) program. Ten of the 20 coalitions had memberships comprised of mainly local residents in the planning phase, and five maintained a high level of resident involvement in governance during the implementation phase (Kegler et al., 2009). In Bolivia, Citizen Voice mechanisms were significant in exposing bribery and deterring informal payments and the overpricing of medical supplies (Gray-Molina et al., 2001). A JHU systematic review of the strategies to link families and facilities found moderate quality evidence that community mobilization with high levels of community engagement can increase institutional births and significantly reduce perinatal and early neonatal mortality (Lee et al., 2009). Their meta-analysis showed a doubling of skilled birth attendance and a 36% reduction in early neonatal mortality. Similarly, Gogia & Sachdev (2010) and Pronk, Peck & Goldstein (2004) found beneficial effects of community mobilization and stakeholder collaboration activities.

However, systematic reviews tend to not find any impact of participatory approaches, community mobilization, consumer involvement, or inter-agency collaboration on health outcomes mainly because of methodological weaknesses of the studies conducted in this realm. Methodological weaknesses have prevented development of a robust evidence base. A review (Nilsen et al., 2006) indicates that randomized controlled trials are feasible for providing evidence in this regard. The field is waiting to see the generation of this kind of high-quality evidence.

Table 10: Client participation in decision-making processes
<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tbody>
<tr>
<td>Gogia &amp; Sachdev (2010)</td>
<td>Norwegian Knowledge Centre for the Health Services, Oslo, Norway</td>
<td>Home visits for antenatal and neonatal care, together with community mobilization activities, are associated with reduced neonatal mortality and stillbirths in southern Asian settings with high neonatal mortality and poor access to facility-based health care.</td>
</tr>
<tr>
<td>Pronk, Peck &amp; Goldstein (2004)</td>
<td>HealthPartners</td>
<td>Pronk et al. (2004) used a systematic approach to synthesize evidence from research and stakeholder dialogue on the way in which multiple behavioral risk factors (smoking, sedentary lifestyles, poor diet) are addressed in primary care. They conclude that the risk factors that impact on the 'big killers' (cancers, CVD and coronary heart disease) can be successfully addressed only by a collaborative approach, including: • development of platforms for multiple stakeholder dialogues • using stakeholder views to inform priorities and policy • supporting initiatives aimed at getting evidence into practice • further research and development of innovative projects (through demonstration projects) • further research on multiple risk factor interventions.</td>
</tr>
<tr>
<td>Crawford et al., 2002</td>
<td>Primary Care and Population Health Sciences, Imperial College, London</td>
<td>The objective was to examine the effects of involving patients in the planning and development of health care. Papers often described changes to services that were attributed to involving patients, including attempts to make services more accessible and producing information leaflets for patients. Changes in the attitudes of organizations to involving patients and positive responses from patients who took part in initiatives were also reported. Evidence supports that involving patients has contributed to changes in the provision of services across a range of different settings. An evidence base for the effects on use of services, quality of care, satisfaction, or health of patients does not exist.</td>
</tr>
<tr>
<td>Nilsen et al. (2006)</td>
<td>Norwegian Knowledge Centre for the Health Services, Oslo, Norway. Social Science Research Unit, Institute of Education, University of London, London</td>
<td>The objective was to assess the effects of consumer involvement and compare different methods of involvement in developing healthcare policy and research, clinical practice guidelines, and patient information material. There is little evidence from comparative studies of the effects of consumer involvement in healthcare decisions at the population level. The studies included in this review demonstrate that randomised controlled trials are feasible for providing evidence about the effects of consulting consumers to inform these decisions.</td>
</tr>
<tr>
<td>Swainston (2008)</td>
<td>NICE</td>
<td>Twenty one primary studies covering a range of community engagement methods/approaches were identified which focused on the planning, design and/or delivery of primary health promotion interventions. No studies relating to community collaboratives or citizens juries were identified and no data regarding priority setting, resource allocation or governance was found. Six of the 21 primary studies provided the evidence for determining the barriers to using community engagement methods/approaches. However, no data describing interventions to overcome barriers or information pertaining to what doesn’t work was provided.</td>
</tr>
<tr>
<td>Evans, Pilkington, McEachran (2010)</td>
<td>University of the West of England</td>
<td>This systematic review demonstrates that there is very little evidence in the peer-reviewed literature of participatory approaches by UK public health units or of such approaches having any noteworthy impact on health and social outcomes. Five thousand four hundred and fifty-one references were identified, reduced to 2155 once duplicates were removed. Only eight papers covering seven studies were relevant and included in the analysis. Only two studies met more than half of the relevant quality appraisal criteria. The studies fell into two distinct groups: four used qualitative methods to illustrate the complexities of effective community participation; three claimed success for their participative initiative without providing adequate evidence to substantiate such claims.</td>
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</table>
Leadership

The best evidence in this regard comes from a program evaluation in Kenya conducted in 2010 by Management Sciences for Health (MSH). MSH evaluated the impact of the Leadership Development Program (LDP) on service delivery outcomes through a study comparing intervention versus no intervention (usual practice). The main objective of the evaluation was to find out whether the LDP intervention produced changes in health outcomes that did not occur in no-intervention areas where the LDP was not implemented. The study results showed that the LDP intervention improved health service delivery outcomes, and that these improvements were sustained after the LDP intervention ended. This study used a quasi-experimental design that compared before and after measures of outcome addressed by 67 LDP teams against comparison areas that did not receive the intervention.

Having a no-intervention group for comparison is a strength of this study. However, there is difficulty in attributing the results to the intervention for several reasons. First, the intervention teams, facilities and districts and the comparison areas were not randomly assigned. Second, there could be systematic differences in the intervention teams, facilities and districts and the comparison areas. Third, there are differences in the measurement strategies. Data were collected for the LDP teams by contacting each of the 67 team leaders whereas data for comparison areas were collected through the Health Management Information Systems (HMIS). The HMIS Officers extracted data from service delivery registers and district health records for the comparison areas. In addition, there was non-equivalence in the measurement strategies in the intervention and the no-intervention areas. The teams participating in the intervention also may have also been biased in reporting which could lead to overstatement of results. The six-month period of the study would also be considered too short to infer the long-term sustainability of results.

Table 11: Competencies of governors: political, technical and leadership

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
</tr>
</thead>
</table>
| MSH (2010) | Management Sciences for Health, Cambridge, Massachusetts, USA | With support from USAID’s Office of Population and Reproductive Health, Management Sciences for Health conducted a collaborative programmatic assessment in Kenya in 2009-2010 to evaluate the impact of the Leadership Development Program (LDP) on service delivery outcomes through a rigorous study using comparison groups. The main objective of the assessment was to demonstrate whether the LDP intervention produces changes in health outcomes that do not occur in comparison areas where the LDP was not implemented.

The study results show that the LDP intervention improved health service delivery outcomes, and that these improvements were sustained after the LDPs ended. Similar changes were not observed in the comparison areas. |
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Institution</th>
<th>Summary</th>
</tr>
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<tbody>
<tr>
<td>Mansour, Mansour, &amp; El Swesy (2010)</td>
<td>Management Sciences for Health, Cambridge, Massachusetts, USA</td>
<td>In 2003, after participation in the LDP, the districts of Aswan, Daraw and Kom Ombo increased the number of new family planning visits by 36%, 68% and 20%, respectively. The number of prenatal and postpartum visits also rose. After the United States funding ended, local doctors and nurses scaled up the program to 184 health care facilities (training more than 1000 health workers). From 2005 to 2007, the Leadership Development Program participants in Aswan Governorate focused on reducing the maternal mortality rate as their annual goal. They reduced it from 85.0 per 100,000 live births to 35.5 per 100,000. The reduction in maternal mortality rate was much greater than in similar governorates in Egypt. Managers and teams across Aswan demonstrated their ability to scale up effective public health interventions though their increased commitment and ownership of service challenges. When teams learn and apply empowering leadership and management practices, they can transform the way they work together and develop their own solutions to complex public health challenges. Committed health teams can use local resources to scale up effective public health interventions.</td>
</tr>
<tr>
<td>Kebede et al., 2012.</td>
<td>Yale GHLI</td>
<td>The authors sought to assess the contributions of a systems-based approach, the Ethiopian Hospital Management Initiative (EHMI), which established hospital chief executive officers (CEOs) trained through a Masters of Healthcare and Hospital Administration (MHA) degree program in Ethiopia. This is a pre-post study of 24 hospitals that are managed by CEOs in the MHA program. The authors measured changes in hospital functioning based on adherence to a set of 86 hospital performance standards across 12 management domains published in the Standards for Hospital Management in Ethiopia. They found that adherence to hospital performance standards increased significantly during the one-year follow-up (27% compared with 51% of standards met at baseline and follow-up, respectively; P-value &lt; 0.001); overall improvement was driven by improvement in seven of the 12 management domains.</td>
</tr>
<tr>
<td>Huss et al., (2010)</td>
<td>University of Leeds, Nuffield Centre for International Health and Development, Leeds, UK, Karuna Trust, Karnataka State, Bangalore, India</td>
<td>Governance in the health sector is affected by positive and negative forces. A key positive factor was the combined social, cultural and symbolic capital of the two leaders which empowered them to challenge corrupt behavior and promote good governance. Although change was possible, it was precarious and requires continuous political support to be sustained.</td>
</tr>
<tr>
<td>Fung-Kee-Fung et al., 2009</td>
<td>The Ottawa Hospital, Ottawa, Ontario, Canada.</td>
<td>A systematic review of the literature identifying regional collaborations in surgical practice examining practices related to quality improvement was carried out. A community of practice framework incorporating the success elements described in the systematic review of the literature can be used as a valuable model for collaboration amongst surgeons and healthcare organizations to improve quality of care and foster continuing professional development. One of the success elements is clinical leadership.</td>
</tr>
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</table>

**Other enablers**

**Evidence**

We know from evidence that there are numerous clinical and public health interventions that promote health and lead to better health outcomes. For example, we know that conditional cash transfer programs are effective in increasing the use of preventive services and sometimes in improving health status (Lagarde, Haines, & Palmer, 2009). We know from evidence that insecticide-treated-nets (ITNs) are highly effective in reducing childhood mortality and morbidity from malaria (Lengeler, 2009). We also know that there are interventions aiming to influence or change physicians’ behavior (usually towards compliance with clinical guidelines) which work (Grimshaw et al., 2002).

Recently a global team of researchers led by researchers from Swiss Tropical and Public Health Institute, University of Basel, McMaster University, and Norwegian Knowledge Centre for the Health Services published a three-part series that sets out
how evidence should be translated into guidance to inform policies on health systems and improve the delivery of clinical and public health interventions.  

Two research questions in this context are whether the research evidence has informed policy or a decision (that is research informed the conceptual approach to problem definition, or research informed the identification or characterization of policy options or implementation strategies), and whether the research evidence informed policymaking or decision-making has resulted in better health outcomes.

Though it may seem obvious that evidence-based policy making leads to better health outcomes, we do not have high quality evidence to establish this hypothesis. The research in this field is emerging. For example, Armstrong et al. (2011) have published a protocol for a review of the effectiveness of knowledge translation strategies (or processes) aimed at facilitating evidence-informed public health decision-making by managers and policymakers. Yet the research question whether evidence-based policymaking leads to better health outcomes remains unexplored.

Armstrong et al. (2011) identify from literature four challenges in linking evidence to policy.

“In understanding these barriers and facilitators, four commonly cited challenges in linking evidence to policy include the following (Lavis 2009):

1. Research evidence competes with many other factors in the policy-making process (e.g. institutional constraints, interest group pressure, citizens’ values, and other types of information like politicians’ and civil servants’ past experiences).

2. Research evidence is not valued enough by policy-makers as an information input.

3. Research evidence is not relevant to the policy issues that policy-makers face.

4. Research evidence is not easy to use, which may be as a result of one or more of the following factors: research is not communicated effectively (e.g. policy-makers hear ‘noise instead of music’ coming from the research community), research evidence is not available within the urgent timelines in which policy-makers typically work, or in a form that they can readily use; policy-makers lack mechanisms to prompt them to use research evidence in policy-making (e.g. policy makers can get caught up in the urgency of policy-making processes without asking whether and how research evidence could support different stages of what is a highly dynamic and iterative process); anc policy-makers and researchers don’t create opportunities for issue-focused discussions that are informed by research evidence and by the tacit knowledge brought to the table by those who will be involved in, seek to influence and be affected by decisions in a given domain.”

Table 12: Evidence-based policymaking

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tbody>
<tr>
<td>Lagarde, Haines, &amp; Palmer (2009) Cochrane summaries</td>
<td>London School of Hygiene &amp; Tropical Medicine, London, England.</td>
<td>Overall, the evidence suggests that conditional cash transfer programs are effective in increasing the use of preventive services and sometimes improving health status. The conditional cash transfers (CCT) schemes may result in a number of benefits to health for poor populations. Many conditional cash transfer programs include a number of components, including incentivizing attendance for health education, measurements of height and weight, immunizations and nutritional supplementation. Conditional cash transfer programs appear to be an effective way to increase the uptake of preventive services and encourage some preventive behaviors. In some cases programs have noted improvement of health outcomes.</td>
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<tr>
<th>Author(s)</th>
<th>Research Group/Institution</th>
<th>Text</th>
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<tr>
<td>Lengeler (2009) Cochrane summaries</td>
<td>Public Health and Epidemiology, Swiss Tropical Institute, Basel, Switzerland</td>
<td>ITNs are highly effective in reducing childhood mortality and morbidity from malaria. Widespread access to ITNs is currently being advocated by Roll Back Malaria, but universal deployment will require major financial, technical, and operational inputs. Sleeping under mosquito nets treated with insecticide aims to prevent malaria in areas where the infection is common. They are widely promoted by international agencies and governments to reduce the bad effects of malaria on health. This review showed that good quality studies of impregnated nets markedly reduce child deaths and illnesses from malaria.</td>
</tr>
<tr>
<td>Chaudhury et al. (2006)</td>
<td>Development Research Group at the World Bank</td>
<td>Results from surveys are reported in which enumerators made unannounced visits to primary schools and health clinics in Bangladesh, Ecuador, India, Indonesia, Peru and Uganda and recorded whether they found teachers and health workers in the facilities. Averaging across the countries, about 19 percent of teachers and 35 percent of health workers were absent.</td>
</tr>
<tr>
<td>Grimshaw et al. (2002)</td>
<td>Health Services Research Unit, University of Aberdeen, Aberdeen, Scotland Centre for Health Services Research, University of Newcastle Upon Tyne, England</td>
<td>In a review of 235 studies of interventions aiming to influence or change physicians' behavior (usually towards compliance with clinical guidelines), Grimshaw et al. (2002) conclude that interventions involving active dissemination of good quality information, educational outreach, reminders and multifaceted (as opposed to single-factor) approaches based on assessment of potential barriers to change were most likely to be effective.</td>
</tr>
<tr>
<td>Jepson, Harris, Platt, &amp; Tannahill (2010)</td>
<td>Department of Nursing and Midwifery, University of Stirling, UK</td>
<td>There are interventions that are effective in achieving behavioral change.</td>
</tr>
<tr>
<td>Liu, Hotchkiss, &amp; Bose (2008)</td>
<td>National Institutes of Health, Fogarty International Center, Bethesda, MD 20892, USA.</td>
<td>Overall, while the review of the selected studies suggests that contracting-out has in many cases improved access to services, the effects on other performance dimensions such as equity, quality and efficiency are often unknown.</td>
</tr>
<tr>
<td>Patouillard, Goodman, Hanson, &amp; Mills (2007)</td>
<td>Health Economics and Financing Programme, London School of Hygiene and Tropical Medicine, London, UK.</td>
<td>Authors report the impact of private sector interventions on quality and/or utilization of care by the poor. Many interventions have worked successfully in poor communities and positive equity impacts can be inferred from interventions that work with types of providers predominantly used by poor people.</td>
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Meta-analysis showed that interventions that contain at least 1 Chronic Care Model (CCM) element improve clinical outcomes and processes of care—and to a lesser extent, quality of life—for patients with chronic illnesses.

Kaseje et al. (2010)
Great Lakes University of Kisumu, Kenya

Great Lakes University of Kisumu developed and tested a model of evidence-based dialogue with communities for facilitating improvement in the performance of the District Health System (DHS) and, hence, the health status of poor households served. The model consisted of evidence-based dialogue between the communities and service providers, working with service consumers as partners in improving service delivery and outcomes. The study was undertaken in partnership with the Ministry of Health (MOH) and the Communities. The model was tested by introducing it in selected sites and carrying out health facility and household sample surveys at the beginning of the intervention and two years later in both intervention and control sites. Among the key improvements noted were: governance and management of the health system; service delivery and health outcomes in terms of immunization coverage; usage of insecticide treated nets; and utilization of skilled attendance at childbirth.

Based on the results, the Kenyan MOH adopted the model as a strategy for the implementation of the Kenya Essential Package for Health countrywide. The University developed the implementation guidelines and training materials for rolling out the strategy countrywide.
Qualitative data can help to define the pressures and social norms related to corruption, and to assess the detailed pathways by which corruption happens. For example, interviews with providers and patients in Bulgaria, Albania, Armenia, Azerbaijan and the Republic of Georgia revealed many details about why providers feel pressured to accept unofficial payments for services that are supposed to be offered free of charge, and why patients feel pressured to make these payments.

Authors used qualitative methods to better understand pressures behind the pilfering of public supplies of drugs by government employees in Mozambique and Cape Verde. Qualitative data may identify potential barriers to accountability, citizen voice and the other factors that influence opportunities for corruption.

Technology

We did not come across any literature on effectiveness of the use of technology in governance. We cite two examples of how the use of technology in management has resulted in more effective health care and more effective health service.

Table 14: Technology: ICT, eGovernance, etc.

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tr>
<td>Cohen &amp; Montoya. (2001)</td>
<td>World Bank</td>
<td>There are a number of steps that hospitals can take to increase drug procurement transparency, thus promoting cost-effectiveness and increasing equity to access to those in need. In Chile, the creation of an electronic bidding system and the use of the Internet for information dissemination, in a process that involved the stakeholders, enabled hospitals to determine fair practices and prices and achieve significant savings.</td>
</tr>
<tr>
<td>U4 Policy Brief No. 3 (October 2006, <a href="http://www.u4.no">http://www.u4.no</a>).</td>
<td>Anti-Corruption Resource Centre, Chr. Michelsen Institute, Bergen, Norway.</td>
<td>A large government provincial referral hospital in Kenya identified a problem with theft of user fee revenue. This problem was seen as serious, both because user fee revenue accounted for about 24% of the hospital's non-personnel expenditure budget, and because patients had complained about the abuse. With donor assistance, the hospital conducted a patient survey and review of control systems to collect more information. They found many systemic weaknesses, including a large number of fee collection points, manual receipt and ledger book system that did not allow timely account reconciliation, unclear policies, and infrequent supervision. The main intervention used to address these abuses was the installation of networked electronic cash registers. To limit discretion, multiple cash collection points were reduced to five, and procedures were put in place to separate the functions of billing and fee collection. The cash registers helped improve internal accountability by speeding the data collection and analysis, producing automated reports which allowed managers to see daily and cumulative monthly revenue, by item, cash collection point, cost center and by cashier. The system helped to detect corruption by facilitating the comparison of reported revenue with expected revenue, based on prices and number of patients or services provided. The system increased transparency by providing patients with an itemized receipt for the services billed, amount paid and change received. External accountability and citizen voice were improved by sharing information on user fee system performance with the hospital management committee, which had citizen representation, and with other district and MOH officials. Within 3 months, user fee revenues increased 47% with no effect on service utilization. Over the next 3 years, annual collections increased 400%, due mainly to better revenue controls (though one modest price increase did take place as well during this period). Several factors were essential to the successful application of anti-corruption theory in this case. First, the hospital management team and Board of Directors were committed to improving the quality and responsiveness of the hospital, and were not colluding with the fee collection agents. Where collusion is present, this type of control system might not be implemented fully, and external accountability mechanisms become more important. In addition, the hospital management team had sufficient autonomy that fee collection agents who resisted the new system could be removed from their jobs and replaced by carefully screened new agents. Without this level of autonomy in merit-based personnel management, it is doubtful the system would have achieved its goals.</td>
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Free media environment

We provide an example from literature on how broadcasts of local government audits over the radio for a random selection of sub-counties in Uganda led to changes in the knowledge, attitudes, and behaviors of citizens and in the performance of public officials. We did not find examples pertaining to the health sector in the literature.

Table 15: Free media

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<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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Culture

Two examples are cited from the UK setting where culture was found to be an important determinant of the effectiveness of clinical governance.

Table 16: Culture

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tbody>
<tr>
<td>Tait AR (2004)</td>
<td>Lothian Primary Care Trust, The University of Edinburgh, Edinburgh, UK</td>
<td>Clinical governance is about changing the way people work; demonstrating that leadership, teamwork and communication is as important to high quality care as risk management and clinical effectiveness. Whilst the sharing of information between practices is seen to be increasing with multi-professional study days occurring in some areas this in turn needs commitment for time and funding. The organizational and cultural environment within the trust as well as resource issues needs continuous attention if high quality governance is to become the norm.</td>
</tr>
<tr>
<td>Marshall et al., (2002)</td>
<td>University of Manchester</td>
<td>Senior primary care managers regard culture and cultural change as fundamental aspects of clinical governance. The most important desirable cultural traits were the value placed on a commitment to public accountability by the practices, their willingness to work together and learn from each other and the ability to be self-critical and learn from mistakes. The main barriers to cultural change were the high level of autonomy of practices and the perceived pressure to deliver rapid measurable changes in general practice. The culture of general practice is perceived to be an important component of health system reform and quality improvement.</td>
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How does governance relate to health system strengthening and health outcomes?

The evidence on the causal impact of governance on health system strengthening and health outcomes is not well developed. Three studies are informative, one in which effective governance was strongly associated with lower under-five mortality rates; another in which governance was found to have influence on health of individuals indirectly through its positive impact on income or the quality of the health care sector; and the third in which public health spending was found to lower child and infant mortality rates in countries with good governance. All three studies are country level studies.
### Table 17: Whether governance in general matters for health outcomes?

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Main finding</th>
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<tbody>
<tr>
<td>Olafsdottir et al., (2011)</td>
<td>Centre for Public Health Research, Brunel University, West London, UK; Global Public Health, Jeffrey Cheah School of Medicine and Health Sciences, Monash University, Bandar Sunway, Malaysia</td>
<td>Governance was strongly associated with U5MR and moderately associated with the U5MR quintile ratio. After controlling for possible confounding by healthcare, finance, education, and water and sanitation, governance remained significantly associated with U5MR. Governance was not, however, significantly associated with equity in U5MR outcomes. This study suggests that the quality of governance may be an important structural determinant of health systems performance, and could be an indicator to be monitored. The association suggests there might be a causal relationship. However, the cross-sectional design, the level of missing data, and the small sample size, forces tentative conclusions. Further research will be needed to assess the causal relationship, and its generalizability beyond U5MR as a health outcome measure, as well as the geographical generalizability of the results.</td>
</tr>
<tr>
<td>Klomp &amp; De Haan (2008),</td>
<td>Faculty of Economics and Business, University of Groningen, PO Box 800, 9700 AV Groningen, The Netherlands, CESifo, Munich, Germany</td>
<td>Government governance is not directly related to the health of individuals once economic and demographic control variables are included. Indirectly, however, governance has influence on health via its positive impact on income and the quality of the health care sector. However, the significance of these indirect effects differs across country groups. In countries with a relatively healthy population, governance has a positive indirect effect through the quality of the health care sector, but not via income. In countries with poor health, governance has a positive indirect effect through income, but not via the quality of the health care sector.</td>
</tr>
<tr>
<td>Andrew Sunil Rajkumar &amp; Swaroop (2002)</td>
<td>Georgetown University World Bank</td>
<td>Public health spending lowers child and infant mortality rates in countries with good governance. Results also indicate that as countries improve their governance, public spending on primary education becomes effective in increasing primary education attainment. These findings have important implications for enhancing the development effectiveness of public spending. The lessons are particularly relevant for developing countries, where public spending on education and health is relatively low, and the state of governance is often poor.</td>
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</table>

Three additional studies suggest promising future research opportunities. The first one is a qualitative study from Rwanda which found enhanced health governance at local level contributed to improved health outcomes. The second study is a systematic review of literature on the most effective strategies for improving quality and safety of health care, and it found clinical governance arrangements have not been adequately evaluated with regard to effectiveness. There is a paucity of studies in this area. The third study reviews the evidence from systematic reviews of the effects of health system arrangements and implementation strategies, with a particular focus on evidence relevant to primary health care in LMICs. The authors of this study did not find any systematic reviews that addressed questions regarding governance arrangements for primary health care other than franchising, regulation and accreditation, for example, decentralization of decision-making, the regulation of training, or the control of corruption.

### Table 18: Whether governance in health sector matters for health outcomes?

<table>
<thead>
<tr>
<th>Citation</th>
<th>Affiliation</th>
<th>Finding</th>
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</thead>
<tbody>
<tr>
<td>Brinkerhoff, Fort &amp; Stratton (2009)</td>
<td>RTI International</td>
<td>This study investigates how Twubakane’s efforts to support the decentralization of Rwanda’s health system and to build the capacity of local governments to plan, budget for, and deliver health services have enhanced health governance and contributed to improved health outcomes. The majority of Twubakane’s impacts on health governance outcomes reside in three areas: efficiency and effectiveness; accountability; and responsiveness. These three are followed next in importance by voice and transparency.</td>
</tr>
<tr>
<td>Scott (2009)</td>
<td>Internal Medicine and Clinical Epidemiology, Princess Alexandra Hospital, Brisbane, Queensland, Australia</td>
<td>Manager/policy-maker driven quality improvement strategies (QIS) including continuous quality improvement programs, risk and safety management systems, public scorecards and performance reports, external accreditation, and clinical governance arrangements have not been adequately evaluated with regard to effectiveness.</td>
</tr>
<tr>
<td>Lewin et al. (2008)</td>
<td>Department of Public Health and Policy, London School of Hygiene and Tropical Medicine</td>
<td>One of the prioritized reviews focused in part on the effects of governance strategies. This review addressed strategies for working with the private for-profit sector – including franchising, regulation and accreditation – to improve the utilization of quality health services by the poor. There was some evidence that regulation may improve the quality of pharmacy services. The review also showed that the accreditation of pharmacy outlets may have weak positive effects on the use of unregistered drugs, compared to non-accredited facilities. Franchising interventions had mixed effects on quality of care, health care behaviors and client satisfaction. Although few studies included detailed socio-economic data on participants, the authors concluded that many of these interventions were likely to be effective in poor communities.</td>
</tr>
</tbody>
</table>
Appendix

Ethical principles of justice/fairness

1. Rule of law
   - Accountability for the proper exercise of authority and use of public resources
   - Equity in administering rewards and punishments
   - Equality of rights and opportunities
   - Participation in the consultative process for collective decision-making
   - Merit system in contracting personnel

2. Ethical principles of truth
   - Truthfulness in reporting the facts
   - Honesty in managing resources
   - Evidence-based decision-making
   - Transparency of decision-making and resource management for public scrutiny
   - Safeguards for whistle-blowers

3. Ethical principles of service to the common good
   - Consensus-building in relation to the common good
   - Application of human development indicators
   - Inclusiveness
   - Spirit of service
   - Respect for human dignity

4. Ethical principles of trusteeship
   - Legal contract between government and public servant
   - Responsible stewardship
   - Efficient and effective service of the public interest
- Transparency regarding possible and apparent conflict of interest
- Recognition of merit and adequate remuneration


**Capabilities for moral leadership**

1. Capabilities that facilitate personal transformation

   - The capability to evaluate one's strengths and weaknesses without involving the ego: self-evaluation
   - The capability to learn based on the systematic reflection on action within a coherent and evolving conceptual framework
   - The capability to take initiative in a creative and disciplined manner
   - The capability to persevere in achievement of goals and objectives
   - The capability to oppose one's lower passions and negative impulses by concentrating one's mind on higher and noble purposes

2. Capabilities that facilitate interpersonal relationships (team work)

   - The capability to participate effectively in consultation for collective decision-making
   - The capability to build consensus in constructing a shared vision
   - The capability to encourage the heart of others (motivate and inspire)
   - The capability to mediate the resolution of conflicts
   - The capability to promote unity in diversity

3. Capabilities that facilitate social transformation

   - The capability to promote and establish justice
   - The capability to comprehend and transform relationships of domination towards relationships of collaboration, complementarity and mutual service
   - The capability to understand and interpret current events within an appropriate historical perspective
   - The capability to construct consensus about the common good by means of dialogue and consultation
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Ferrinho et al. (2004). Pilfering for survival: how health workers use access to drugs as a coping strategy. Human Resources for Health, 2:4


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stakeholder dialogue sessions. *American Journal of Preventive Medicine, 27* (SUPPL.), 4-17.


Transparency International (2006)


The USAID Leadership, Management, and Governance project is a five-year cooperative agreement with a funding ceiling of $200 million and is able to accept funding from all accounts. Missions and bureaus may access these state-of-the-art services and receive technical oversight and leadership from LMG through field support or sub-obligations on an annual or multi-year basis.

The LMG Consortium is also engaging with private sector partners to increase the impact of our activities and interventions, in particular to strengthen the capacity of our local partners to serve as stewards of the health systems and institutions they lead.

For further information, and to explore options for requests to address critical health leadership, management and governance challenges and needs in your country, please contact:

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