

GOVERNANCE AND HEALTH RESOURCE GUIDE

GOVERNANCE, EQUITY AND HEALTH PROGRAMME INITIATIVE

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2nd Edition

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Foreword – Needs to be replaced

There is increasing recognition that accountability, transparency, and vigorous citizen participation are essential to achieving a viable society, sustainable economic growth, and equitable distribution of the benefits and risks of growth. Similarly, there is a growing consensus that many of the chronic problems faced by African countries relate to poor governance. In many of these countries, for example, it has been shown that citizens lose confidence in governments that are unable to deliver basic services.¹ An important challenge, then, is to support mechanisms through which vulnerable groups can effectively exercise their rights to health in an informed and proactive way. If democratic forms of governance are to be effective, they must rely on public participation, accountability, and transparency.²

The health sector and health systems can be seen as a microcosm of these challenges and dynamics. Examples of health policy and system failures abound. Where the disease incidence is disproportionately higher among the poor, such as the case of tuberculosis, lack of access to health services exacerbates the problem. Public health systems continue to be underfunded, poorly managed, and affected by “brain drain” to the North as well as the loss of large numbers of trained personnel to AIDS. While new vaccine, treatments and interventions are certainly needed, they will not help the poor – and indeed can consume resources which might otherwise benefit them – unless policies, systems, and financial and human resources ensure that they are available, accessible, affordable, and acceptable. Concrete measures to improve participation, transparency and accountability in health service delivery can also help to deepen and strengthen democratic governance, through offering examples of effective implementation of “rule of law” and the creation of public spaces for dialogue and institutional change.

Good health is an outcome of many determinants and processes, most of which lie outside the health sector. Social inequalities, persistent poverty, an eroded public sector – and in Africa AIDS and its fellow travelers – are important and interrelated factors that contribute to persistent poor health status and aggravate social and political tensions. They cannot be tackled in isolation of each other, nor can they be mitigated without careful attention to socio-cultural, political, economic, and environmental realities as well as the bio-epidemiological situation.

While research and evidence has been shown to strengthen civic engagement and catalyze political and values-based action, the linkages between research, policy and practice remain insufficiently developed. To address this situation, however, researchers need to influence the broader environment in which policy choices are made, which requires an in-depth understanding of issues relating to equity, governance, power, social dynamics, and more.

Within this broader context, this resource guide is intended to provide researchers with a road map to issues of governance, and more specifically as it relates to health and health systems research. It is intended to provide an overview of key concepts related to governance, identify various tools and indicators that can be used to measure specific governance-related issues, as well as identify key resources available in the literature. It is hoped that this resource guide will strengthen individual

¹ Anderson, 1999; Bond and Zandamela, 2000; McDonald and Pape, 2002; Seddon and Walton, 2004; USAID, 1998.

² Equinet, 2000.

researchers' capacity to conduct applied research that will both strengthen and monitor the capacity of governments to ensure equitable financing and delivery of priority public health and health care services, especially to marginalized and underserved populations.

FIGURE 1: GOVERNANCE, EQUITY AND HEALTH

"Created in 2003, Governance, Equity and Health (GEH) is a Programme Initiative of the International Development Research Center, Canada. Through its program of work, it aims to contribute to a shift in thinking and practice among key actors so that political and governance challenges, equity concerns, and technical health and health policy questions are increasingly considered as integrally related.

GEH remains one of the very few sources of funding and technical support available to Southern research teams for developing and implementing the research and knowledge translation agendas arising from [the] renewed global interest [on health systems and health systems research].... Moving beyond descriptive measurement, GEH supports research efforts that seek to understand and redress health inequities facing the populations of the South."

Specifically, GEH's work addresses three specific objectives:

- **Making a difference on the ground:** To inform and support, through research-derived evidence, the development and implementation of a GEH vision of health policy and health systems, in specific LMIC contexts;
- **Informing global policy debates:** To influence, in Canada and globally, the arenas of health policy, research and systems by informing policy dialogue related to areas of GEH thematic focus, particularly by supporting a stronger voice for Southern health researchers and health institutions; and
- **Institutionalizing a GEH approach:** To develop research capacities, build a GEH Community of Practice, and support the adoption of a GEH approach to health systems research and policymaking beyond IDRC.

Source: *Governance, Equity and Health Prospectus, April 2006-March 2011*. Ottawa: IDRC, 2006.

For more information, please visit: www.idrc.ca/geh

Acronyms

ART	Anti-retroviral treatment
ASSALUD	Asociación Colombiana de la Salud
CGD	Centre for Global Development
CPI	Corruption Perception Index
DALE	Disability Life Expectancies
EQUINET	Regional Network for Equity in Health in East and Southern Africa
FCTC	Framework Convention on Tobacco Control
FSDoH	Free State Department of Health
GEGA	Global Equity Gauge
GEH	Governance, Equity and Health
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GHG	Global Health Governance
HIS	Health Information System
HRBA	Human Rights-Based Approach
IDRC	International Development Research Center
IDS	Institute of Development Studies
IHG	International Health Governance
MAP	World Bank's multi-country HIV/AIDS programme
MDG	Millennium Development Goal
NEPAD	New Partnership for Africa's Development
NGO	Non-governmental organisation
OECD	Organization for Economic Co-operation and Development
OHCHR	Office of the High Commission for Human Rights
PAHO	Pan American Health Organization
PALSA	Practical Approaches to Lung Health South Africa
PEPFAR	President's Emergency Plan for Aids Relief
PHM	People's Health Movement
PPP	Public-private partnership
RITC	Research for International Tobacco Control
UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United National Development Program
WB	World Bank
WGI	World Governance Indicators
WHO	World Health Organization

1. Introduction to the Guide

1.1. The aims of this Guide

This resource guide is primarily designed to assist individuals and groups conducting research in a variety of areas related to Governance and Health. It aims to provide information to researchers with a range of knowledge backgrounds, from those who are seeking to learn about what governance is and how it broadly relates to health systems, to those who are seeking frameworks to analyze particular governance issues in a specific context. It should however be noted that while researchers (and more specifically health researchers) represent the primary audience for this resource guide, many of the sections may be of interest to a wider variety of actors, including – but not limited to – health practitioners, programme managers, policy analysts, and policy makers.

This resource guide is intended to provide a road map to issues of governance, and more specifically as they relate to health and health systems research. It offers an overview of key concepts related to governance and health, identifies various tools and indicators that can be used to measure specific governance-related issues, and identifies key resources available in the literature. The overall purpose of this guide is therefore to ‘set the scene’ by untangling some of the various concepts and issues related to governance and health (and health systems), introducing some of the key debates in the field, and highlighting some key references. As such, it does not purport to list all available resources on governance, health, and related issues, nor does it attempt to resolve any current debates in the field. Instead, it should only be seen as the starting point for further research.

It is hoped that this resource guide will strengthen individual researchers’ capacity to conduct applied research that will both strengthen and monitor the capacity of governments to ensure equitable financing and delivery of priority public health and health care services, especially to marginalized and underserved populations.

Specifically, this guide aims to assist researchers in the preparation, modification and evaluation of research that considers issues in Governance and Health or that explores various issues through a governance lens. This resource guide can therefore serve a variety of purposes, and can:

- Serve as a starting point to conduct a more in-depth literature review;
 - Assist researchers seeking to modify an existing research proposal to enhance the content on Governance and Health;
-

- Assist researchers in the assessment, analysis, monitoring and evaluation of various topics relevant to a study of Governance and Health;
- Assist in the interpretation of research outcomes and the evaluation of research findings.

1.2. How to use this guide

Section 2 contains definitions and descriptions of relevant terms and concepts. These are meant to place the issues being discussed in context, and begin to demystify the various meanings often given to specific terms. In addition to terminology, this section includes an exploration of the prevailing notions about the meaning of governance and related concepts, with attention being paid to controversial areas and competing schools of thought. The processes and actors involved in ‘governance’ are also explored.

Questions addressed include: What is governance? Good governance? Health governance? Global Governance? Global health governance? What does governance look like in practice? Who is involved in governance?

Section 3 presents various frameworks, indicators, checklists and diagrams that can be used to explore issues of governance in a more systematic manner.

Section 4 explores the relationship between governance and health and contains suggested publications from a variety of sources. This section is not exhaustive: it focuses on two selected issues - decentralization and public participation – and introduces the reader to two additional issues (health information systems and health and governance in fragile states).

Section 5 gives examples of important health topics that reveal governance issues: HIV/AIDS; tobacco control; and maternal and child health.

In an effort to facilitate the efficient and timely location of information on desired topics, the resource guide contains the following features to assist readers. First, each sub-topic in sections 3, 4 and 5 begins with an introduction providing background information on the topic. This is then followed by complete references and, in some cases, a short summary of content for articles or resources related to the sub-topic. A list of additional relevant resources is also provided (references only). Note that in section 4, summaries are not generally provided, as this section is meant to serve more as a non-exhaustive bibliography that can guide further research and assist the researcher in determining whether the scope of the literature is suited to his/her purposes, and identify additional related articles. In addition, some sub-sections contain general literature, as well as literature that focuses on specific country contexts, grouped according to five of the WHO’s six regions (see **Annex A** for a presentation of these regions). Finally, throughout the guide, specific projects are highlighted and described in order to provide concrete examples of research that addresses governance and related issues.

2. Exploration of terminology and description of concepts

The following section explores the various notions of Governance and related terms and concepts

2.1. Governance

While the use of the term ‘Governance’ is now widespread, its emergence into mainstream vocabulary is relatively new and can be traced to the last few decades. When first adopted by individuals and organizations active in international development, the concept was initially used to analyze the various ways in which power was exercised, and the frame of reference was limited to the actions and institutions of governments.³ It is, however, increasingly being recognized that ‘governance’ extends well beyond the exclusive prerogative of ‘governments’ (or states), and an increasing range of actors is now taken into account. As Rosenau explains,

“Governance is not synonymous with government. Both refer to purposive behaviour, to goal oriented activities, to systems of rule; but government suggests activities that are backed by formal authority...whereas governance refers to activities backed by shared goals that may or may not derive from legal and formally prescribed responsibilities and that do not necessarily rely on police powers to overcome defiance and attain compliance.”⁴

Similarly, a 1997 United Nations Development Programme (UNDP) policy document explains how “governance encompasses the state, but it transcends the state by including the private sector and civil society organizations.”⁵

Governance “is about power, relationships and accountability: who has influence, who decides, and how decision makers are held accountable... Governance is not only about where to go, but also about who should be involved in deciding and in what capacity.”

Plumptre and Graham, 1999.

³ Bratton and Rothchild, 1992.

⁴ Rosenau, 1995.

⁵ UNDP, 1997.

While today the distinction between government and governance is widely acknowledged, there remain a variety of conceptions about the exact meaning of governance, who it involves, as well as how the process actually unfolds. As such, consensus around a single definition of governance has yet to develop. In most cases, however, definitions of governance look at how decisions are made, by whom and in pursuit of what objectives. When referring to different resources, researchers should pay attention to the ways in which governance is defined, as this will influence how events, actions, projects and systems are analyzed and interpreted. As Bonnie Campbell explains, discussions of governance can address a variety of aspects, including the form of a political regime, the processes by which authority is exercised in the management of a country's economic and social resources, and the capacity of a government to design, formulate, and implement policies and the general way in which it discharges its functions.⁶ The definitions given below are intended to provide a general overview of the state of the literature on the issue.

According to the *Institute on Governance*, “governance determines who has power, who makes decisions, how other players make their voice heard and how account is rendered.”

What is Governance? Institute on Governance

The UNDP defines governance as “the system of values, policies and institutions by which a society manages its economic, political and social affairs through interactions within and among the state, civil society and private sector. It is the way a society organizes itself to make and implement decisions – achieving mutual understanding, agreement and action. It comprises the mechanisms and processes for citizens and groups to articulate their interests, mediate their differences and exercise their legal rights and obligations. It is the rules, institutions and practices that set limits and provide incentives for individuals, organizations and firms. Governance, including its social, political and economic dimensions, operates at every level of human enterprise, be it the household, village, municipality, nation, region or globe.”

UNDP Strategy Note on Governance for Human development, 2004

The World Bank (WB) defines 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.”

World Bank Institute, 2004

“In broad terms, governance can be defined as the actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals...Defined in this way, governance pertains to highly varied sorts of collective behaviour ranging from local community groups to transnational corporations, from labour unions to the UN Security Council. Governance thus relates to both the public and private sphere of human activity, and sometimes a combination of the two.”

Dodgson, Lee and Drager, 2002

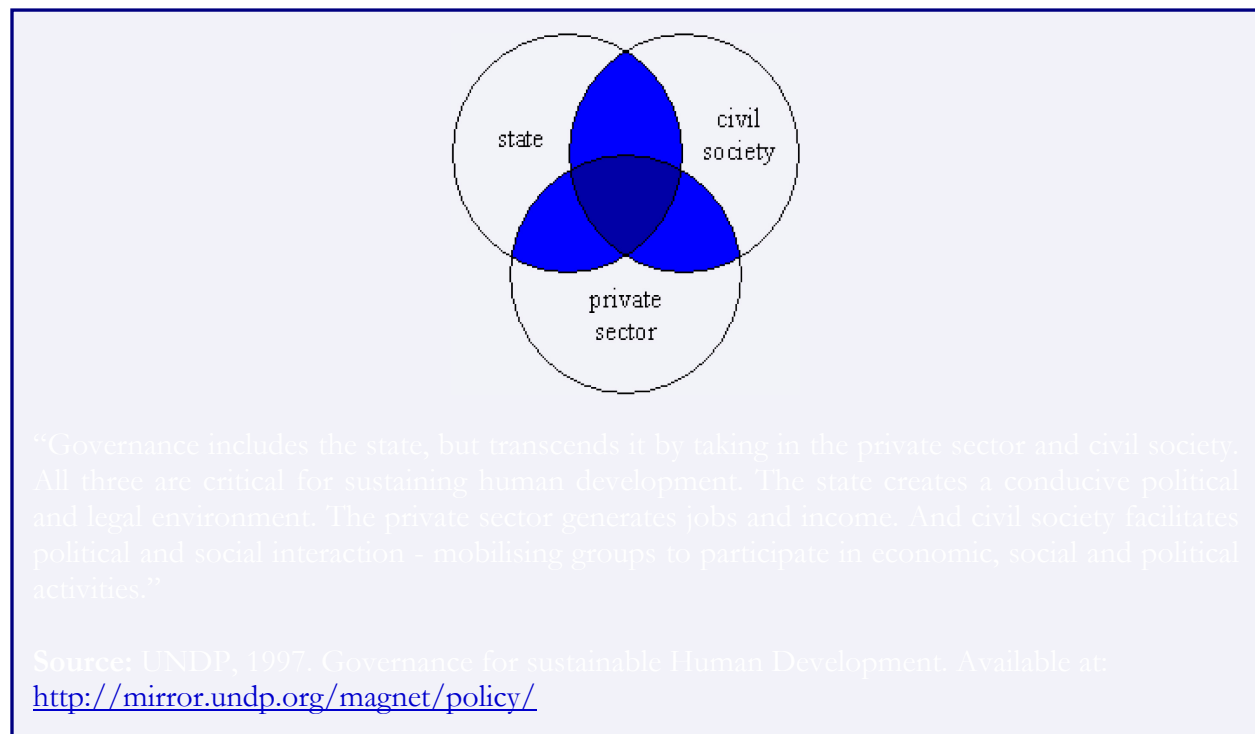
⁶ Campbell, 1997.

2.1.1. Who is involved in Governance?

While initial approaches to, and conceptualizations of, governance tended to focus on the role of central governments, the concept is now generally understood to encompass a wide variety of actors. The government and its various sectors and institutions certainly remain central players (and at various levels: multilateral/transnational, national, state/provincial, local, village level, etc), but other actors include private enterprises (for example, financial, manufacturing, or trading institutions), public and private partnerships (PPPs), national or international non-governmental organisations (NGOs), community associations, donor agencies, research groups, social movements, and more, whether these groups be organized into formal bodies or not. According to the UK's Overseas Development Institute, six main areas matter in terms of governance: civil society; political society; government; bureaucracy; economic society; and the judiciary (see **Annex B**).⁷

The use of the term governance as a synonym for government can have negative policy implications. For example, if a particular issue is defined as a problem of 'government', the onus of responsibility for addressing this problem is likely to be placed on such an entity. This approach can unnecessarily limit policy options and effectively hamper the involvement of other sectors of society that would be well suited to contribute to finding a 'solution.' As Plumptre and Graham explain, "confusion over terminology related to governance can have important practical consequences: it may affect not only the definition of a problem, but also the policy analysis about how to resolve it."⁸

FIGURE 2: GOVERNANCE ACTORS



⁷ Court, 2006.

⁸ Plumptre and Gramham, 1999.

2.1.2. Good Governance

The concept of ‘good governance’ first entered mainstream development dialogue when it was introduced by the World Bank (WB) “as an explanation for problems being experienced in many countries, namely the weakness of public sector institutions and management and as a basis for setting further lending conditionalities.”⁹ At the time, the WB defined good governance as being “epitomized by predictable, open and enlightened policy making; 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.”¹⁰ Various other development agencies and organizations adopted the term and concept in an attempt to understand and explain – with an eye on formulating recommendations – the differences in performance between countries that were undergoing similar reforms and receiving similar aid packages. While the WB’s focus still tends to be on the performance of the government, many others understand good governance as going beyond public sector management.¹¹

In recent years, the focus on good governance has been reinforced by empirical evidence demonstrating the positive correlation with development. As former Secretary General of the United Nations Kofi Annan’s once explained, “good governance is perhaps the single most important factor in eradicating poverty and promoting development.”¹² Similarly, good governance is now being recognised as critical to sustained economic growth.¹³

Good governance and its indicators are by no means easily agreed-upon concepts. As Plumptre and Graham suggest, identifying criteria for ‘good governance’ depends on one’s values and cultural norms, as well as on the desired outcomes.¹⁴ Notwithstanding such caveats, some norms and values do appear to be valid across various contexts, and these include **participation, legitimacy, fairness, accountability and performance**. With some variation, the characteristics of global governance articulated by the UNDP in 1997 are widely accepted as indicators of good governance (See **Annex C** for further details). These are:

- Participation;
- Rule of law;
- Transparency;
- Responsiveness;
- Consensus orientation;
- Equity;
- Effectiveness and efficiency,
- Accountability; and,
- Strategic vision.¹⁵

Recently, investing in public health is increasingly being perceived as a key criterion of good governance.¹⁶ At its core, good governance refers to a situation where citizens are given a voice in the process of

⁹ Dodgson, Lee and Drager, 2002.

¹⁰ World Bank, 1994.

¹¹ Ibid.

¹² United Nations Organization, 1998.

¹³ Kaufmann and Kraay, 2008.

¹⁴ Plumptre and Graham, 1999.

¹⁵ UNDP, 1997.

¹⁶ Kirton, *et al*, 2009.

decision-making and the allocation of resources through mechanisms that are transparent and that hold authorities accountable for their actions.

Measuring (or monitoring and evaluating) governance for its part requires not only sound and well-delineated indicators, but it also requires reliable and readily available evidence that can be used to measure performance (or lack thereof) against targets and objectives. **Section 3** discusses measurements issues in more detail, while **Section 4** introduces health information systems as one potential source of sound evidence.

FIGURE 3: THE AFRICAN PEER REVIEW MECHANISM (APRM)

In 2001, the New Partnership for Africa's Development (NEPAD) was launched by African heads of states to address current challenges facing the African continent, notably poverty, underdevelopment, gender issues, and improve its level of integration with the global system. As part of NEPAD, the APRM was launched in 2003 as "an instrument voluntarily acceded to by Member States of the African Union as an African self-monitoring mechanism" whose mandate is to "ensure that the policies and practices of participating countries conform to the agreed values in the following four focus areas: democracy and political governance; economic governance; corporate governance; and socio-economic development." The APRM entails periodic reviews of the policies and practices of participating countries to assess progress being made towards mutually agreed goals as well as compliance in the four focus areas. As of 19 June 2008, the APRM counts 29 member states.

For more information, please visit: <http://www.aprm-international.org/>

2.1.3. Health Governance

While the past decade has seen increased interest in 'health governance' – often also referred to as health systems governance – the literature on the subject is not abundant.¹⁷ A very useful definition is however given by Dodgson, Lee and Drager, where health governance is defined as:

"the actions and means adopted by a society to organize itself in the promotion and protection of the health of its population. The rules defining such organization, and its functioning, can be formal (i.e., Public Health Act, International Health Regulations) or informal (i.e., Hippocratic oath) to prescribe and proscribe behavior. The governance mechanism can be situated at the local/sub national (i.e., district health authority), national (i.e., Ministry of Health), regional (i.e., Pan American Health Organization), or international (i.e., WHO) level. Health governance can be public, private or a combination."¹⁸

Similarly, Brinkerhoff and Bossert explain that health governance "is about developing and putting in place effective rules...for policies, programs, and activities related to fulfilling public health functions so as to achieve health sector objectives. These rules determine which societal actors play which roles, with what set of responsibilities, related to reaching these objectives."¹⁹

"Governance is a function of the state yet it cannot function without all actors across the health system – communities, civil society, private providers, membership organizations, public health. Good health governance, for its part, largely depends on good governance in other sectors of society – in other words, how a country performs with respect to other governance indicators (including Siddiqi S, et al, 2009.

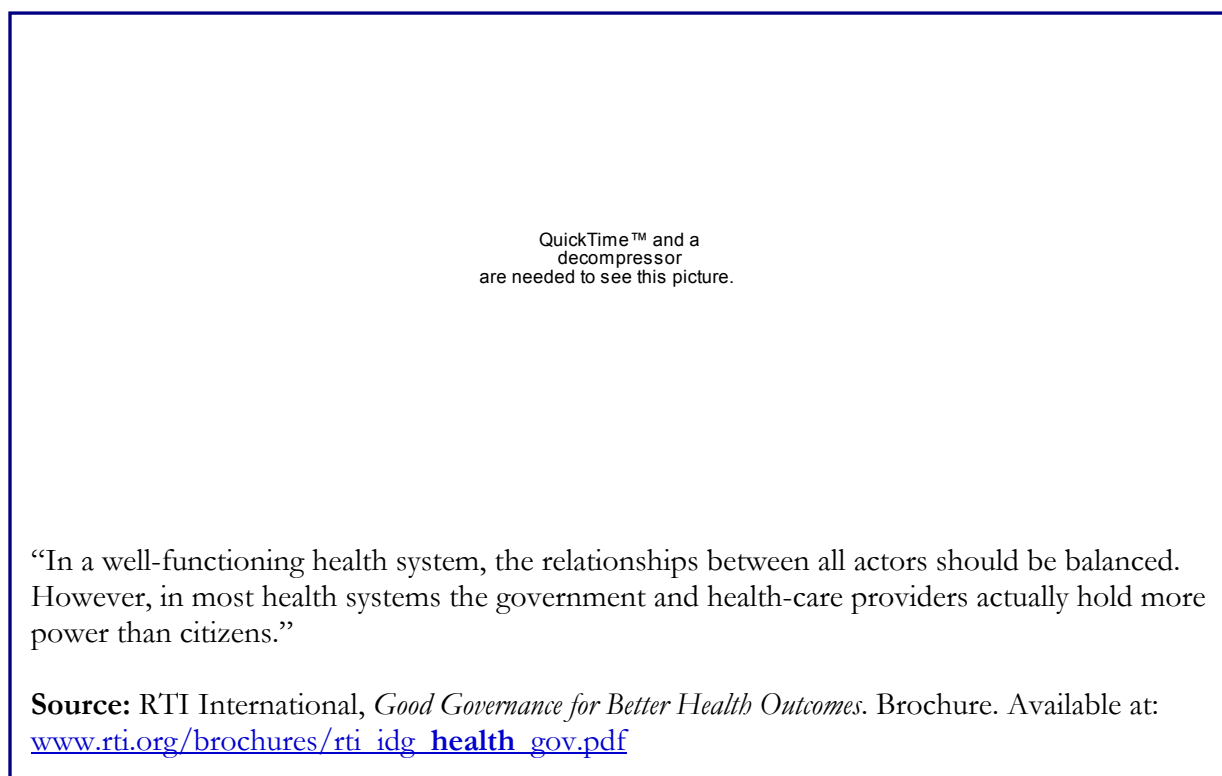
¹⁷ Siddiqi S, et al., 2009.

¹⁸ Dodgson, Lee and Drager, 2002.

¹⁹ Brinkerhoff and Bossert, 2008.

macroeconomic arenas) is likely to affect the governance of its health sector. Aggregate governance indicators and frameworks (as discussed in **section 3** of this resource guide) can therefore be of use when analyzing health governance.

FIGURE 4: HEALTH GOVERNANCE AND ITS ACTORS



2.1.4. Global Health Governance

Underlying the concept of global health governance, *global governance* itself broadly refers to

“Not only the formal institutions and organizations through which the rules and norms governing world order are (or are not) made and sustained – the institutions of the state, inter-governmental cooperation and so on – but also those organizations and pressure groups – from MNCs, transnational social movements to the plethora of non-governmental organizations – which pursue goals and objectives which have a bearing on transnational rule and authority systems.”²⁰

When the first attempts at global health governance (GHG) – at that time referred to as international health governance (IHG) – emerged in the late 19th century, the focus was on national level governments, seen as the main actors responsible for the health of their population. When necessary, it was expected that these governments would cooperate in addressing pressing international challenges that affected their own populations. In recent decades, however, and with the rapid increase in the scope and pace of globalization, there has been a shift towards the global sphere and a broadening of the response to determinants of health. Kelley Lee identifies three ways in which GHG differs from the earlier concept of

²⁰ Held, *et al*, 1999.

IHG.²¹ First, she argues that whereas IHG involves cross border cooperation between governments concerned primarily with the health of their own populations, GHG addresses transborder flows that impact on health. Second, instead of focusing solely on the role of national governments, GHG “embraces both governmental and non-governmental actors and a wider range of formal and informal governance mechanisms.”²² Finally, GHG looks beyond the health sector to address the broad determinants of health, including impacts from non-health sectors.

“**International health**’ was already a term of considerable currency in the late 19th and early 20th century, when it referred primarily to a focus on the control of epidemics across the boundaries between nations (i.e., “international”). ‘Intergovernmental’ refers to the relationships between the governments of sovereign nations—in this case, with regard to the policies and practices of public health.

‘**Global health**,’ in general, implies consideration of the health needs of the people of the whole planet above the concerns of particular nations. The term ‘global’ is also associated with the growing importance of actors beyond governmental or intergovernmental organizations and agencies—for example, the media, internationally influential foundations, nongovernmental organizations, and transnational corporations.”

Brown T.M., *et al*, 2006.

Health risks are no longer seen as limited to geopolitical boundaries, and various actors are now recognized as active participants.²³ As James Ricci argues, “from SARS to Andrew Speaker²⁴ to the H1N1 pandemic, infectious diseases are no longer confined to specific geographical areas and through the machinery of globalization impact peoples separated by vast distances within short periods of time.”²⁵ In part, such a shift emerged from the recognition that, within as well as beyond the health sector, national governments alone were often unable to appropriately address new challenges that increasingly transcend national borders. In terms of the health sector, as Dodgson, Lee and Drager explain, such new challenges include:

- 1) the increase in transborder health risks;
- 2) the increase in the number and influence of non-state actors;
- 3) the socioeconomic, political and environmental problems brought about by globalization; and,
- 4) the decreasing capacity of governments to deal with global challenges on an individual basis.

For these authors, “global health emphasizes the need for governance that incorporates participation by a broadly defined ‘global’ constituency, and engaging them in collective action through agreed institutions and rules.”²⁶

²¹ Lee, 2007.

²² Lee, 2007.

²³ Tarantola, 2005.

²⁴ The Andrew Speaker example refers to an incident where an individual with a rare form of tuberculosis traveled across the Atlantic Ocean by air and in the process came into contact with thousands of individuals who were unaware of his disease status. It is used to illustrate the changes in the way diseases can now be spread.

²⁵ Ricci, 2009

²⁶ Dodgson, Lee and Drager, 2002.

In practice, however, such inclusive participation and collective, democratic decision making by a “global constituency” is an ideal that, in today’s international system, is the exception rather than the rule.²⁷ Often, institutions that are created to address issues that are beyond the control of individual nation-states are neither transparent nor accountable to a global constituency, but instead remain under the effective control of a select few – a situation commonly referred to as the ‘global democratic deficit’.²⁸ Creating democratic institutions and rules that are meant to regulate the conduct of global affairs is certainly not an easy endeavour. As John S. Dryzek comments, “it is thinly democratic when nation-states gather and negotiate international agreements; at best this is democracy at one remove, piggybacking on any degree of democracy present in the states involved.”²⁹ In turn, such a realization has brought others to question whether global governance even requires the creation of formal organizations, or if instead “governance without government” might not be a preferable alternative.³⁰ For James Bohman, examples of inadequate global governance calls for a new approach – specifically the idea of “cosmopolitan democracy,” which in Bohman’s formulation “seeks to overcome the democracy deficit through a strategy of building up transnational agreements (and their resultant international ‘regimes’) as emergent norms and institutions.”³¹ As with other writers on cosmopolitan democracy, the focus here is not such much on equal access to power for all, but rather on equal access (in terms of opportunity as well as capability) to influence the decision making process and have a voice within it.³²

The often-advanced idea of “bottom-up cosmopolitanism” envisages a new type of global governance achieved from the ground up and “from the group up”.³³ Unlike globalization-from-above or Held’s (1995) early conceptions of cosmopolitanism that would essentially “supersize” existing governing bodies under-girded by a humane code of laws, bottom-up cosmopolitanism is built upon civil society’s active but often informal participation in the policy process. Many authors now conceive of civil society as the emergent “model or strategy for global democracy and democratization,”³⁴ with the “deliberative public sphere” central to most conceptions of civil society essential to any project of bottom-up cosmopolitanism. Civil society’s deliberation, networking, fluidity, grassroots character and inclusiveness can make it, in this vein, the “universum which competing nations have never succeeded in creating”.³⁵

Further adding to the debate, representatives from a range of civil society organizations working in health recently met in Geneva (May 14-15, 2010) to discuss the need, and potential for reform of current GHG structures. Participants concluded that “the way in which the contemporary regime of GHG operates contributed to the continued high burden of avoidable ill-health globally and this regime should be challenged and reformed.”³⁶ As such, the meeting resolved to launch a GHG reform initiative and commissioned an interim steering group to follow this through.

These various perspectives highlight the need to look beyond the current state of affairs and question whether the institutions and rules that were put in place decades ago remain appropriate. The *HIV Monitor*, presented in **Figure 5**, is one example of a research program that seeks to understand and

²⁷ Dryzek, 1999.

²⁸ Bohman, 1999.

²⁹ Dryzek, 1999.

³⁰ Rosenau, 1994.

³¹ Bohman, 1999.

³² Ibid.

³³ Baker, 2002.

³⁴ Goodhart, 200.

³⁵ Ghils, 1992.

³⁶ People’s Health Movement. 2010.

evaluate global mechanisms whose actions have an undeniable impact on activities and policies at the local level but whose decision making structure are not directly accountable to local constituencies.

FIGURE 5: THE HIV MONITOR

From 2001 to 2006, global funding for HIV/AIDS has more than quadrupled, passing from \$2.1 billion to an estimated \$8.9 billion. Behind such an increase lies the burgeoning of three major financing initiatives: the Global Fund to Fight AIDS, Tuberculosis, and Malaria (the Global Fund), the World Bank's multi-country HIV/AIDS programme (MAP), and the United States' Emergency Plan for Aids Relief (PEPFAR). While such funding is certainly needed, its disbursement by three entities that design, deliver and manage their assistance differently and are neither always transparent nor accountable to their recipients is likely to pose many challenges.

The HIV Monitor is a program that seeks to contribute to improving funding agencies' policymaking by undertaking and disseminating comparative analyses of the three major sources of international funding for HIV/AIDS prevention, treatment and care. Its overall goal is "to improve the performance of all three initiatives by examining key issues in their design and approach, and providing timely analyses to improve the efficiency and effectiveness of each initiative." The project, led by the Centre for Global Development (CGD), will examine the operations, procedures, and performance of the three initiatives in three African countries, with complementary research activities and assessments conducted at the global level. Based on the recommendations that have come out of its research, the HIV Monitor has been tracking policy changes among the three agencies, and these can be explored on the project's website.

For more information, please visit: <http://www.cgdev.org/section/initiatives/active/hivmonitor>

2.2. Additional Key Terms and Concepts

2.2.1. Health Systems³⁷:

Although health systems can be characterized in a variety of ways, for the purposes of this resource guide we use the definition put forward by the World Health Organization (WHO) in its 2000 World Health Report where health systems "are defined as comprising all the organizations, institutions and resources that are devoted to producing health actions. A health action," in turn, "is defined as any effort, whether in personal health care, public health services or through intersectoral initiatives, whose primary purpose is to improve health."³⁸ According to the same report, the boundaries of a health system are generally seen to include:

- Formal health services, including the professional delivery of personal medical attention;
- Actions by traditional healers and all use of medication, whether prescribed by a provider or not;
- Home care of the sick;

³⁷ For a in-depth discussion of issues surrounding past, current and future African health system directions, you are encouraged to visit www.research-matters.net where you will find a synthesis of six speculative working papers looking at what an affordable and sustainable 21st century sub-Saharan African health system might look like.

³⁸ WHO, 2000.

- Traditional public health activities as health promotion and disease prevention, and other health enhancing interventions like road and environmental safety improvement.

While not mentioned in this particular report, additional and important underlying determinants of health that should be included within the boundaries of a health system include: safe water, sanitation, food, housing, health information, and gender equality.

Actions that are not primarily intended to improve the health of a given population will not be included within a health system. Those, however, that are “intended chiefly to improve health indirectly by influencing how non-health systems function – for example, actions to increase girls’ school enrolment or change the curriculum to make students better future caregivers and consumers of health care” – should also be included.³⁹

FIGURE 6: HEALTH SYSTEMS REFORM IN TANZANIA: THE DRAMATIC RESULTS OF THE TANZANIA ESSENTIAL HEALTH INTERVENTIONS PROJECT (TEHIP)

In the early 1990s, Tanzania’s health system was in shambles. Many Tanzanians had stopped seeking health care for themselves or their children. Health care was not properly planned; there was a shortage of drugs, equipment and skilled health workers needed to deliver services; and facilities were dilapidated and understaffed. UNICEF estimated that Tanzania’s under-five child mortality rate at the time was 160 per 1000 (vs. Canada’s rate of 5 per 1,000 in 1990).

The Tanzania Essential Health Interventions Project (TEHIP), a collaboration established in 1997 between IDRC and the Tanzanian health ministry, began work on several fronts to pioneer new approaches to health planning and priority setting, by linking operational research with development as well as setting up systems to accurately monitor the impact on the health of people. The goal underpinning TEHIP was to produce knowledge, tools and strategies to fix bottlenecks and progressively ensure that all parts of the decentralised district health system work with increasing efficiency.

In just a few years, TEHIP produced dramatic results that put Tanzania on course to achieving the Millennium Development Goal of cutting under-five deaths by two-thirds ahead of the 2015 target date. The country reduced child mortality by 40% over five years in two TEHIP pilot districts at a cost of less than 80 cents per capita to health budgets. Since then, Tanzania has rolled out these tools and interventions nationwide. TEHIP’s success has had profound influence on African and global thinking through stressing the fundamental importance of strong, well-governed and prioritised health systems. Burkina Faso, Ghana, Nigeria and other African countries are using the TEHIP model in reforming their health systems.

For more information, please visit: http://www.idrc.ca/en/ev-3170-201-1-DO_TOPIC.html

2.2.2. Stewardship:

Stewardship featured prominently in the Work Health Report 2000, where it was presented as one of the four functions of a health system (the others being service delivery, investment, and financing). In the report, the WHO explains how “stewardship encompasses the tasks of defining the vision and direction of health policy, exerting influence through regulation and advocacy, and collecting and using information. At the international level, stewardship means mobilizing the collective action of countries to generate

³⁹ WHO, 2000.

global public goods such as research, while fostering a shared vision towards more equitable development across and within countries. It also means providing an evidence base to assist countries' efforts to improve the performance of their health systems."⁴⁰

2.2.3. Civil society:

A comprehensive definition of the term, or concept, is offered by the London School of Economics:

"Civil society refers to the arena of uncoerced collective action around shared interests, purposes and values. In theory, its institutional forms are distinct from those of the state, family and market, though in practice, the boundaries between state, civil society, family and market are often complex, blurred and negotiated. Civil society commonly embraces a diversity of spaces, actors and institutional forms, varying in their degree of formality, autonomy and power. Civil societies are often populated by organizations such as registered charities, development non-governmental organizations, community groups, women's organizations, faith-based organizations, professional associations, trades unions, self-help groups, social movements, business associations, coalitions and advocacy group."⁴¹

2.2.4. Partnership:

The term partnership is yet another one for which there is little consensus over its exact meaning. A literature review conducted by Wildridge *et al.* however, identified the following elements as being common to most definitions: between organizations, groups, agencies, individuals, and disciplines; common aims, vision, goals, mission or interests; joint rights, resources and responsibilities; new structures and processes; autonomous, independent; improve and enhance access to services for users and carers; equality; and trust.⁴²

For Brinkerhoff, any definition of partnership must include the following two elements: 1) Mutuality (as interdependence and commitment between partners, equality in decision-making, rights and responsibilities), and 2) Organizational identity (i.e. the maintenance of each partner's own mission, strategies and values).⁴³

Additional definitions of partnership include:

- Understood and mutually enabling, interdependent interaction with shared intentions.⁴⁴
- A collaborative venture between two or more organizations that pool resources in pursuit of common objectives.⁴⁵
- Power shared equally with all partners.⁴⁶

Policy Partnerships, for their part, "aim to provide all partners with a better strategy to address a specific project or goal than any partner could muster, operating independently."⁴⁷

⁴⁰ WHO, 2000.

⁴¹ London School of Economics. "What is Civil Society?"

⁴² Wildridge, *et al.*, 2004.

⁴³ Brinkerhoff, 2004.

⁴⁴ Cromwell, Lucas and Pasteur, 2000.

⁴⁵ Edgar and Chandler, 2004.

⁴⁶ Cromwell, Lucas and Pasteur, 2000.

⁴⁷ Edgar and Chandler, 2004.

2.2.5. Accountability:

As explained by Cromwell *et al.*, accountability addresses the management of power relations and involves “giving an account to another party who has a stake in what has been done.”⁴⁸ It refers both to a sense of responsibility, and to the act of being held to account by others. For Brinkerhoff, answerability is at the core of accountability, and he identifies two types of questions that can be asked: the first asks only to be ‘informed’, while the second asks for explanations and justifications.⁴⁹

“Accountability encompasses holding individuals and organizations responsible for performance measured as objectively as possible. Public accountability refers to the spectrum of approaches, mechanisms, and practices used by governments to ensure that their activities and outputs meet the intended goals and standards. This notion of accountability is applicable to all levels of government, public enterprises, individuals, and groups.”⁵⁰

2.2.6. Equity:

Equity is by no means an easily defined or agreed upon concept, but the basic tenets of *justice* (social and distributive) and *fairness* are usually agreed to be core elements of any definition. In an effort to offer a definition that can lead to operationalisation and measurement, Braveman and Gruskin define equity in health as “the absence of systematic disparities in health (or in the major social determinants of health) between social groups who have different levels of underlying social advantage/disadvantage – that is, different positions in a social hierarchy.”⁵¹

FIGURE 7: REGIONAL NETWORK FOR EQUITY IN HEALTH IN EAST AND SOUTHERN AFRICA (EQUINET)

EQUINET was established in 1997 by southern African institutions and individuals as a response to the political call for equity in health arising at a meeting in Kasane, Botswana, that took place that same year. The network is dedicated to influencing and supporting national and regional policies and practices to promote equity in health. In practice, EQUINET commissions, supports and undertakes research; builds capacity for research and policy analysis; initiates conferences, workshops and dialogue; and published and disseminates information. By analyzing the links between health, health resources, public policies and practice in health care, and governance itself, EQUINET seeks to build human and institutional capacity, involve stakeholders in policy dialogue, and above all promote equitable health policies. The Equinet website contains a number of useful resources, including their Newsletter, a bibliography on equity in health as well as numerous publications on various theme areas.

For more information, please visit: www.equinet africa.org

An important distinction to note is that equity is not synonymous with equality. Indeed, the former term “focuses attention on the distribution of resources and other processes that drive a particular kind of health inequality – that is, systematic inequality in health (or its social determinants) between more or less

⁴⁸ Cromwell, Lucas and Pasteur, 2000.

⁴⁹ Brinkerhoff, 2004.

⁵⁰ UN-SIA, 1998.

⁵¹ Braveman and Gruskin. 2003.

advantaged social groups, in other words, a health inequality that is unjust or unfair.”⁵² Within this framework, two main types of equity can be defined:

Horizontal equity is the principle that says that those who are in identical or similar circumstances should pay similar amounts in taxes (or contributions) and should receive similar amounts in benefits.

Vertical equity is the principle that says that those who are in different circumstances with respect to a characteristic of concern for equity should, correspondingly, be treated differently, e.g., those with greater economic capacity to pay should pay more; those with greater need should receive more.⁵³

The importance of understanding the basic tenets of the concept of equity is highlighted by the fact that it can serve as a strong underpinning in the development and governance of health systems that will contribute to the health and well being of the population. In Southern Africa for example, there exist many positive examples of equity-based public policies and health system developments that led to improvements in health status and reductions in health inequalities.⁵⁴ Such public policies include the redistribution of health budgets towards prevention, investments in community-based health care, improved access to and quality of rural, informal urban and primary care infrastructures and services, and removing cost barriers to primary care services at point of use.⁵⁵ In many contexts, however, inequities in health persist and current policies only serve to reinforce the status quo, again bringing to the fore the need for more and better research that can inform the development of equity-oriented policies and health systems.

FIGURE 8: IMPROVING THE PERFORMANCE AND ENHANCING THE GOVERNANCE OF PRIMARY HEALTH CARE IN LATIN AMERICA

The concept of Primary Health Care (PHC) first came into focus through the Alma-Ata Declaration in 1978. PHC was defined as essential health care based on a multidisciplinary approach, community participation and appropriate, cost-effective technologies, and being the first level of contact with the health system in a continuing, comprehensive and integrated health care process accessible to all individuals and families. Most LMIC countries, including those in Latin America, have implemented fragmented, inequitable health services involving a minimum basket of poor quality services directed at low-income population groups. Additionally, current policy initiatives aimed at reforming Latin American health systems tend to focus on technical components while neglecting issues of governance.

Carried out in Argentina, Brazil, Paraguay and Uruguay, the *Southern Cone Countries Multi-Center Study in Primary Health Care* project aims to identify the limits and opportunities of adopting PHC as a core strategy to achieve more integrated and universal health systems. Meanwhile, the *Governance Analytical Framework: an Approach to Health Systems Research* project developed and tested a Governance Analytical Framework, hoping it will contribute to a better understanding of health policies, both their development and implementation, in Latin America, with a focus on PHC strategies at the municipal level in Argentina and Bolivia.

For more information, please visit: http://www.idrc.ca/en/ev-128718-201-1-DO_TOPIC.html
http://www.idrc.ca/en/ev-67575-201_103998-1-IDRC_ADM_INFO.html

⁵² Ibid.

⁵³ European Observatory on Health Systems and Policy.

⁵⁴ Equinet, 2004.

⁵⁵ Ibid.

3. Frameworks, Indicators, Checklists and Diagrams – Aids in exploring issues of governance

In this section, note that the topic is presented first, followed by key article references, and a brief summary of content.

3.1. Why measure governance?

When governance is seen as providing “pathways to desired conditions and outcomes,” it becomes evident that measuring current states of overall governance in a specific context can serve to better understand, explain and eventually alter health outcomes.⁵⁶ As Besançon explains, measuring governance allows us to “set standards for improvement and achievement as well as indicate where funds could best be of use and where policy might prove most effective.”⁵⁷ Governance indicators can also serve important monitoring and evaluation functions and lead to the identification of benchmarks, targets, aims and objectives. An assessment of the current state of governance within a specific country can in turn facilitate the formulation of reforms that are feasible and that are sensitive to the local context.⁵⁸ At the same time, there are risks inherent to any attempt to use indicators to measure governance, including the fabrication or manipulation of data to serve vested interests, the subjective character of many of the indicators, and the lack or low levels of systematic data collection efforts.

As Court, Hyden and Mease explain, “measuring issues of governance poses challenges that are not encountered in the economic or social development fields. While it is easier to provide firm indicators of such things as economic growth or primary school enrolment, it is much more difficult to find and agree upon indicators of a political macro phenomenon like governance or political rights.”⁵⁹

Notwithstanding such caveats, international organizations, international financial institutions, governments, development agencies, NGOs and others are using governance indicators to analyze

⁵⁶ Plumptre and Graham, 1999.

⁵⁷ Besançon, 2003.

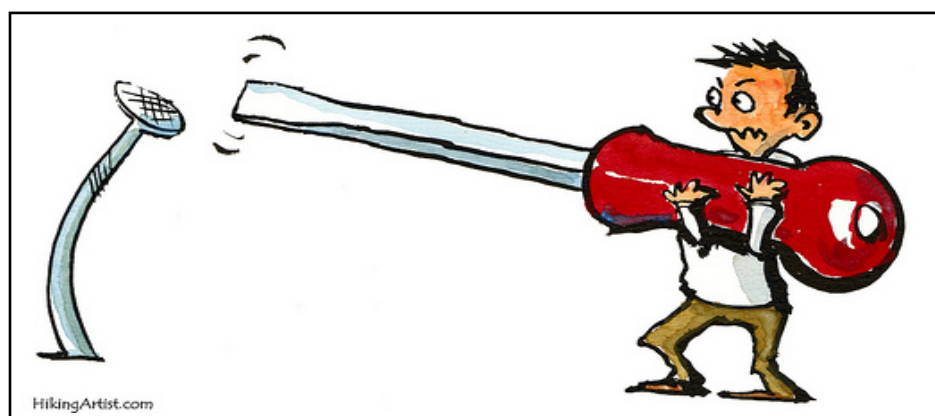
⁵⁸ Court, 2006.

⁵⁹ Court, Hyden and Mease, 2002.

issues of governance, compare performances across countries, monitor and evaluate programmes and projects, as well as to set priorities and policies. It is therefore important to be aware of and understand the measures that are currently being used with an eye on finding ways to improve their objectivity and cohesiveness.

When using any particular indicator, or combination of indicators, however, individuals should pay close attention to the definitions being used, the stated purpose of the indicators, and the sources of the data. When analysing and interpreting any governance measures, it is also critical to be aware of potential (and inevitable) measurement errors.⁶⁰ In addition, as Devarajan aptly points out: “it would be dangerous to use indicators to jump to simple conclusions without understanding the specific relation between governance and development in a particular country; the indicators should certainly not be used by themselves to design policy responses to problems of weak governance.”⁶¹ Finally, selection of an indicator or set of indicators should be appropriate to the task at hand.⁶²

FIGURE 9: MATCHING OUR TOOLS AND PURPOSE



3.2 Governance Indicators

A recently published article by Daniel Kaufmann and Aart Kraay titled “Governance Indicators: Where are We, Where Should We Be Going?” acts as a good starting point for anyone interested in making use of governance indicators. As such, it offers a very useful perspective on different types of indicators available today, their purposes, the evidence they rely on, and the ways in which they are compiled. The authors also highlight a number of issues that researchers should bear in mind when using governance indicators.

Among other things, the authors make a useful distinction between *rules-based* and *outcomes-based* indicators. The former measure “rules on the books”, and “codify details of the constitutional, legal, or regulatory environment: the existence or absence of specific agencies, such as anticorruption commissions or independent auditors; and so forth – components intended to provide the key *de jure* foundation of governance.” For their part, the latter look at “rules on the ground” and “assess *de facto* governance outcomes that result from the application of these rules (Do firms find the regulatory environment

⁶⁰ Kaufmann and Kraay, 2008.

⁶¹ Devarajan, 2008

⁶² Kaufmann and Kraay, 2008.

cumbersome? Do households believe the police are corrupt?).”⁶³ In the second section of their article, the authors explore these two types of indicators in more detail, and look at the pros and cons of each.

Where the article is also useful is in its discussion of the sources of evidence for governance indicators (i.e. expert assessments vs. survey firms and individuals) as well as the differences between aggregate and individual indicators. Finally, the authors discuss three of the major existing aggregate governance indicators: the World Governance Indicator (WGI), the Corruption Perceptions Index (CPI) of Transparency International, and the Ibrahim Index of African Governance.

Finally, as Kaufmaan and Kraay explain, “while most indicators of governance have many virtues, all face distinct challenges. Researchers, therefore, need to look at a variety of indicators and sources when monitoring or assessing governance across countries, within a country, or over time.”⁶⁴

With that caveat in mind, we have first listed a number of sources of governance indicators, followed by some of the major indicators available today. These lists are by no means exhaustive, but provide a good starting point for anyone interested in measuring, evaluating, or assessing governance.

3.2.1. Selected indicators and rankings

 **World Bank. 2009. *Governance Matters 2009: Worldwide Governance Indicators, 1996-2008*. Available at: <http://info.worldbank.org/governance/wgi/index.asp>**

Summary: The WGI offers aggregate and individual governance indicators for 212 countries and territories over the period 1996–2008, for six dimensions of governance: voice and accountability; political stability and absence of violence; government effectiveness; regulatory quality; rule of law; and control of corruption. The sources of the aggregate indicators include views from numerous enterprise, citizen and expert survey respondents in industrial and developing countries.

The website includes interactive charts and tables, comparative graphics, a governance world map, and more.

For documentation of the latest update of the WGI, readers should also refer to *Governance Matters VII: Aggregate and Individual Governance Indicators, 1996-2008*, written by Kaufmann, Kraay, and Mastruzzi (2009) and available at: http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1424591

 **Transparency International. 2009. *Corruption Perception Index (CPI)*. Available at: http://www.transparency.org/policy_research/surveys_indices/cpi/2009/cpi_2009_table**

Summary: This index, published on an annual basis, uses information gathered through expert and business surveys about perceptions of corruption among public officials and politicians to rank countries and territories around the world. For the purposes of the CPI, corruption is defined as “the abuse of public office for private gain.” The 2009 edition of the index ranks a total of 180 countries and territories.

⁶³ Kaufmann and Kraay, 2008.

⁶⁴ Ibid.

Mo Ibrahim Foundation. 2009. *Ibrahim Index of African Governance*. Available at: <http://www.moibrahimfoundation.org/en/section/the-ibrahim-index>

Summary: The *Ibrahim Index* provides a comprehensive ranking of African countries according to the quality of their national governance, and its stated aim is to inform and empower citizens to hold their governments and public institutions accountable. Indicators are used across four main pillars: Safety and Rule of Law; Participation and Human Rights; Sustainable Economic Opportunity; and Human Development. These are used as “proxies for the quality of the processes and outcomes of governance.” The *Ibrahim Index* is a very broad indicator of governance in Africa, assessing governance against 84 criteria, and making use of qualitative and quantitative data. The website provides scores and rankings for 53 countries and offers multiple graphical analyses as well as tables by country and by category.

FIGURE 10: CORRUPTION AND GOOD GOVERNANCE IN THE SENEGALESE HEALTH CARE SYSTEM


Petty corruption has been well known and widespread in Senegal's health system for many years. With high-level political support and in the general political climate of the time, *Forum Civil*, the Senegalese branch of Transparency International, was able to launch a multi-disciplinary research project to examine corruption in the health system. The study took place in six villages, and examined a range of hospitals and other health facilities. Using interviews, focus groups, and direct observation, the study revealed a "pathogenic governance of health structures," featuring "profound distortions" in the hierarchy and the system of control. The result was that the health system operated through informal networks based on personal connections, rather than clearly delimited roles and responsibilities.

Results were made public through a final report and a national forum, then repackaged in a DVD and as cartoons into a form easily understood by doctors and health workers, ministry officials and citizens.



For more information, please visit www.research-matters.net

3.2.2. Sources of additional governance indicators

 **Sudders, M. and Nahem, J. 2006. *Governance indicators: A user's guide (2nd Edition)*. Oslo: UNDP. Available at:**
http://www.undp.org/oslocentre/flagship/democratic_governance_assessments.html.

Summary: Written in two parts, this guide provides generic guidance for users of indicators (taking the reader from Issue to Information) while the second part acts as a '*source guide*' and takes the reader through specifics about currently available data sources.

This publication identifies 35 sources of indicators and provides the reader with information on the source as well as some guidance as to how to use it. Sources contained in the guide were 'live' and accessible as of the winter of 2006.

 **UNDP. 2006. *Bibliography of Governance and Democracy Indicators Resources*. Oslo: UNDP. Available at:**
http://www.undp.org/oslocentre/docs06/Bibliography_of_governance_and_democracy_indicators_resources.pdf.


Summary: Last updated in September 2006, this bibliography of resources on governance and democracy indicators contains more than 100 reference sources that are available online. These resources are organized under a number of headings, including: general governance indicators literature; governance indicators literature by theme; and governance related indexes, databases and datasets.

 **UNDP. 2003. *Sources for Democratic Governance Indicators*. Available at:**
http://www.undp.org/oslocentre/flagship/democratic_governance_assessments.html.

Summary: The stated purpose of this guide is to provide an easy to use overview of governance indicators that are accessible via the Internet (52 sources in total). For each source, the guide provides an overview of the scope, key elements as well as dimensions of governance covered.

 **Besançon, Marie. 2003. *Good Governance Rankings: The Art of Measurement*. Cambridge: World Peace Foundation. Available at:**
<http://belfercenter.ksg.harvard.edu/files/wpf36governance.pdf>

Summary: In an effort to reflect on current efforts to measure governance and inform future research and policy agendas, the author has alphabetically inventoried 47 projects currently in place to measure governance. The list covers both quantitative and qualitative types of datasets, and addresses "subjective measures of governance, subjective and objective measures of democracy, and subjective measures of corruption and risk." Projects are listed alphabetically by title, and the author provides information about how to access the data, a short summary of the context, the range of countries and years that were covered and the type(s) of indicator(s) being used.

 Corinna Zöllner and Isabel Teichmann. *Mapping of Corruption and Governance Measurement Tools in Sub-Saharan Africa*. Transparency International and UNDP, Oslo, 2007. Available at: http://www.undp.org/oslocentre/docs08/mapping_corruption_africa.pdf

Summary: Provides guidance to uses and limitations of 42 different international, national and local tools for measuring corruption in 28 countries in sub-Saharan Africa.


 Marie Wolkers, Eva Mayerhöffer and Alexandra Wilde. *Mapping of Corruption and Governance Measurement Tools in Latin American Countries*. Transparency International and UNDP, Oslo, 2006. Available at: http://www.undp.org/oslocentre/docs06/LAC_survey.pdf

Summary: This mapping provides guidance to uses and limitations of nearly 100 different international, national and local tools for measuring corruption in 17 countries in Latin America.

3.2.3. Additional tools, indicators and frameworks for assessing governance

 Scott, C. and Wilde, A. 2006. *Measuring Democratic Governance: A Framework for Selecting Pro-poor and Gender Sensitive Indicators*. UNDP, Oslo. Available at: <http://www.undp.org/oslocentre/docs06/Framework%20paper%20-%20entire%20paper.pdf>.

Summary: This UNDP guide presents a framework for generating pro-poor gender sensitive indicators to help policy makers monitor and evaluate democratic governance at the country level. It argues that indicator selection is itself a governance process.

 UNDP. 2009. *Planning a Governance Assessment: A guide to approaches, costs and benefits*. UNDP, Oslo Governance Centre. Available at: http://www.undp.org/oslocentre/docs09/UNDP_GA_Guide_070408_V4.pdf


Summary: This guide is a useful starting point for anyone wanting to develop and carry out an in-country governance assessment. The paper compares various approaches and methodologies in terms of their quality and costs.

 UNDP. 1997. “Good governance and sustainable human development.” In *Governance for sustainable human development*. A UNDP Policy Document. Available at: <http://mirror.undp.org/magnet/policy/chapter1.htm>.

Summary: These indicators reflect the attributes of ‘good governance’, and similarly can be utilized in the monitoring and evaluation of governance programmes in a particular context. The nine core indicators are identified as:


- Participation;
- Rule of law;
- Transparency;
- Responsiveness;
- Consensus orientation;

- Equity, effectiveness; and
- Efficiency, accountability and strategic vision.

 **Economic Commission for Africa. 2002. *Codes and Standards for Good Economic and Corporate Governance in Africa: Summary of Key Issues and Declaration of Principles*. Prepared for the NEPAD Steering Committee. Available at: <http://www.uneca.org/itca/governance/Documents/DECLARATION2.pdf>.**

Summary: This document is the outcome of consultations with the NEPAD Steering Committee as well as a Committee of African Ministers of Finance and Governors of Central Banks. It is intended as a resource to assist African governments who are attempting to improve the quality of governance in their countries. A list of codes and standards on economic and corporate governance that countries should strive to observe is identified. These include:

- codes of good practices on transparency in monetary and financial policies;
- code of good practices on fiscal transparency;
- best practices for budget transparency;
- guidelines for public debt management;
- principles of corporate governance;
- international accounting standards;
- international standards on auditing; and
- core principles for effective banking supervision.

 **Asian Development Bank. 2010. *Toolkits for Governance Assessment*. Available at: http://www.adb.org/governance/gov_toolkits.asp**

Summary: This website presents a number of toolkits and checklists to assess the state of governance in a sector or institution. Among many other resources, the website includes Guidelines for preparing and completing a Country Governance Assessment and a Governance and Capacity building Assessment Guide.

FIGURE 11: GOVERNANCE ASSESSMENT PORTAL


The *Governance Assessment Portal* is an on-line resource funded and managed by the *UNDP Global Programme on Democratic Governance Assessments* as a “hub of information and a valuable entry-point on democratic governance assessments.” The website site includes a number of useful resources, including: tools for assessing governance; overviews of existing initiatives for measuring democratic governance at various levels (national, regional, and global); practical information on how to measure governance and how to better use existing indicators; as well as opportunities to connect with other practitioners and experts, and more.

The website is also very useful for those looking for regional information and resources, as the website presents a number of regional initiatives, including those for Africa; Arab States; Asia and the Pacific; Europe and CIS, Latin America and the Caribbean. In addition, users can search the website by country, area of governance, and type of initiative.

For more information, please visit: <http://gaportal.org/>

3.4. Frameworks for Analysis of Decentralization

[Readers are invited to refer to **Section 4.2.1** for further discussion of, and resources on, decentralization]

 Bossert T. 1998. “Analyzing the decentralization of health systems in developing countries: Decision space, innovation and performance.” *Social Science & Medicine* 47(10): 1513-1527. Available at: <http://new.paho.org/hss/index.php>

Summary: The following frameworks may be utilized to analyze the effectiveness of decentralization for reaching health systems goals:

- a. **Public Administration Approach:** focuses on the distribution of authority and responsibility for health services within a national political and administrative structure.
- b. **Local Fiscal Choice:** developed by economists to analyze the choices made by local governments, while using both, transfers from other levels of government as well as their own locally generated resources. It is assumed that local governments make these choices to satisfy the local voters (who are also taxpayers).
- c. **Social Capital Approach:** attempts to explain why decentralized governments in certain localities have better performance than those in other localities. Due to the existence of civic institutions in a society (i.e., recreational/volunteer organizations) that help to provide experiences that encourage people to work together (called ‘social capital’), this builds trust among community members. This trust fosters behaviour that makes for better performance in local institutions.
- d. **Principal Agent Approach:** There is a ‘principal’ with specific objectives, and ‘agents’ who are needed to implement activities in order to achieve these objectives. However, the agents may either share the principal’s objectives or have their own objectives. Thus, the principal tries to achieve its objectives by shaping incentives for the agent that are in line with the agent’s own self-interest, as well as provides punishments and monitoring.
- e. **Decision Space Approach (modification of the Principal Agent Approach)**

These frameworks may include the following attributes, which could assist researchers to analyze the processes and outcomes of decentralization in a particular context:

- Provide a consistent means of defining and measuring decentralization in different national systems
- Define the degrees of decentralization
- Define the mechanisms that are used to influence and control decisions at local levels
- Develop performance indicators to evaluate the impact of choices made by local decision makers, based on how the choices contribute to health system goals.

FIGURE 12: HELPING MAKE MUNICIPAL SERVICES DELIVERY MORE EQUITABLE IN SOUTH AFRICA: THE MUNICIPAL SERVICES PROJECT (MSP)

In the mid-1990s, the South African government implemented a national policy to commercialize and privatize basic services delivery, including water and electricity. As the national government subsequently reduced direct subsidies to municipalities, the policy put an immediate pressure on local governments to recover costs. Many municipalities had no tax base or alternative source of income and their reaction was to divert that pressure. This move had direct bearing on the living conditions of the poorer sections of the South African population.

The Municipal Services Project (MSP) is a research, policy and capacity-building initiative examining the restructuring of municipal services such as water, sanitation, and electricity in South Africa. It has critically assessed the health impacts essential service delivery restructuring (e.g. privatization / decentralization of water and sanitation) and is currently identifying alternatives to privatisation. MSP has exposed equity and quality gaps that resulted from emerging private sector influence. Addressing questions of governance through improved articulation of the needs and demands of civil society, the project found that privatization of basic services like electricity failed to deliver services that were promised and increased socio-economic inequities.

Thus far, MSP has sparked debates in the public and in local governments on the privatization of municipal services, and has highlighted that the equitable governance of public services is integral to health outcomes. For example, MSP drew links between the introduction of prepaid water meters, poor water delivery and the 2000/2001 cholera epidemic in South Africa. MSP radio spots reached audiences of 2.2 million people and raised the profile of urgent South African municipal issues such as water delivery. The project also adopted a successful knowledge dissemination strategy, distributing its newsletter to over 1000 regional government officials.

For more information, please visit: http://www.idrc.ca/en/ev-32265-201-1-DO_TOPIC.html AND <http://www.municipalservicesproject.org/>

3.5. Assessing Health System Performance and Governance

Governance affects the performance of health systems, which can in turn be judged by comparing health outcomes against a set of health systems goals and objectives. Thus, assessing the degree of goal achievement may aid in the exploration of the strengths and weaknesses of a particular governance model. The WHO defined, in its 2000 Report, three intrinsic goals of the health system:


- 1) to improve health;
- 2) to be responsive to the legitimate demands of the population; and,
- 3) to ensure that no one is at the risk of serious financial losses because of ill health.⁶⁵

Measuring health system performance can provide decision makers with information that will allow them to make evidence-informed policy decisions, monitor and evaluate past or proposed reforms, as well as allow citizens to hold these actors accountable for decisions that affect their well being. Identifying

⁶⁵ WHO, 2000.

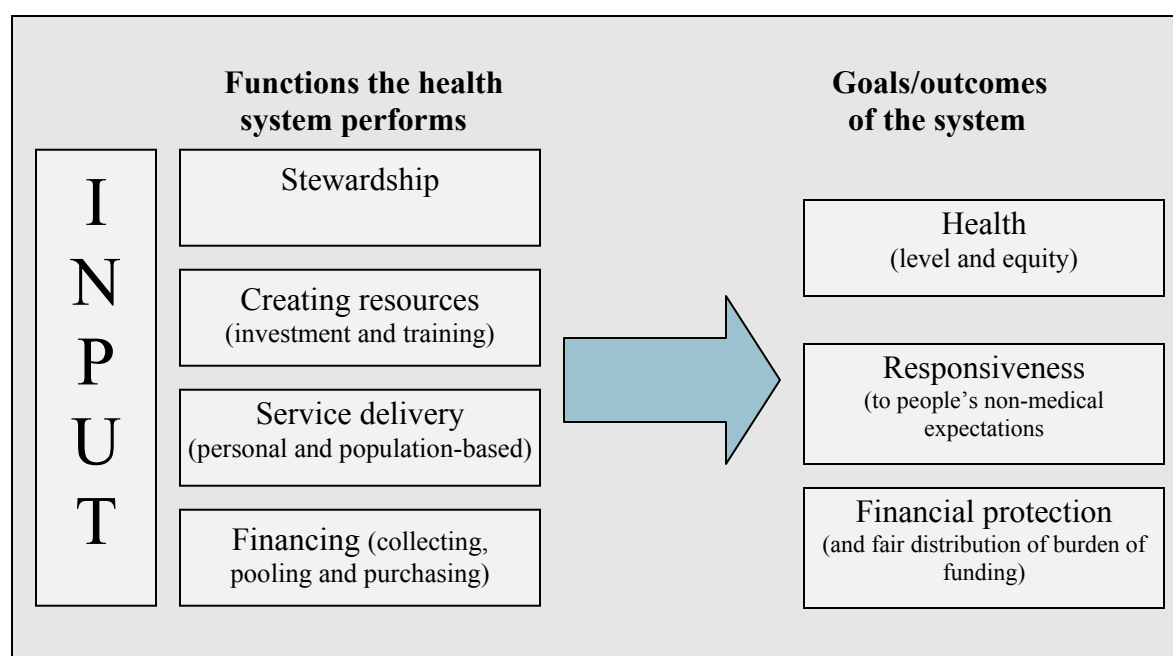
systematic ways to monitor performance also allows for comparisons “across time for individual systems, across different levels of a system, and between health systems.”⁶⁶

While efforts to formally assess health system governance in countries are still in their infancy, this section nonetheless presents a number of useful resources, including the WHO’s *Health Systems Performance Framework* as well as a very recently developed framework for assessing governance of the health system in developing countries (which itself discusses frameworks developed by the WHO and PAHO). For their part, articles by Murray and Frenk and by Bossert provide statements of health goals, in varying amounts of detail. For Murray and Frenk, the three main goals of health systems are *health, responsiveness and fairness*. Bossert, for his part, refers to the goals of health system reform, which he identifies as: *improving equity* (which includes universal coverage, access and solidarity), *efficiency, quality and financial soundness*.

 **WHO. 2001. *Health Systems Performance: a comprehensive resource from the WHO*.**
Available at: <http://www.who.int/health-systems-performance/>

Summary: According to the WHO, stewardship – the careful and responsible management of the well being of the population – is the very essence of good government, and in turn ultimate responsibility for performance of the country’s health system lies with government. This resource developed by WHO “aims to support the development of systematic ways to monitor performance in countries, in a way that allows comparisons across time within individual systems, across different levels of a system, and between health systems.” The website includes a glossary of relevant terms, diagrams of the WHO health systems performance framework, links to debates and new work generated since the release of the World Health Report 2000, as well as links to additional tools and websites.

**FIGURE 13: WHO’S HEALTH SYSTEM PERFORMANCE FRAMEWORK:
FUNCTIONS AND GOALS**



Source: Adapted from http://www.euro.who.int/healthsystems/20070323_1

⁶⁶ WHO, 2001.

📖 Siddiqi S, *et al.* 2009. “Framework for assessing governance of the health system in developing countries: Gateway to good governance.” *Health Policy* 90(1): 13-26.

Summary: This article presents a framework for assessing health system governance at the national and sub-national levels. The authors consider and discuss four existing frameworks: WHO’s domains of stewardship; PAHO’s essential public health functions; WB’s six basic aspects of governance; and the UNDP’s principles of good governance. Their own framework includes 10 principles: strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics. To demonstrate the framework, the authors discuss its successful administration in Pakistan.

📖 Boerma Ties, *et al.* 2009. *Monitoring and evaluation of health systems strengthening: An operational framework*. Geneva: WHO. Available at:
http://www.who.int/entity/healthinfo/HSS_MandE_framework_Nov_2009.pdf

Summary: This paper offers a framework for monitoring and evaluation of health system strengthening and discusses how this framework can be operationalized at the country level and how global partners can work together to support implementation. The framework is intended to be of use to countries, global health partnerships, donors and agencies.

📖 Balabanova Dina, *et al.* 2006. *Monitoring health system performance – synthesis of some experiences from low-income countries*. Presentation given at the Health System Metrics meeting, Glion, 28-29 September 2006. Available at:
<http://www.who.int/healthinfo/systems/healthsystemmetrics/en/index.html>

Summary: This PowerPoint presentation presents results from a study that used the WHO’s health system performance framework to review the experiences of selected low-income countries with health system performance monitoring and use of data. The countries included in the review were: Georgia, Rwanda, Uganda, and West Bengal (India) – the study also made use of materials from other countries.


FIGURE 14: EASTERN MEDITERRANEAN REGIONAL HEALTH SYSTEM OBSERVATORY

“The WHO Regional Office for Eastern Mediterranean took the initiative to develop the Eastern Mediterranean Regional Health Systems Observatory. The main purposes is to contribute to the improvement of health system performance and outcomes in the countries of the Eastern Mediterranean Region, in terms of better health, fair financing and responsiveness of health systems. This Observatory will monitor health system and policy reforms in countries of the Eastern Mediterranean and evaluate the attainment of outcomes and the efficiency of the health systems in ways that allow comparison over time and across countries, thus informing policy-makers. It will also build an evidence base on the relationship between the functions of the health system and overall performance.”

Hussain A. Ghezali, WHO Regional Director for Eastern Mediterranean

The Observatory developed a standard template to provide all Members States in the Region with a health system profile as well as a health system database to allow for comparison of health system indicators across countries in the region.

For more information, please visit: <http://gis.emro.who.int/healthsystemobservatory/main/Forms/main.aspx>


 Murray CJL. & Frenk J. 2000. “A framework for assessing the performance of health systems.” *Bulletin of the World Health Organization* 78 (6). Available at: [http://whqlibdoc.who.int/bulletin/2000/Number%206/78\(6\)717-731.pdf](http://whqlibdoc.who.int/bulletin/2000/Number%206/78(6)717-731.pdf)

Summary: Variations in health systems performance may be related to the design, content and management of health systems – factors which all fall within the scope of governance. As a result of such differences, countries with similar levels of income, education and health expenditure may have very different abilities to attain health goals. Highlighting the relationship between governance and the performance of health systems, this article provides a framework to guide future studies on the issue. It defines the key areas in which decisions are made in health systems, and subsequently affect system performance. It proposes that the latter is a function of *how the health system organizes four key functions*:

- Financing
- Service Provision
- Resource Generation
- Stewardship

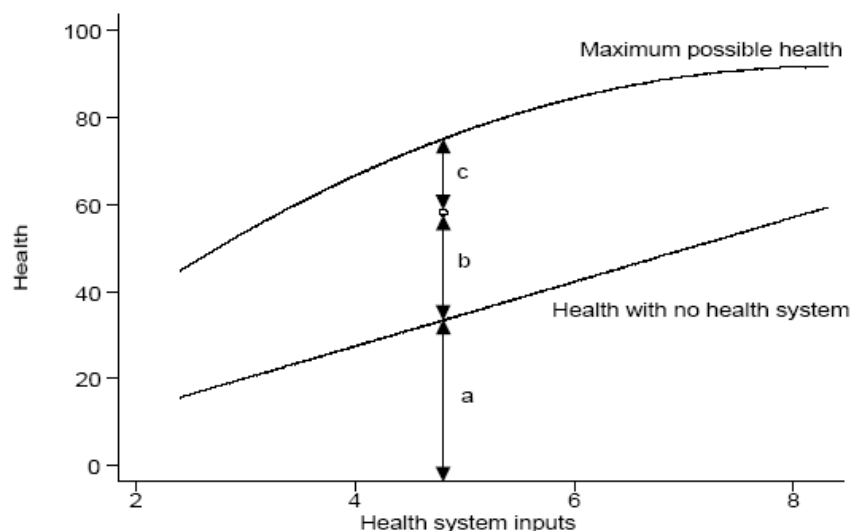
In each of these areas, decisions must be made to determine how to design, implement, evaluate and reform the organizations and institutions that carry out these functions. These decisions involve:

- Strategic design
- Structural arrangements
- Implementation Management
- These decisions subsequently affect performance.

 Evans, David B., et al. 2000. *The Comparative Efficiency of National Health Systems in Producing Health: An Analysis of 191 Countries*. GPE Discussion Paper No. 29. Available at: www.who.int/entity/healthinfo/paper29.pdf

Summary: Focusing on performance in terms of achieving the goal of improving health – which the authors measure by using the Disability Life Expectancies (DALE) indicator – this article offers a way of evaluating the impact of health sector reforms and to monitor health sector performance over time. As the authors explain, “it is hoped that the resulting discussion will lead to the development of ways of routinely measuring and monitoring the performance of health systems with a resulting improvement in the health of the affected populations.”

FIGURE 15: ASSESSING HEALTH SYSTEM PERFORMANCE



“The goal of the health system is measured on the vertical axis (here, labelled health) while the inputs to producing the goal are on the horizontal axis. The upper line represents the frontier, or the maximum possible level of the goal (health) that could be obtained for a given level of inputs.”

Source: Evans D, *et al.* 2000.

FIGURE 16: IMPROVING THE GOVERNANCE AND GLOBAL COORDINATION OF NATIONAL HEALTH RESEARCH SYSTEMS: COHRED

Inequities in major health indicators between the North and South persist and in some cases are actually worsening, while emphasis on health research continues to focus on northern countries. Within this context of growing inequity, there is a need for organisations to act as advocates, brokers and enablers to coordinate, harmonize and enhance the governance of national health research systems.

The Council on Health Research for Development (COHRED) works at the country and global levels, focusing its activities on developing tools and approaches for health research systems governance, and providing a accessible forum to disseminate country-level health research systems knowledge and data. IDRC support helped COHRED to evolve into a decentralized, enabling actor that assists low and middle-income countries (LMICs) to more effectively put in place and use health research to foster improved health, health equity and development.

COHRED has created a mechanism and space to exchange, consolidate and compare country-level experience in global health research systems. LMICs have used COHRED tools and support to undertake national health research priority setting exercises. COHRED's *Health Research Web (HRWEB)*, a standout resource in the field of health research, is a comprehensive, authoritative and evolving source of information on research for health that facilitates national decision-making. COHRED's contribution to *Global Health Watch 2005-2006*, an alternative to the *World Health Report*, elaborated an approach on how to invite civil society participation in health research.

For more information, please visit www.cohred.org or www.idrc.ca/geh/ev-101212-201-1-DO_TOPIC.html

3.6. Enhancing Accountability

“Securing greater accountability is increasingly seen as an essential element in improving health system performance. However, there are different forms of accountability, which depend on different types (administrative, financial, political) and directions (horizontal, downwards, upwards) of accountability relations. These, in turn, imply specific configurations of power and particular roles for different stakeholders.


In the health sector, accountability relations between central and local/decentralised administrative units and among health professionals, service users and managers are particularly important. Strategies for reform therefore need to incorporate a clear vision of who they are seeking to make more accountable, for what and how.”

Source: <http://www.eldis.org/go/topics/resource-guides/health-systems/governance-and-health/accountability-mechanisms>

Given the importance of accountability with regards to health system performance, below are a number of resources that discuss the issue.

 **Eldis. *Accountability mechanisms*. Resource Guide, DFID Health Resource Center.**
Available at: <http://www.eldis.org/index.cfm?objectId=2354577F-BE12-E417-BEE90AC5A34B8BA2>

Summary: This web-based resource guide provides a list of 28 recommended resources related to accountability and health systems.

 **Brinkerhoff, Derick W. 2004. “Accountability and health systems: toward conceptual clarity and policy relevance.” *Health Policy and Planning* 19(6): 371-379.**


Summary: Within the context of health systems, this article offers a definition of accountability and looks at three types of accountability: financial, performance and political/democratic. The author proposes an analytical framework for mapping accountability and describes three accountability purposes: reducing abuse, assuring compliance, and improving performance and learning.

 **Cromwell A, Lucas H, Pasteur K. 2000. “Accountability through participation: Developing workable partnership models in the health sector.” *IDS Bulletin* 31(1): 1-13.**


Summary: This article provides a checklist for enhancing accountability through participation, with points under the following categories: Stakeholders, Partnerships, Community Control, Transparency and Mechanisms for dealing with disabling environments.

 **Loewenson, Renée. 2000. “Participation and accountability in health systems: The missing factor in equity?” *Discussion paper 1*. Zimbabwe: Training and Research Support Centre (TARSC). Available at: <http://www.equinet africa.org/bibl/docs/DIS1gov.pdf>**

Summary: “This paper examines the features of social and governance systems that support vertical equity in health and their current application within health systems. It proposes measures and mechanisms that need to be included or strengthened within health systems if we are to enhance the relationship between citizen and state towards enhancing vertical equity. Finally it suggests further work towards strengthening the social dimensions of equity in health.”

 **Alliance for Health Policy and Systems Research. 2008. “Neglected Health Systems Research: Governance and Accountability.” *Research Issues 3*. Geneva: WHO. Available at: http://www.who.int/entity/alliance-hpsr/resources/AllianceHPSR_ResearchIssue_HIS.pdf**

Summary: This paper looks at the importance of governance and accountability with regards to health systems, and discussed the interactions between these various concepts. It also provides definitions of key terms and an overview of the state of research on governance and accountability in health as well as the barriers to such research. Finally, the paper highlights ways in which future research could “make a difference.”

 **Brinkerhoff, Derick. 2003. *Accountability and Health Systems: Overview, Framework and Strategies*. Bethesda: Abt Associates.**

Summary: The author offers a definition of accountability allowing the concept to then be used as an organizing principle for health sector reform. As such, accountability is divided into three categories: financial, performance, and political/democratic. The article offers an ‘accountability-mapping tool’ as well as various strategies to enhance accountability: 1) reducing abuse, 2) assuring compliance with procedures and standards, and 3) improving performance/learning.

FIGURE 17: GLOBAL HEALTH WATCH

The World Health Report is the WHO's leading publication on global health. Each year, the Report highlights a specific health issue, with the primary goal of providing countries, international organizations, donor agencies and others with the information necessary to make policy and funding decisions to improve the health of populations.

While such a report is certainly valuable, the People's Health Movement (PHM), Global Equity Gauge (GEGA) and Medact believe that reporting on global health should go further. It should include performance monitoring of the global health institutions themselves; reporting should challenge national and global health policy decisions on the values of equity and social justice. In addition, it should mobilize the global health community – and particularly health workers – into action on the prominent health and development issues of the day. For these three organisations, the vehicle for this is an alternative to the World Health Report: the *Global Health Watch*, a report that combines research and policy analysis with a commitment to bringing the views of poor and vulnerable groups to the attention of international and national policymakers. The reports draw attention to the politics of global health and the policies and actions of key actors.

Published in 2008, the second edition includes chapters on: climate change; the United States foreign assistance programme; the Gates Foundation; the WB, the WHO and the Global Fund.

For more information, please visit: www.ghwatch.org/

4. The Relationship between Governance and Health Systems

4.1. Overview

The design, content and management of health systems influence performance, which in turn influences health outcomes.⁶⁷ Health systems have the power and potential to affect extraordinary improvements in the health of communities. However, poorly structured, inadequately funded, badly led, inefficiently organized and/or unaccountable health systems can misuse their power, squander their potential, and do more harm than good.⁶⁸

In the context of development assistance, with respect to increased spending on health (including donor funding), it is essential that such spending occur in the context of good governance. “Without a supportive policy and institutional environment there is every likelihood that more money in the public system will be squandered or stolen, or both.”⁶⁹

Thus, not only does governance affect health systems, but this relationship is reciprocal. For example, the performance of the health sector influences how the state is viewed, and the devastating effect of a condition like HIV/AIDS, which depletes personnel and other resources, may adversely affect governance.

4.1.1 General Resources

 Eldis. 2010. “Governance and Health.” *Health Systems Resource Guide*. DFID Health Resource Center. Available at: <http://www.eldis.org/healthsystems/governance/>


Summary: This website explores a number of issues that are relevant to governance and health systems, and contains links to electronic resources, which are organized under the following headings:

⁶⁷ Murray and Frenk, 2000.


⁶⁸ WHO, 2000.

⁶⁹ Feachem, 2000.


accountability mechanisms; budgetary management; corruption; institutional development; post-conflict states; public sector reform; regulation; and stakeholder participation.

 **Brinkerhoff, Derick and Saul Helfenbein. 2008. *What do Health Professionals Think About Good Governance Practices? Results of an Online Survey*. Policy Brief, Health Systems 20/20. Available at: <http://www.healthsystems2020.org/content/resource/detail/2095/>**


Summary: This web-based survey, carried out in 2007, was administered to 119 individuals and posed a set of good practices related to health governance and asked respondents to indicate whether their experience confirmed or disconfirmed those practices. The responses offer a relatively negative picture of good governance practices in developing country health systems, but point to a number of actionable recommendations.

 **Brinkerhoff, Derick W. and Thomas J. Bossert. 2008. *Health Governance: Concepts, Experience, and Programming Options*. Policy Brief, Health Systems 20/20. Available at: <http://www.healthsystems2020.org/content/resource/detail/1914/>**

Summary: This paper provides an overview of health governance to: clarify its meaning; identify health governance issues and challenges; develop a model for health governance that highlights its practical dimensions; review selected experience with interventions to improve health governance; and propose options for health governance programming that can strengthen health systems and ultimately lead to increased use of priority services.

 **WHO. 2007. *Health system governance for improving health system performance: Report of a WHO global consultation, 7-9 November 2007, Cairo, Egypt*. WHO-EM/PHP/043/E. Available at: <http://gis.emro.who.int/HealthSystemObservatory/PDF/Publications/Reports%20of%20Workshops%20and%20Meetings/PHP043healthsystemgovernancefinal.pdf>**

Summary: This document reports on a global consultative meeting on health system governance for improving health system performance that was held in Cairo, Egypt on 7–9 November 2007. The consultation aimed to inform the state of the art on various aspects of health system governance as well as learn about the work undertaken by WHO in that area. The meeting also discussed health systems governance assessments carried out in nine countries and identified key issues and challenges related to health system governance and aid effectiveness.

 **Task Force on Health Systems Research. 2004. “Informed choices for attaining the Millennium Development Goals: towards an international cooperative agenda for health-systems research.” *The Lancet*, 364: 997-1003. Available at: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2804%2917026-8/abstract>**

Summary: The Task Force on Health Systems Research was convened by WHO in 2003 to develop an international research agenda and suggest areas for collaboration to support the attainment of the Millennium Development Goals and the improvement of current health systems. Within the context of initial consultations, governance emerged as one of the topics that deserve more attention and research. Among other things, the article discusses how “ensuring strong systems of governance and appropriate accountability mechanisms within the health sector underpins health-sector performance.”

Additional references:






-  Dodgson R, K. Lee K and N. Drager. 2002. *Global health governance: A conceptual review*. Discussion paper No. 1. World Health Organization. Available at: <http://cgch.lshtm.ac.uk/globalhealthgovernance.pdf>
-  Lewis, Maureen and Gunilla Pettersson. 2009. *Governance in Health Care Delivery: Raising Performance*. World Bank Policy Research Working Paper #5074. Available at: <http://www.g7.utoronto.ca/conferences/2010/ghdp/lewis-pettersson.pdf>
-  Organisation for Economic Cooperation and Development. 2005. *OECD Reviews of Health Systems: Mexico*. Paris and Washington D.C.: OECD.
-  Feachem, Richard G.A. 2000. “Health Systems: more evidence, more debate.” Editorial. *Bulletin of the World Health Organization*, 78(6). Available at: <http://www.scielo.org/pdf/bwho/v78n6/v78n6a02.pdf>
-  Hunt, Paul and Gunilla Backman. 2008. “Health systems and the right to the highest attainable standard of health.” *Health and Human Rights* 10(1): 81-92.

FIGURE 18: HEALTH SYSTEMS GOVERNANCE AND ACCESS TO CARE IN COLOMBIA: LEVERAGING RESEARCH FINDINGS TO FOSTER CHANGE

By the mid-2000s, the ongoing civil conflict in Colombia had caused the internal displacement of millions of people, many of whom experienced obstacles in accessing health care. Meanwhile, despite a national health insurance system with clear exemption guidelines, the goal of universal coverage had not been met, with only half of Colombians possessing health insurance coverage. In the mid 2000s, the government of Colombia considered alternative strategies for reforms grounded in the need to improve equitable access to quality health services and insurance coverage. As the government prepared to launch new reform efforts, the need for research was greatly heightened.

IDRC supported policy-relevant research in Colombia that aimed to bridge research and policy; strengthen governance and citizen engagement in the Colombian health system; enhance social protection in health; and create an arena for advancing policy recommendations on health sector reforms by relevant stakeholders supported by analytical evidence. The Participatory Evidence-Based Health Policy Formulation in Colombia project used a model-building and consultative, consensus-building exercise, while Extending Social Protection in Health in LAC: Building Research and Practice Phase II used allied research to examine policy instruments that promote equity in health.

These projects had tangible governance outcomes, strengthened research to policy strategies, and led to the development of a governance and equity framework for health in Colombia. Notably, the Participatory project findings were presented in a series of consultations with regional health actors and members of Congress, and eventually incorporated into legislated health performance incentives for administrators, insurers and health providers. Additionally, findings from the Extending project were critical to developing Bogota's municipal district health policies for the internally displaced. These findings will be relevant in other settings with internally-displaced populations.

For more information, please visit: www.idrc.ca/geh/ev-87310-201-1-DO_TOPIC.html and www.idrc.ca/geh/ev-68521-201-1-DO_TOPIC.html

4.2. Issues in Governance and Health Systems

4.2.1. Decentralization

Decentralization involves the transfer of responsibility for planning, management, and the raising and allocation of resources from the central government and its agencies to: field units of government agencies, subordinate units or levels of government, semi-autonomous public authorities or corporations, area-wide, regional or functional authorities, or NGO, private or voluntary organizations.⁷⁰

It is possible to identify four forms of decentralization:

Deconcentration: shifting of power from the central offices to the peripheral offices of the same structure (e.g. from the Ministry of Health main office to its regional or district offices).

Devolution: shifting of responsibility and authority from central offices to separate administrative structures still within the public administration (e.g., from the Ministry of Health to local governments of provinces, states, municipalities).

Delegation: shifts responsibility and authority to semi-autonomous agencies (e.g., a separate regulatory commission or an accreditation commission).

Privatization: transfers operational responsibilities and in some cases ownership to private providers, usually with a contract to define what is expected in exchange for public funding.

Key issues to be considered in any decentralization design include:

- To what level?
- To whom?
- What tasks?

According to Renée Loewenson, “the most significant shift in governance within health systems in the past decade has been around decentralisation.”⁷¹ If this is the case, and considering the many possible variations in the design of a decentralized health system, it is worth exploring the topic in further detail. The resources below are meant as a starting point in that direction.

Decentralization – General

📖 Brinkerhoff, Derick and Thomas J Bossert. 2008. *Decentralization and Governance in Health*. Health Systems 20/20. Available at: <http://www.healthsystems2020.org/content/resource/detail/1974/>

📖 Kolehmainen-Aitken, Riitta-Liisa. 2004. “Decentralization’s impact on the health workforce: Perspectives of managers, workers and national leaders.” *Human Resources for Health* 2: 5. Available at: <http://www.human-resources-health.com/content/2/1/5>.

⁷⁰ Gilson, Kilima and Tanner, 1994

⁷¹ Loewenson, 2000.

- Brinkerhoff Derick, and C. Leighton. 2003. *Decentralization and health system reform: insights for implementers*. Bethesda: PHRplus, Abt Associates. Available at: <http://www.healthsystems2020.org/content/resource/detail/860/>
- Bossert, T. 1998. "Analyzing the decentralization of health systems in developing countries: Decision space, innovation and performance." *Social Science & Medicine* 47(10): 1513-1527.
- Harpham, Trudy and Jane Pepperall. 1994. "Decentralising urban health activities in developing countries." *Development in Practice*, 4(2): 92-99. Available at: <http://www.informaworld.com/smpp/content~db=all~content=a713994001>
- Mills A, JP Vaughan, DL Smith and I. Tabibzadeh, eds. 1990. *Health system decentralization: Concepts, issues and country experience*. Geneva: World Health Organization. Available at: <http://whqlibdoc.who.int/publications/9241561378.pdf>

Decentralization – Africa

- Munga, Michael A, *et al.* 2009. "The decentralization-centralisation dilemma: recruitment and distribution of health workers in remote districts in Tanzania." *BMC International Health and Human Rights* 9(Special Edition): 1-11. Available at: <http://www.biomedcentral.com/1472-698X/9/9>
- Loubiere, Sandrine, *et al.* 2009. "Decentralization of HIV care in Cameroon: Increased access to antiretroviral treatment and associated persistent barriers." *Health Policy* 92(2/3): 165-173.
- Akin, John, Paul Hutchinson and K Coleman Strumpf. 2005. "Decentralisation and Government Provision of Public Goods." *The Journal of Development Studies*, 41(8): 1417-1443.
- Olowu, Dele and James S. Wunsch. 2004. *Local Governance in Africa: The Challenges of Decentralization*. London: Lynne Rienner Publishers.
- Fosu, Augustin Kwasi and Terence C.I. Ryan. 2004. "Public Sector Delivery: A Synthesis." *Journal of African Economies*, 13(Supplement 1): i137-i141.
- Bossert T, MB Chitah and D. Bowser. 2003. "Decentralization in Zambia: Resource allocation and district performance." *Health Policy and Planning* 18 (4): 357-369.
- Bossert, Thomas J. and Joel C Beauvais. 2002. "Decentralization of health systems in Ghana, Zambia, Uganda and the Philippines: a comparative analysis of decision space." *Health Policy and Planning*, 17(1):14-31.
- Wunch, James. 1998. "Decentralization, Local Governance and the Democratic Transition in Southern Africa: A Comparative Analysis." *African Studies Quarterly: The Online Journal for African Studies* 2(1). Available online: <http://web.africa.ufl.edu/asq/v2/v2i1a2.htm>
- Munga S, and W. Owino. 1997. *Decentralization of financial management systems: Its implementation and impact on Kenya's health care delivery*. Discussion Paper No. DP006/97. Available at: <http://www.kenyagranary.or.ke/files/dp06.pdf>

- 📖 Kalamba K. 1997. *Towards an equity-oriented policy of decentralization in health systems under conditions of turbulence: The case of Zambia*. Discussion Paper No. 6. Zambia: WHO.




Decentralization – Latin America

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4.2.2. Public Participation

Following the Declaration of Alma Ata of 1978, community participation became a central feature of primary health care, and participation (although labelled differently over the years) has remained a key element of health systems and health systems performance ever since. While various definitions of participation exist, a useful one was provided by Equinet’s Regional meeting on public participation in health systems (2000), where participation was defined as involving:

- “genuine and voluntary partnerships
- between different stakeholders from communities, health services and other sectors; based on
- shared involvement in, contribution to, ownership of, control over, responsibility for and benefit from
- agreed values, goals, plans, resources and actions around health.”⁷²

Communities, or service users more generally, are no longer seen as passive recipients of health care, but rather their active participation is seen as a means to potentially achieve the benefits of enhanced accountability and improved responsiveness of services.

Public – or community – participation itself involves issues of governance, and therefore its institutional dimensions need to be considered. To this end, a number of relevant questions deserve greater attention:⁷³

⁷² Loewenson, 2000.

- What kinds of roles can community based organizations adopt, and what might be needed to prepare them for these roles?
- How do community based organizations relate to existing health management, local government, NGO and provider interests? What strategies might help to build closer and more equitable relationships between these different actors?
- How do institutions take account of different community needs, and how do community members hold their institutions accountable?
- What is needed to enable the values of participation and partnership to be internalized, even in highly bureaucratic systems?
- What are the relative costs and benefits to different actors of establishing and operating the mechanisms necessary for participation and partnership?
- Whose interests do community organizations represent, and how can the voices of the less powerful in the community be heard?

FIGURE 19: PUBLIC PARTICIPATION



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FIGURE 20: SOCIAL AUDIT AS A USEFUL METHOD FOR ASSESSING HEALTH SYSTEMS GOVERNANCE IN SETTINGS OF CONFLICT: THE EXPERIENCE IN TWO DISTRICTS OF AFGHANISTAN

The health system in Afghanistan has been chronically neglected during decades of war and conflict. As the country emerges from this situation, it is overwhelmed by a long list of priorities in almost every sector.

CIET Canada developed an innovative methodology to conduct community-based social audits in two Afghan districts: Bagrami and Qarabagh. The main purpose of the project was to document health service performance and community experiences with public health services, with an important aim to demonstrate to policymakers the usefulness of social audit as a tool to raise the quality of health services and minimize system leakage.

Social audit was found to be an effective tool for gathering data on health systems governance and for capturing stakeholder perspectives in challenging, often dangerous research settings such as Afghanistan. The findings, which CIET shared with the Ministry of Public Health of Afghanistan, provide useful insights into the delivery of health services from the point of view of service users and the public at large. For example, focus groups confirmed that corruption is common in government health services, but people were oath to talk about it in individual interviews for fear of repercussions.

For more information, please visit:

http://www.idrc.ca/en/ev-93891-201_104963-1-IDRC_ADM_INFO.html and
<http://ciet-new.dev.bayteksystems.com/en/documents/projects/2008821172039.asp>

4.2.3. Additional Issues

As mentioned in the introduction, this resource guide aims to serve as a road map to issues of governance and health, introducing the reader to various topics and providing links or references to key resources. The issues listed in this sub-section should therefore not be seen as exhaustive, as there are many more that are relevant to a discussion of governance and health. Furthermore, the two issues presented below are not being addressed in detail, but rather links to more in-depth discussions on the topic are presented.

Health governance and health information systems

Accurate and timely health information is critical to the planning, programming, as well as monitoring and evaluation of health services. Similarly, reliable health information systems (HIS) provide the evidence that is required to assess progress against targets or objectives, as well as hold decision makers accountable for their health actions. In 2003, the WHO defined a HIS as an “integrated effort to collect, process, report and use health information and knowledge to influence policymaking, programme action and research.”⁷⁴


The strengthening of health information systems therefore forms an important part of efforts to improve health systems, and as the WHO explains, investing in HIS could lead to a number of benefits, including:⁷⁵


- helping decision makers to detect and control emerging and endemic health problems, monitor progress towards health goals, and promote equity;
- empowering individuals and communities with timely and understandable health-related information, and drive improvements in quality of services;
- strengthening the evidence base for effective health policies, permitting evaluation of scale-up efforts, and enabling innovation through research;
- improving governance, mobilising new resources, and ensuring accountability in the way they are used.


“Reliable and timely health information is an essential foundation of public health action and health systems strengthening, both nationally and internationally. This is particularly so when resources are limited and funding-allocation decisions can mean the difference between life and death. The need for sound information is especially urgent in the case of emergent diseases and other acute health threats, where rapid awareness, investigation and response can save lives and prevent broader national outbreaks and even global pandemics.”


WHO, 2008.

For further discussion of the importance of, and role to be played by, health information systems, readers are encouraged to consult the following **websites and resources**:

 Health Metrics Network: Better information. Better decisions. Better health. Website: <http://www.who.int/healthmetrics/en/>




 Health Information Systems Programme. Website: <http://www.hisp.org/>

 WHO: Health statistics and health information systems. Website: <http://www.who.int/healthinfo/systems/en/>

 World Bank: Health Information Systems. Website: <http://go.worldbank.org/X0ZQJ72Z00>

⁷⁴ WHO, 2003.

⁷⁵ Carlson.

-  Carlson, Cindy. “Health management information systems.” *Eldis Health Key Issues*. DFIF Health Resource Centre. Available at: <http://www.eldis.org/go/topics/resource-guides/health-systems/key-issues/health-management-information-systems>
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Health, governance and fragile states

In the past decade, there has been increasing interest in state building, and subsequently in the relationship between health systems strengthening and governance in fragile states. While the field is still relatively new, *Eldis* and the *Health and Fragile States Network* have recently provided a very useful entry-point into this area in the form of an on-line dossier. The dossier offers an overview of key issues, including:

- “What are fragile states?
- How can the health-related MDG be met in these states?
- What are the best approaches to delivering health services in fragile states?
- How can the WHO’s six building blocks for health systems strengthening be used as a framework for planning and priority setting in fragile states?
- What are the implications of the International aid effectiveness agenda for the building of resilient and responsive states to delivery basic services?”⁷⁶

As stated in the dossier, “the role of the health sector in the state-building and governance agenda is uncertain at this point, and needs further exploration.”⁷⁷

For a more in-depth introduction to, and discussion of, these various issues, as well as links to available resources, readers are invited to refer to:

- Eldis. 2010. “Health and Fragile States.” *Dossier*. Available at: <http://www.eldis.org/go/topics/dossiers/health-and-fragile-states/health-and-the-governance-agenda>.
- Alliance for Health Policy and Systems Research. 2008. “Neglected Health Systems Research: Health Policy and Systems Research in Conflict-Affected Fragile States.” *Research Issues* 1. Geneva: WHO. Available at: http://www.who.int/entity/alliance-hpsr/resources/AllianceHPSR_ResearchIssue_FragileStates.pdf

⁷⁶ Eldis, 2010.

⁷⁷ Ibid.

5. Governance and Selected Health Topics

The final section of the resource guide provides examples of three important health topics that reveal governance issues: HIV/AIDS; tobacco control; and maternal and child mortality. For each topic, an overview of key issues is presented, followed by a list of relevant resources.

5.1. HIV/AIDS

The Joint United Nations Program on HIV/AIDS (UNAIDS), in its 2008 report on the global epidemic, estimated that 33 million people were living with HIV in 2007, down from 38.6 million in 2005.⁷⁸ Since the disease was first recognized in 1981, over 25 million individuals are believed to have died of HIV-related causes. While incidence rates peaked in the late 1990s, the actual number of individuals living with HIV has stabilized at a relatively high rate.⁷⁹ Such a situation poses obvious challenges to both the functioning and governance of health systems, especially in resource-constrained settings. Among other things, HIV/AIDS poses a burden to a country's financial and human resources and can have an impact on a number of sectors. At the same time, governance is likely to affect how a country responds to HIV/AIDS, both in terms of prevention and treatment. For example, a country's governance ranking (particularly in terms of accountability and transparency) can impact – positively or negatively – on its capacity to attract donor funding for HIV/AIDS programmes.


Over the past decade, countries have varied in their response to the epidemic, and some experiences have been more successful than others. As governments, international organizations, civil society groups and individuals search for ways to address the governance challenges posed by HIV/AIDS, more research is needed into the lessons that have been learned and the potential for scaling-up positive experiences.

 **Royal Tropical Institute. 2010. “Governance & HIV and AIDS.” *KIT Information Portal*.**
Available from: <http://portals.kit.nl/eCache/FAB/17/292.html>


⁷⁸ UNAIDS, 2008.

⁷⁹ Ibid.

Summary: This Information Portal, made available by the Royal Tropical Institute, provides links to numerous resources (295) that deal with various aspects of Governance and HIV/AIDS. Users can search through all resources according to keywords, titles, regions, as well as themes.

 **Chirambo, Kondwani. 2007. *AIDS, politics and governance: preliminary results on the impact of HIV/AIDS on the electoral process in Namibia, Malawi, Senegal, South Africa, Tanzania and Zambia*. IDASA. Available at:**
<http://www2.warwick.ac.uk/fac/soc/csgr/activitiesnews/conferences/2007/hivaids/papers/Chirambo.pdf>


Summary: The purpose of the study was to establish the impact of HIV/AIDS on the electoral process in seven African countries, using democratic governance as the analytical concept. Preliminary results show that the epidemic is undermining parliamentary capacity, leading to increased governmental expenses.

 **Price-Smith, Andrew T. 2007. “Vicious Circle – HIV/AIDS, State Capacity, and National Security: Lessons from Zimbabwe, 1990-2005.” *Global Health Governance* 1(1). Available at:**
http://ghgj.org/Price-Smith_1.1_ViciousCycle.htm

Summary: This article looks at the impact of HIV/AIDS on governance, economics and security in Zimbabwe from 1990 to 2005, using process-tracking techniques. It provides evidence of HIV/AIDS’ ability to negatively impact on political stability and national security. The author argues that: “HIV/AIDS reinforces a vicious spiral within affected societies that will threaten the stability of the state.”

 **Menon-Johanson, Anatole S. 2005. “Good governance and good health: The role of societal structures in the human immunodeficiency virus pandemic.” *BMC International Health and Human Rights* 5(4). Available at:** <http://www.biomedcentral.com/1472-698X/5/4>

Summary: This study tested the null hypothesis that “Human Immunodeficiency Virus (HIV) prevalence is not associated with governance” for 149 countries by using the World Bank’s six dimensions of governance as well as the 2002 adult HIV prevalence estimates are reported by UNAIDS. The null hypothesis was rejected in all 140 countries and the author concludes that HIV is significantly associated with poor governance.

 **Putzel, J. 2003. *Institutionalising an emergency response: HIV/AIDS and governance in Uganda and Senegal*. Special Report. London, UK; Crisis States Research Centre. Available at:** <http://www.research4development.info/SearchResearchDatabase.asp?OutputID=173655>

Summary: The purpose of this article is to examine the impact of governance on controlling HIV/AIDS, through examining the experiences in Uganda and Senegal. These two countries have had very different experiences with the epidemic; with Uganda successfully achieving a control of a previously rampant epidemic, while Senegal has consistently prevented the epidemic from reaching high prevalence levels. This article explores the reasons behind these different experiences (political, economic, social, medical), and details the responses of each country. The article presents nine dimensions that are reported to be central to the governance agenda in the fight against HIV/AIDS; topics include:

- Individual rights versus public health protection
- Decentralization and privation – are they appropriate?


- Resource investment medical treatment, and discussion about commercial sex industry legalization
- Targeting high-risk groups
- Allocation of resources for anti-retroviral therapies
- International funding financing issues


 De Waal, Alex. 2003. "How Will HIV/AIDS transform African Governance." *African Affairs*, 102(406), 1-23.


Summary: This article discusses the impact of the HIV/AIDS pandemic, specifically addressing the ways in which demographic changes in turn lead to economic, institutional and governance-related transformations. As such, it seeks to address the gap in information with regards to the causal relationship between the pandemic and measures of state capacity (issues of governance and democracy). The author's objective is to demonstrate that 'the governance impacts of HIV/AIDS can be shaped by political action,' and his article therefore offers recommendations for future actions.


Additional references:


 Harman, Sophie. 2009. "Fighting HIV and AIDS: Reconfiguring the state?" *Review of African Political Economy* 36(121): 353-67.


 Jing, Gu and Neil Renwick. 2008. "China's Fight Against HIV/AIDS." *Journal of Contemporary China* 17(54): 85-106.

 Meini, Bruno. 2008. "HIV/AIDS, crime and security in southern Africa." *African Journal of Criminology and Justice Studies* 3(2): 35-84.

 Chandrasekaran, P., *et al.* 2006. "Containing HIV/AIDS in India: the unfinished agenda." *The Lancet Infectious Diseases* 6(8): 508-521. Available at:
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 Rau, Bill. 2006. "The politics of civil society in confronting HIV/AIDS." *International Affairs*, 82(2): 285-295.

 Swidler, Ann. 2006. "Syncretism and subversion in AIDS governance: how locals cope with global demands." *International Affairs*, 82(2): 269-284.

 Williams, Elizabeth. 2005. "Asian Culture and AIDS." *Brown Journal of World Affairs* 12(1): 209-223.

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 Jones, Peris. 2005. "'A Test of Governance': rights-based struggles and the politics of HIV/AIDS policy in South Africa." *Political Geography*, 24: 419-447.

- 📖 Hartwig, Kari A., *et al.* 2005. “AIDS and ‘shared sovereignty’ in Tanzania from 1987 to 2000: a case study.” *Social Science and Medicine*, 60: 1613-1624.
- 📖 Menon-Johansson, Anatole. 2005. “Good governance and good health: The role of societal structures in the human immunodeficiency virus pandemic.” *BMC International Health and Human Rights*, 5(4).
- 📖 Sekwat, Alex. 2004. *HIV/AIDS in sub-Saharan Africa: A Governance Challenge*. Conference Papers – Miswestern Political Science Association, Annual Meeting, Chicago.

FIGURE 21: PUBLIC SECTOR ANTI-RETROVIRAL TREATMENT (ART) SOUTH AFRICA

In August 2003, the national government of South Africa announced that it would provide the universal coverage of antiretroviral treatment (ART) to all those in need. The challenge of rolling-out such a program nation-wide laid mainly in the fragility of the health system, particularly constrained by a large number of HIV-infected citizens.

Careful assessment of implementation and governance challenges of the roll-out was needed at the provincial level. In the province of Free State, Department of Health (FSDoH) invited PALS (Practical Approach to Lung Health South Africa) group to examine ART’s impact on the health system with the aim to support and evaluate this policy process.

Based on key lessons learned, PALS made recommendations about more efficient administrative practices in ART delivery, suggested innovative solutions to address shortages of skilled staff. The nurse-initiated treatment is one example. Research findings advocated the demand-driven approach to ART and, what is especially remarkable, allowed a stronger voice for HIV patients. In short, the project became a catalyst for a shift in the governance paradigm. At the policy and managerial level, critical assessments of health system interventions proved to be valuable as they helped address the issues of transparency and corruption.

The success of PALS project attracted interest in other provinces: research results and recommendations were later tailored to address governance issues in the politically influential province of Western Cape. Today ART treatment and health system at large are much more accountable to HIV patients in South Africa.


For more information, please visit: http://www.idrc.ca/evaluation/ev-92115-201-1-DO_TOPIC.html

5.2. Tobacco control


Worldwide, tobacco use is, to this day, the leading cause of preventable death and disability among adults, a situation which is no longer a problem faced only by high-income countries but that has also spread widely to the developing world. In fact, by 2030, 80% of deaths attributable to tobacco are expected to occur in low- and middle-income countries. Currently, tobacco related illnesses are responsible for 5 million deaths per year, worldwide. If current trends persist, this number is set to increase to 8 million by the year 2030.⁸⁰ According to the WHO, tobacco kills more than “AIDS, legal drugs, illegal drugs, road accidents, murder, and suicide combined.”⁸¹ Such a situation is not however irreversible, but changing current patterns of behavior, reducing the number of individuals that take up tobacco consumption, as well as addressing the health burden posed by the epidemic will require strong leadership and the appropriate mix of policies.

In 2003, a landmark in the history of global health governance was reached with the signing of the WHO's Framework Convention on Tobacco Control (FCTC), the first legally binding treaty under the auspices of the WHO. As of July 2009, the FCTC had more than 160 parties, covering 86% of the world's population.⁸² The FCTC offers opportunities for governments to work together to address this pressing issue, and there is growing evidence that progress is being made. In 2008, for example, “154 million people, mostly in low- and middle-income countries, became newly covered by comprehensive smoke-free laws.”⁸³

Further research is now needed to document the experiences of countries that have successfully adopted national smoke-free policies, and to look at additional ways in which countries can be supported to ratify and implement the FCTC. At the local level, interactions between public policies, social norms and governance frameworks need to be better understood if countries are to be able to implement strategies that will yield positive results.

 **Waverley, Linda Bridgen and Joy de Beyer, eds. 2003. *Tobacco Control Policy: Strategies, successes and setbacks*. Washington and Ottawa: World Bank and IDRC/RITC.**

Summary: This book discusses the experiences of six countries – Bangladesh, Brazil, Canada, Poland, South Africa, and Thailand – with an emphasis on the successes and setbacks that they each faced in the formulation and implementation of policies aimed at reducing tobacco use. These various studies effectively demonstrate the positive impacts that knowledge and evidence can have when these are used and applied efficiently and effectively through a process in which researchers, policymakers and civil society groups are involved.

 **Collin J, Lee K and Bissell K. 2002. “The framework convention on tobacco control: The politics of global health governance.” *Third World Quarterly* 23(2): 265-282.**

Summary: The sphere of operation of the tobacco industry, the public health effects of tobacco, and tobacco control are global health issues. As such, tobacco control poses challenges for global health governance, and regulation requires a transnational governance mechanism. This article explores a

⁸⁰ WHO, 2009.

⁸¹ Mackay and Eriksen, 2002.

⁸² WHO, 2009.

⁸³ Ibid, 8.

particular initiative that aims to respond to this challenge by creating a governance mechanism called the FCTC of the WHO. The article presents information on the globalization factors involved in tobacco control, the challenges of tobacco control in various countries, and describes the characteristics of the FCTC, and the process it is engaged in that reflects global health governance.

FIGURE 22: CASE STUDY ON THE RATIFICATION OF THE “FRAMEWORK CONVENTION FOR TOBACCO CONTROL





Tobacco use is the leading preventable cause of premature death and disability worldwide. The established link between tobacco use and poverty, and the efforts of the transnational tobacco industry to market its products to disadvantaged population groups, pose serious challenges to addressing health inequities in developing countries. The Framework Convention on Tobacco Control (FCTC) is the world's first ever public health treaty and signifies a new form of global health governance. It is underpinned by the realization that national health systems must address transnational health risks and threats, such as the tobacco epidemic.



In March 2006, the Fundacao Ary Frauzino para Pesquisa e Controle do Cancer (FAP) produced a case study of the FCTC ratification process in Brazil, which involved a broad range of stakeholders, power relations and stakeholder interests. The case study captures dynamics at play among key actors including tobacco farmers and producers, tobacco industry representatives, rural and urban social movements, professional groups, non-governmental organizations and political authorities. It also explores the processes of negotiation, polarization, conflict, social participation and consensus among all these stakeholder groups.

The central lesson gleaned from this case study is that civil society and governments need to be prepared to lead in these types of political processes. The study calls attention to the need to consider political skills as an indispensable component in strengthening health systems governance. As governments strive to effectively address the rising burden of chronic diseases, the lessons learned through this case study will usefully inform other health issues that require a global health policy response.

For more information, please visit: http://www.idrc.ca/en/ev-124738-201-1-DO_TOPIC.html

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5.3 Maternal and child health

In 2000, world leaders came together to agree on a comprehensive set of eight development goals for tackling the numerous dimensions of extreme poverty – the Millennium Development Goals (MDGs). Goals number four and five are very closely related, and are respectively to reduce child mortality and to improve maternal health. In the case of child mortality, the target that was set is a two-thirds reduction of the under-five mortality rate between 1990 and 2015. Similarly, MDG five aims to reduce the maternal mortality ratio by three-quarters (between 1990 and 2015) and to achieve universal access to reproductive health by 2015.

While progress has been made on both of these goals, progress with regards to improvements in maternal health remains disappointing. As such, the global annual maternal mortality rate of decline of 1.3% between 1990-2008 falls short of the 5.5% needed to reach MDG targets.⁸⁴ Furthermore, fewer than half of all pregnant women attended four antenatal visits – the WHO recommended-minimum – from 2000 to 2008 and fewer than half of all births in the WHO regions of Africa and Southeast Asia had skilled assistance.⁸⁵ Globally, greater improvements can be seen with regards to child mortality, where between 1990 and 2010 death rates have dropped by about 2 percent per year, on average.⁸⁶ Absolute numbers however remain unacceptably high, with 7.7 million children under the age of five expected to die in 2010 (compared to 11.9 million in 1990). Today, 49.6% of these deaths occur in sub-Saharan Africa.⁸⁷

Governance, and most specifically poor governance, is increasingly being recognized as a factor affecting maternal and child health. As Tatum Anderson explains, “even if governments prioritise maternal and child mortality, and there is cash available and clear evidence about what strategy will be most effective, governance problems still stand in the way. A poorly functioning government bureaucracy, lack of accountability, bad or unenforced rules, lack of transparency, and corruption will all contribute to failing progress in child, maternal, and newborn health.”⁸⁸ Others such as Daniel Kaufman have also found links between corruption levels and under-five mortality in developing countries.⁸⁹

Another way to look at these issues is through the lens of the Human Rights-based Approach (HRBA) to Health, where maternal mortality and morbidity is seen as a matter of human rights. In 2009, the Human Rights Council, in its Resolution 11/8, provided a good explanation of this perspective, recognizing that:

“most instances of maternal mortality and morbidity are preventable, and that preventable maternal mortality and morbidity is a health, development and human rights challenge that also requires the effective promotion and protection of the human rights of women and girls, in particular their rights to life, to be equal in dignity, to education, to be free to seek, receive and impart information, to enjoy the benefits of scientific progress, to freedom of discrimination, and to enjoy the highest attainable standard of physical and mental health, including sexual and reproductive health.”⁹⁰

⁸⁴ Hogan *et al*, 2010.

⁸⁵ WHO, 2010b.

⁸⁶ Rajaratnam *et al*, 2010.

⁸⁷ Ibid.

⁸⁸ Anderson, 2010.

⁸⁹ Kaufman, 2010.

⁹⁰ Human Rights Council, 2009.

In the same vein, a recent report by the *Office of the United Nations High Commissioner for Human Rights* (OHCHR) goes on to explain that because numerous rights are at play when looking at maternal mortality and morbidity, “a range of States’ human rights responsibilities may be engaged. When women die in pregnancy or childbirth because the Government fails to use its available resources to take measures necessary to address the preventable causes of maternal death and ensure availability, accessibility, acceptability and good quality of services, the responsibility of the States may be engaged in respect of a violation of a women’s right to life.”⁹¹ The report goes on to explain that preventable deaths might also entail violations of numerous other rights, such as those highlighted by the *Human Rights Council* and listed above.

FIGURE 23: HUMAN RIGHTS-BASED APPROACH TO HEALTH - OVERVIEW

“A human rights-based approach to health specifically aims at realizing the right to health and other health-related human rights. Health policy making and programming are to be guided by human rights standards and principles and aim at developing capacity of duty-bearers to meet their obligations and empowering rights-holders to effectively claim their health rights. Elimination of all forms of discrimination is at the core of HRBA. Gender mainstreaming is a key strategy to achieving gender equality and eliminating all forms of discrimination on the basis of sex.”

WHO, 2010a.

The UN common understanding of a human rights-based approach to health (2003)

- All programmes of development cooperation, policies and technical assistance should further the realization of human rights as laid down in the Universal Declaration of Human Rights and other international human rights instruments.
- Human rights standards and principles guide all development cooperation and programming in all sectors and phases of the programming process.
- Development cooperation contributes to the development of the capacities of ‘duty-bearers’ to meet their obligations and/or of ‘rights-holders’ to claim their rights.

For further information on the HRBA, readers are encouraged to refer to:

WHO. 2010. “A Human Rights-Based Approach to Health.” *Information Sheet*. Geneva: WHO. Available at: http://www.who.int/entity/hhr/news/hrba_to_health2.pdf

UNAIDS. 2004. “What Constitutes a Rights-based Approach? Definitions, Methods, and Practices.” *Issue Paper*. Available at: http://data.unaids.org/...Rights/hrissuepaper_whatconstitutesrba_en.pdf

WHO. *Health and Human Rights*. Web Site: <http://www.who.int/hhr/en/>

HRBA Portal: UN Practitioner’s Portal on HRBA Programming. Web Site: <http://hrbaportal.org/>


Such an approach to maternal mortality and morbidity has a number of implications. Among other things, importance is given not only to outcomes, but also to the processes such as participation, equality, non-discrimination and accountability, all of which need to be integrated into all stages of the health programming process.⁹² In addition, as the OHCHR explains, “an approach to preventable maternal mortality and morbidity that applies the human rights principles of equality and non-discrimination will

⁹¹ OHCHR, 2010.


⁹² WHO, 2010a.

provide stakeholders, including States, international organisations, and members of both the human rights and public health communities, with a vital tool in their ongoing efforts to address the problem. It can facilitate the identification of high-risk groups, enable analysis of the complex gaps in protection, participation and accountability they are facing, and promote the identification of comprehensive and sustainable solutions.”⁹³


What can we learn from the experiences of countries with low or declining maternal and child mortality rates? How can we combat discrimination against women that has an impact on preventable mortality and morbidity? What can we learn from other human rights issues? How can we best address governance challenges in order to improve the current situation and move closer to achieving the MDGs? Researchers have started exploring the linkages between governance, health systems, human rights and maternal and child mortality, but additional research is needed to contribute to our understanding of those linkages and of the best ways to overcome existing challenges and obstacles.

 **OHCHR. 2010. *Preventable maternal mortality and morbidity and human rights*. Advance Edited Version. Human Rights Council. Available at:**
http://www2.ohchr.org/english/bodies/hrcouncil/docs/.../A.HRC.14.39_AEV2.pdf

Summary: This study looks at maternal mortality and morbidity as a human rights issue, and offers an overview of the current state of affairs as well as an explanation of the human rights dimension of preventable maternal mortality and morbidity. It also discusses relevant existing international legal frameworks as well as relevant initiatives and activities within the UN system.

 **Anderson, Tatum. 2010. “How can child health and maternal mortality be cut?” *BMJ* 340(7740): 240-242. Available at:**
http://www.who.int/pmnch/topics/maternal/201001_bmj/en/index.html

Summary: This article looks at the obstacles towards reducing death of women in childbirth and of children under the age of five, as per MDGs Four and Five. The author provides examples to support the view that reductions in both of these death rates are closely related to governance and to the strength of a country’s health system. He does however caution that other factors, including lack of human and financial resources, are also affecting progress towards the MDGs.


 **Paruzzolo, Silvia, *et al.* 2010. *Targeting poverty and gender inequality to improve maternal health*. New-York: Women Deliver. Available at:**
<http://www.icrw.org/files/publications/Targeting-Poverty-and-Gender-Inequality-to-Improve-Maternal-Health.pdf>

Summary: This paper looks at the ways in which poverty and inequality pose significant barriers to maternal health care access and utilization, therefore having an impact on maternal mortality. The authors argue that targeting both poverty and gender inequality is critical to achieving MDG 5.


 **Bhutta, Zulfiqar A, *et al.* 2010. “Countdown to 2015 decade report (2000-10): taking stock of maternal, newborn, and child survival.” *The Lancet* 375: 2032-44. Available at:**
<http://www.thelancetglobalhealthnetwork.com/wp-content/uploads/2008/04/countdown.pdf>

⁹³ OHCHR, 2010.

Summary: The authors present the result of their review of progress between 1990 and 2010 with regards to maternal and child deaths in 68 countries which are part of the *Countdown to 2015 for Maternal, Newborn, and Child Survival* (an initiative which monitors coverage of priority interventions to achieve the MDGs for child mortality and maternal health).


 Rajaratnam, Julie Knoll, *et al.* 2010. "Neonatal, postneonatal, childhood, and under-5 mortality for 187 countries, 1970-2010: a systematic analysis of progress towards Millennium Development Goal 4." *The Lancet* 375(9730): 1988-2008. Available at: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960703-9/abstract>

Summary: This article presents the findings of an assessment of levels and trends in child mortality for 187 countries from 1970 to 2010. Results show a decrease in under-five mortality at the global level, with evidence of accelerating declines in 13 regions of the world, including sub-Saharan Africa.

 Hogan Margaret C, *et al.* 2010. "Maternal mortality for 181 countries, 1980-2008: a systematic analysis of progress towards Millennium Development Goal 5." *The Lancet*, 375(9726) :1609-23. Available at: <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2810%2960518-1/abstract>

Summary: The findings of this study support the view that progress towards achieving MDG 5 is lagging behind and reducing maternal mortality remains a major challenge. As such, the authors found a yearly rate of decline of the global maternal mortality rate of 1.3%, which is far below what is needed to achieve the MDG. The authors provide evidence that can be used for resource mobilization as well as planning and assessment of progress.

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FIGURE 24: NEGOTIATING RIGHTS – BUILDING COALITIONS FOR MATERNAL HEALTH IN UTTAR PRADESH, INDIA

Improvement of maternal health is one of the eight Millennium Development Goals. Despite India's booming economy and its overall strengthening of healthcare institutions, in the Indian State of Uttar Pradesh (UP), maternal death rates remain unusually high.

In March 2008 the organization SAHAYOG launched a project to address a crucial governance challenge in UP. Namely, it examined how advocacy coalitions for the right to maternal health could play a role in making health system more responsive. Seeing maternal health through gender and governance lenses, SAHAYOG's ultimate goal was to mobilize collective efforts at district, state and national levels to improve life-saving services for poor pregnant women.

SAHAYOG documented many cases of maternal and child deaths as a result of apathy and neglect towards poor women in labour. It was also found that, although health providers are well informed about the causes of maternal deaths, many of them feel powerless and are reluctant to take initiative without orders from above. In short, such crisis of motivation called for health governance change: making women and "user community" at large actively involved in negotiating better accessibility and quality of care.

Communicating with stakeholders of various levels, SAHAYOG's project built a consensus among health actors with respect to unacceptability of preventable maternal deaths. The project's Action-Research allowed to question existing hierarchies and raise women's voices and concerns with often unjust denial of maternal health services. In the process, SAHAYOG sphere of influence reached many levels of Indian government, while negotiating rights for better care. Empowering "user community" remains an important part of SAHAYOG's work as it strives to improve health system governance.

For more information, please visit: <http://www.sahayogindia.org/>

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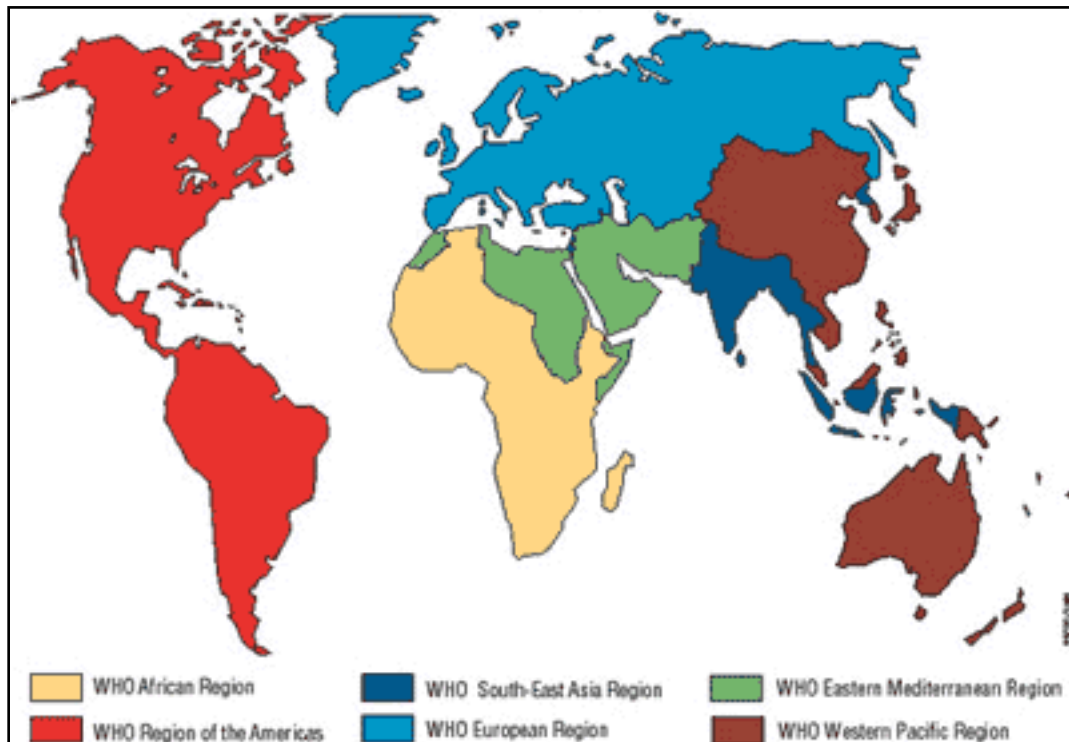
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Annex A

WHO Regions



Source: <http://www.who.int/about/regions/en/index.html>

Annex B

Governance Fundamentals – Based on Political Arenas and Key Principles

Principle / Arena	Participation	Fairness	Decency	Accountability	Transparency	Efficiency
Civil society	Freedom of association	Society free from discrimination	Freedom of expression	Respect for governing rules	Freedom of the media	Input in policy making
Political society	Legislature representative of society	Policy reflects public preferences	Peaceful competition for political power	Legislators accountable to public	Transparency of political parties	Legislative function affecting policy
Government	Intra-governmental consultation	Adequate standard of living	Personal security of citizens	Security forces subordinated to civilian government	Government provides accurate information	Best use of available resources
Bureaucracy	Higher civil servants' part of policy-making	Equal access to public services	Civil servants respectful towards citizens	Civil servants accountable for their actions	Clear decision-making process	Merit-based system for recruitment
Economic society	Consultation with the private sector	Regulations equally applied	Government's respect property rights	Regulating private sector in the public interest	Transparency in economic policy	Interventions free from corruption
Judiciary	Consultative processes of conflict resolution	Equal access to justice for all citizens	Human rights incorporated in national practice	Judicial officers held accountable	Clarity in administering justice	Efficiency of the judicial system

Source: Court, Julius. "Governance and aid effectiveness: has the White Paper got it right?" *Opinion 73*, July 2006. United Kingdom: Overseas Development Institute, 2006.

Annex C

UNDP Characteristics of Good Governance

Participation - All men and women should have a voice in decision-making, 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.

Rule of law - Legal frameworks should be fair and enforced impartially, particularly the laws on human rights.

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.

Responsiveness - Institutions and processes try to serve all stakeholders.

Consensus orientation - Good governance mediates differing interests to reach a broad consensus on what is in the best interests of the group and, where possible, on policies and procedures.

Equity - All men and women have opportunities to improve or maintain their well-being.

Effectiveness and efficiency - Processes and institutions produce results that meet needs while making the best use of resources.

Accountability - Decision-makers in government, the private sector and civil society organisations are accountable to the public, as well as to institutional stakeholders. This accountability differs depending on the organisation and whether the decision is internal or external to an organisation.

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.

Source: UNDP. 1997. *Good governance for sustainable human development*. A UNDP Policy document. Available at: <http://magnet.undp.org/policy/>.

Annex D

Governance Matters IV: The 6 dimensions of Governance Indicators

Voice and Accountability; Political Stability and Absence of Violence; Government Effectiveness; Regulatory Quality; Rule of Law; and Control of Corruption.

Voice and Accountability includes in it a number of indicators measuring various aspects of the political process, civil liberties, political and human rights, measuring the extent to which citizens of a country are able to participate in the selection of governments.

Political Stability and Absence of Violence combines several indicators which measure perceptions of the likelihood that the government in power will be destabilized or overthrown by possibly unconstitutional and/or violent means, including domestic violence and terrorism.

Government Effectiveness combines responses on the quality of public service provision, the quality of the bureaucracy, the competence of civil servants, the independence of the civil service from political pressures, and the credibility of the government's commitment to policies.

Regulatory Quality instead focuses more on the policies themselves, including measures of the incidence of market-unfriendly policies such as price controls or inadequate bank supervision, as well as perceptions of the burdens imposed by excessive regulation in areas such as foreign trade and business development.

Rule of Law includes several indicators which measure the extent to which agents have confidence in and abide by the rules of society. These include perceptions of the incidence of crime, the effectiveness and predictability of the judiciary, and the enforceability of contracts.

Finally, **Control of Corruption** is a measure of the extent of corruption, conventionally defined as the exercise of public power for private gain. It is based on scores of variables from polls of experts and surveys.

Source: Kaufmann, Daniel, Aart Kraay, and Massimo Mastruzzi. 2005. *Governance Matters IV: Governance Indicators for 1996-2004*. World Bank. Available at: <http://www.worldbank.org/wbi/governance/govdata/index.html>

