Transcript of the First Webinar  
Governance in the Public Sector Organizations

Meredith: Good morning, everyone. Welcome to part one of the governance series. My name is Meredith Schlussel. I am a project associate for the Leadership, Management and Governance project and I have here presenters Mahesh Shukla, Jason Wright and Jim Rice.

To begin, I will just go over some brief housekeeping rules for those who are connecting in internationally and audio, just letting everyone know, participants will be automatically muted and those who are connected internationally, please connect your audio to your computer. Unfortunately, you won’t be able to call in. There is a “raise hand” option on the bottom right corner where if you have issues, you may raise your hand and we’ll try to answer your questions, and there is also an ongoing feedback function next to it where you can find ongoing feedback. Below, you will see a Q & A chat where you will have our questions and answers during our follow-up sessions after the presentations.

Please make sure that you make your questions go to all panelists and we can see your questions. Lastly, we will be trying to promote this event on social media. If you have any comments to share, please use the hashtag below #governforhealth. Now, here is Jim Wright.

Jim: Good day, everyone. It’s a pleasure to be with you. We’re going to begin exploring governance in the health sector. We have on the screen a starting definition that we are using throughout the Management Sciences for Health organization.

We look at governance as a structured process of decision making. It involves a group activity and it is designed to deal with all types of health issues, whether it is HIV-AIDS, avoiding preventable maternal and neo-natal death, malaria, TB, non-communicable diseases and the like. As many know, Management Sciences for Health is engaged in governance activities in all three of our centers, the Center for Pharmaceutical Management, the Center for Health Services, and the Center for Leadership Management.
You’ll see on the bottom of this first slide the work that our organization has done to distill good governance into four essential practices with a continuing commitment to enhance and improve those four. You’ll see them on the upper left corner as cultivating accountability, engaging stakeholders, setting strategic direction and stewarding scarce resources. This occurs in public and private institutions for all health challenges and at all health levels. We are launching this series of discussions because we are finding that governance is an essential activity to enable the work of those that deliver and manage. There are 170 thousand governing bodies that have been identified in the public sector in Africa alone.

We’ll go to Slide 4 and look at the overview of our series. Today, we’re dealing with governance as it plays out in the public side of the equation. On April 15th, we will be looking at how governing activities occur in a mix of civil society organizations and then in May, we will be developing and fostering a broad community of practice for people around the world to engage with us on a LeaderNet experience, May 11 and 13. All of these materials are available to be downloaded by all registrants and there will be a recording of both webinars that lead up to the LeaderNet learning experience.

There are three key messages that you’ll be hearing throughout this series. The first is that good governance is not only essential but it’s occurring in many different venues. The second message that we’ll be exploring together is that good governance is an enabler for those that do their work and the bottom line in all of this is that we worry about and try to strengthen these four essential practices of good governance. We’ll be exploring what to do and what to avoid in this three-part series. We’ll also be looking at the kind of infrastructure that’s needed to support these good practices and the principles, and systems that are associated with that.

The last comment I’ll make before we go to our first panelist is that this is a part of a suite of resources that will be made available to the field. There will be a new book coming out this spring on leaders who govern, which will be a sequel to the Management Sciences for Health book that has been well received over the last decade on managers who lead. There will also be three e-learning courses made available through USAID, in their global health e-learning series on governance, and I would remind all that there is an app for Android and Apple phones that deal with these four essential governance practices.

If we go to Slide 5, these are the three characters. You will see that we are gender-challenged in this panel today and that we have three gentlemen that I have also a challenge with growing hair. We will be trying to balance our gender activities in the second panel but let’s move now into the first panelist, Dr. Mahesh Shukla who will be looking at how governance plays out in decentralized systems, using the case study of
the Afghanistan work for the Leadership Management and Governance project.

Mahesh, welcome to this panel.

Mahesh: Thank you, Jim. Hi. I am excited to be with you today. In my short presentation, I’ll briefly touch upon the governance challenges provincial health systems in the public sector are facing, what the leaders who govern these systems could do and what we, in the LMG project have been able to do to help them discover their potential.

I have three messages for you. One, good governance enables the people who manage and the people who deliver health services in decentralized health systems to orientation and education in practices of good governance, help the leaders who govern the systems consistently apply these practices. Three, good governance of these systems can improve their performance.

This potential, I must say, remains under-utilized. When a lot of work is being done to support vertical health programs and other health system building blocks, governance seems to be the final frontier in the reform of health systems where few have gone before. Governance manifests in a variety of ways. What you perceive as a consequence of lack of good governance depends on who you are and where you are. Some people are hard pressed to get the services they need. Health service providers are constrained to provide the best care they can.

Senior management teams are likely to say, “We do not have much authority on resources. All important decisions are taken in the capitol. Even if we had, all of us are trained in clinical subjects. We have no prior experience, orientation or training in management, leave alone governance.” To help leaders who govern and manage these systems, we in the LMG project have developed a theory of change that is shown on the slide. The crux of the theory is governance facilitates management. Management enables delivery of health services and better health services lead to better health outcomes.

At the top, you will see when an organization has a well-defined governing role competent people perform it. They consistently apply practices of good governance and they are able to establish and use governance infrastructures. For example, governance policies, information systems, dashboard, etc.

We can say that the organization is being governed well. This facilitates sound management of medicine, human resources, financial resources and information. As you go down, you will see how we define sound management and reliable service delivery. Competent people, practices and systems are the common denominator. All of this is to say that achieving better health in fact and may largely remain aspirational for a health system, if its governance is not all right.
In the LMG project, we have evolved an approach based on practices of good governance. There are five practices and each practice has multiple domains. Cultivating accountability comprises sharing information, establishing a culture of accountability, measuring performance and effective oversight. Engaging stakeholders include building trust, collaborating with other sectors and being gender-responsive. Setting shared strategic direction encompasses defining and realizing strategic direction, closely working with stakeholders. Stewardship includes mobilizing the sources, wisely using them, pursuit of efficiency and sustainability and practice of ethical and moral integrity. Continuous governance enhancement encompasses cultivating governance competencies, building diversity, performing regular governance assessments and organizing governance orientation and education.

In the next four slides, I describe an example from our field work in Afghanistan, where we successfully deployed and tested an approach based on practices of good governance. We were fortunate to have these structures set up at different levels of Afghan health system. During the past fifteen years, we offered three constructions. These governance bodies at provincial, district health facility and community levels do not perform complete range of governance functions. Oversight of health service delivery is perhaps their most important role.

On this slide, I show governing bodies at each level and number of members in these governing bodies. For example, there are thirty-four provinces in Afghanistan and there is a provincial public health coordination community with twenty-two members in each province. Thus, seven hundred and forty-eight people performing a governing role at province level. Likewise, you will see a multitude of people performing governing roles at district health facility and community levels. Nationwide, the total is more than hundred thousand.

These men and women, they are not fully aware of their governance potential and they help realize only a fraction of it. They need to be supported in terms of governance orientation and governance education. When we support them, these governing bodies are able to make good use of it. We experienced this in three provinces and eleven districts of Afghanistan.

After gaining knowledge of the practices of good governance, through a series of governance workshops, the provincial and district health committees created their governance development plan and implemented them over the next six months. The bar on the left side depicts three provinces and the bar on the right side depicts eleven districts. You will see, these committees were able to implement a large part of their governance development plan, shown in blue, and only a small part shown in orange and red, remain largely unimplemented.
Their governance self-assessment scores improved significantly at the end of six months. Perhaps more importantly, the committee started seeing improvement in the health system performance and pre-natal care visit rates in three pilot provinces increased by twenty percent, compared to controlled provinces. We collected similar data on seven indicators of health system performance and one health outcome. Using differences methodology, we are able to show that the governance intervention increased the pre-natal visit rates. However, other indicators did not change significantly, we believe because six months was too short a duration to make a dent.

Next slide, please. These are the lessons we’ve learned from our work in Afghanistan in the last three years. With the ministry’s support, we have expanded this approach to seventeen provinces and also successfully piloted it at health facility and community levels. The ministry has taken a decision to apply it nationally. The results require consistent application of the practices of good governance and it may take time to show.

We have documented this approach in a peer reviewed article published in the journal Conflict in Health, in January this year. The article is open access and you can access it for free at the journal’s website. LMG project has developed a body of governance learning resources and it’s available in public domain. We will circulate the deck of slide for this webinar and other presentation materials. These will give you links to these governance learning resources. Thank you very much for your attention and I can take a few questions and comments during the next few minutes that I have. Thank you.

Jim: Thank you, Mahesh. We’ve seen how governance can have some early indication of positive results in a very de-centralized and a hostile sometimes setting in Afghanistan. We also see the value of having an intentional work plan to move forward. We will be able to take some questions at the end of the panel. I think in the interest of time, we will move forward into the next panelist, but we would encourage all of you, if you have questions, please enter them into the chat form of the webinar system. If we do not have an opportunity to get to all the questions, we will respond to all of them in writing over the next two days, and also the questions will be framed and used in the learning experience of LeaderNet.

Let’s go to our next panelist, Jason Wright, recently has joined Management Sciences for Health from a large and lustrous career from working in a variety of health-challenged areas in USAID, as well as in the International AIDS Alliance. Jason, welcome. We would like you to share with us some insights into the unique governance model in the public sector, a multisectoral approach to governing at the Global Fund.

Jason has been privileged to represent the US government in a variety of roles with the Global Fund, as well. We are delighted to have you with us and we are looking forward
to learning some lessons about this very unique governance arrangement. Jason, welcome.

Jason: Thank you very much, Jim and good day everyone. Next slide, please.

My presentation format will be as follows. I am going to look at the structure of the Global Fund, both its overall structure, the structure of the board and the country coordinating mechanisms, the CCMs. Two, I am going to look at the functions of the board in the CCM and map them to this MSH governance practices which Mahesh discussed earlier, and three, I am going to look at some of the MSH technical support approaches and tools, which we’ve been able to develop to improve performance against these functions, and I am going to conclude with three lessons learned through this engagement. Next slide, please.

I’ve been privileged to be able to serve on the Global Fund’s board, as well as other boards. With the Global Fund, I’ve been both on the US government board delegation, as well as the developed country delegation, six years with the US government and one and a half years with the developed country NGO delegation, as well as being able to serve with the UNA and CCD, the program coordinating board and the Global Health Council. Next slide.

I wanted to show you the diagram of the overall structure of the Global Fund. Although, we’ll be focusing on the large blue box on the top labeled The Board, and then the small orange box towards the bottom, labeled Country Coordinating Mechanisms.

What is unique about the Global Fund and one of the reasons why they decided to create a new model as opposed to embedding it within the UN was that they did decide not to have a country presence. What the Global Fund does is to contract out services related to programmatic and financial accountability to what are called local fund agents or LFAs.

What I am going to focus on in this presentation is looking at the governing bodies, both at the macro level, so the Board, which meets regularly in Geneva, and then the CCMs, the Country Coordinating Mechanisms, which perform the function of the board at the country level. Next slide.

This is the broad structure of the Global Fund Board. As you can see, there are two different blocks. There is the donor block and the implementer block. They each have ten voting constituencies and that there are five non-voting members. I am not going to go through this in detail, but you’ll see I have italicized certain members in each of the blocks and the non-voting members. What is important about these is they’ve actually incorporated not just governmental representatives, but non-governmental representatives into the structure of the Global Fund from the very beginning. You can
see under the Donor block, you have not just bilateral donors, but also private foundations, which have been represented by the Gates Foundation and the private sector, which has been both represented by the mining and pharmaceutical companies.

In the case of the Implementer block, you can see the first three voting members are italicized. Communities, which are people living with and affected by diseases and then both Southern and Northern NGOs represented as well, and then in the case of the non-voting members, you have not only the UN agencies, the usual actors, but also the three disease partnerships, UNAIDS.tv, Roll Back Malaria, as well as Unitaid.

What is interesting about how they structured the board and the voting procedures is that they actually have an alternation between from the Donor block and the Implementer block in terms of who chairs the board, and then in the case of the two major committees, the strategy committee and the finance committee, they’ve assigned the Donor block the responsibility to chair the strategy committee and the Implementer block the responsibility to chair the finance committee.

Then in terms of voting at the board level, there is a requirement that you have a double-two third majority, so that there is agreement from the majority of both that Donor block and the Implementer block on any major decisions. Next slide.

This, I just wanted to highlight that like with the board at the global level, at the country level, there is also the requirement to go beyond the usual actors of government and donors or development partners, by incorporating civil society and the private sector. I wanted to list how the Global Fund defines civil society and the private sector, but I won’t go through that in detail. The most important aspect is the fact that the CCM membership has to include a minimum of forty percent representation from national civil society actors. Next slide.

I just wanted to remind you the diagram again on the MSH governance practices. We are looking at these four practices as they apply in this case to the Global Fund board and the CCMs. The next two slides will actually map these practices to the board in CCM functions.

First, we have the board functions. As you can see, the Global Fund has assigned its board these six broad functions and they do map very cleanly back to the board governance practices. Next slide. In the case of the CCM functions, of which there are seven, you see a similar clean mapping back. I think the way that you slice and dice, it can be different but for any highly functioning organization, they are going to go back to these four governance practices which are universal across government, non-government and the private sector, as well. Next slide.
I wanted to look at the three different areas that the MSH approaches in tools, which we’ve developed to improve Global Fund performance overall. These are the six CCM eligibility requirements. As I mentioned, very importantly, the Global Fund has incorporated civil society into governance at the country level. What they do is require that the CCM certify at the time of submitting their concept notes, what used to be called proposals, have a transparent, inclusive concept note development process and that they are open and transparent in how they select the principal recipients who directly receive the funding from the Global Fund. Then where the MHS has really had a unique added value is in terms of the eligibility and performance assessments, which are done in annual basis to make sure that the CCMs are performing the last four functions here, oversight planning and implementation, CCM membership of effective communities, processes for electing non-governmental CCM members and managements of conflicts of interest on CCMs.

What we’re seeing overall is that MSH and its partners under both the LMG and the GMS projects, in particular the International HIV-AIDS Alliance, with which I used to work. I’ve really set the gold standard for how you provide the Global Fund technical support overall and in particular, around these ETAs. This is a fairly new process that the Global Fund has been conducting. It’s been something that’s formalized what has been done informally over the course of the years. What we’ve been able to do from MSH is not only provide the technical support but actually train the cadre of consultants who are doing this work, not only under our projects but under other projects, as well and both GMS and LMG, and in cooperation with the Alliance, have been able to create really a new profession to provide the highest standard of technical support in these areas. Next slide.

In order to provide oversight to grant performance at the country level, the GMS project has been able to develop two different what we call dashboards. First of all, there was the CCM dashboard, which is an Excel based tool. On the next slide, I’ll show you a screenshot of the tool itself. It was something that we’ve piloted in 2008 and 2009 in six countries and it’s not just the tool itself. It’s actually a comprehensive package, which includes not only the dashboard tool but also a setup and maintenance guide, a summary of the technical support process and a guidance paper on CCM oversight, which are now a global public good, which is available on the Global Fund website.

Then we have actually taken it to the next level with what’s called a PR dashboard, working with the information technology company SAP to pilot the work in six more countries and that dashboard and supporting documents will be available in the Global Fund website, as well.

As I mentioned, here is the screenshot of the CCM dashboard. As you can see, it doesn’t just take the information and then present it in the static sense. It actually
provides information for decision making so that you can take the indicators, which are already being provided to the Global Fund in finance management and programmatic setting, and actually translates them into recommendations and actions, which assign responsibilities to certain actors and with deadlines for each of the actions. Next slide.

Lastly, I wanted to look at the technical support we’ve been dividing to the two African board delegations. In 2011 and 2012, we’ve worked with the Governance Reform Task Force to create a new governance framework. What we had seen was that there was more of a diplomatic approach to how this was done. There was a rotation among the African countries in terms of who would represent them on the board, but we wanted to really move to a term limited and competency based approach to how the African countries would represent themselves on the Global Fund board, and provide them with the human and financial resources they needed to do this.

We’ve done some work in the last couple of years. I’ve been personally involved in a team that’s been working with both the delegation to create a bureau to provide the policy analysis function and we’ve provided technical support on planning, budgeting, tendering and resource mobilization. We’ve been able to create an interim bureau at the African Population of Health and Research Center in Nairobi, funded by the Gates Foundation, and then a permanent bureau will be set up in Addis Ababa after an open tendering process.

Lastly, I wanted to look at the three lessons learned from the work that we’ve been able to do with the Global Fund. One, in terms of structure, it’s very important to have the relevant stakeholders there. In this case, civil society and the private sector. Two, the functions, as I’ve said before, map very cleanly the functions of both the board and the CCM, and any other effective governing body to the MSH governance practices, and three, we’ve been actually able to create with the MSH some very effective approaches and tools to working with both the CCMs and the board to make sure that we can maximize adherence to requirements, transparency and accountability, and board performance. Thank you very much.

Jim: Thank you, Jason. We are hearing from Mahesh the value of having a work plan and self-assessment to get optimum performance from decentralized systems. We see in a large international-global multisectoral body, the value of being intentional about diverse compositions, clear terms of reference and the use of dashboards.

We will come back to each of you with questions in a moment. We are going to finish the presentations with some remarks that I will share about the development of the capacity of public hospitals in Nigeria. If we could go the next slide.

This is a result of a two-day training program that was done. We can refer to it here as a governance academy. It was asked for by the Commissioner of Health of the Lagos
State. If you can go to the next slide, we’ll look at some of the challenges and the priorities and an approach that these several governing body leaders and executives, and position leaders, a group of about eighty came up with.

They identified these challenges. While the regulations in Nigeria were to make sure that governing bodies were formed in Lagos State, these were defined to be membership of approximately eight people, but these individuals came from diverse backgrounds, some clinical, some business, some civic, some faith based leadership, often found that they had unclear terms of reference. The appointment process was not clear and based on discipline criteria, certain backgrounds and experience in governance, and no real strategic vision for their enterprise.

Let’s go through and look at what these board leaders from the public hospitals in Lagos State did with these challenges. If you go to the next slide. They focused in this governance academy to define clear actions to strengthen their effectiveness. Go to the next slide, please. They identified priorities in these seven areas.

They needed to expand their understanding about the challenges of their hospitals, as well as the process of making decisions to govern them. They were also keenly interested in public-private initiatives to bring more effectiveness from their work. They looked at the need for building competency in quality and patient safety. That was a very high priority. They wanted also some practical ways that they could work with management and their physician leadership to grow service volumes, because in Nigeria, like in many countries, that we see in low and middle income situations, they are expected to generate revenues from their activities, performance based financing is an element of that.

We see patient safety aligning with the health workers and some basic approach to business planning, where their priority is. Next, please. One of the things that we found useful in Nigeria and we would encourage for the audience of this webinar is that these working groups, these governing bodies, they are called various things, boards, councils, committees, will find it useful to have a simple device to define their work going forward.

In Nigeria, we used the technique of a 999 Action Plan. They worked in small groups to identify what would be one or two actions they could do after the governance academy to strengthen their work and effectiveness in the next nine days, a couple of five ideas in the next nine weeks and a couple of ideas in the next nine months. We have a document that captures what they came up with as their key conclusions that you can download. All people registered for this webinar will be able to see and download that file. I am only going to give you a teaser on a couple of the observations that they came
up with which were important and I'll also call your attention to some of the initiatives that they identified to do their work in these six priority operational areas.

I am going to start with the bottom of Slide 37 and then work up to brief comments on what these board leaders felt they needed to concentrate on a short-term basis. They identified actions that you'll see in the download document from ten to twelve things that they can do to raise money, to save lives, to save money, to increase patient satisfaction, to develop stronger recognition and rewards for their employed staff and volunteers, and also to have a more intentional strategic plan that is developed with their community.

The importance on this slide is that these governing bodies to do their work, they don’t want to be educated just about decision making processes. They want to know how that decision making will play out in the real world of the operational challenges that they are dealing with.

In the next nine days, they did identify the need for a self-assessment. They identified in the next nine weeks the desire to develop some specific measures of effectiveness of their board, how they are going to invite additional, more diverse elements of their community into their governance decision making. Over the next nine months is where they started to identify some work they want to do with their management teams and their health workers on building new strengths in these six areas of the operational nature.

They also however identified the need to have an annual self-assessment, and that that self-assessment would drive their passion and their work toward continuous improvement.

As a result of that activity, we are still following how this has played out in Lagos State in terms of improved ability to attract people onto the board, more effective decision making and very importantly, that these hospitals function more effectively to yield better quality of health services, and ultimately of course, we all hope improved health impact or health status improvement for the people in their service areas.

We have now looked at three types of examples. If you'll just go to the next slide, and the next one, please. We’re going to go to a series of questions from those that are signed in. We have over one hundred sixty people registered for this webinar and almost the same number for webinar two. We hope to increase that number over the next several weeks. We are exploring how good governance plays out in three completely different settings here in the public sector.

I am going to ask one quick question for Jason and Mahesh, and then we have time for some dialog with people in the field, as well as in our Medford office, and those here in
Arlington. I’ll start with you Mahesh. You gave a very good overview of how governance is occurring in a complicated setting in Afghanistan. Because I know in your earlier discussions that some of the individuals invited into these provincial and district governing boards did not have a great deal of experience, I would like you to share with the group how they reacted to the need for education and how they took advantage of that in the academies that you conducted there. I’ll give you just a moment on that in a minute.

Jason, I’d like you to think about the challenge of this complicated governance model of Global Fund. How do they, when they come to make decisions, use information wisely? You gave us a glance at the dashboard as one mechanism for that, but I know that the board packets that you’ve had to deal with are complicated. So, what practical advice would you share with the audience about how you make information available for board work that is easy to digest and use? Then, we’ll throw it open for questions from our audience and the colleagues. We have about twenty minutes for conversation and dialog. I am looking forward to the chance to interact with all of you now.

Mahesh, how would you react to that question I posed about these decentralized systems, these several hundred people that you were working with? How did they look education and building their capacity? What should we do to encourage that?

Mahesh: Sure, Jim. These committees, for example, I’ll give what the membership looks like. For the most part, they are provincial public health officials, appointed, provincial hospital director representatives of NGOs, private sector representatives of elected provincial council. Likewise, on the district committee, representative of district government, religious leader of the district, representative of district council.

These people, when they come together, they have a set of responsibilities that have been given by Ministry of Public Health to them. When they went through these governance orientation workshops and when they gained knowledge of the practices of the governance, evaluation sessions clearly stated, this is very useful to us. We had a set of responsibilities, but this gives us how to be successful in discharging those responsibilities and at the end of six months, they got some promising results. They see value. They recommended that this approach should be applied nationally and the Ministry decided in favor of it.

Jim: Our terms of reference are helpful but we still need to invest in orientation and discussion, and education to really breathe life into that. Thank you.

Jason, my question to you is the board for Global Fund, how does it use information and how do you make information to fuel their decision making? What would you share as lessons for our colleagues?
Jason: You had mentioned, when you previously phrased the question about the fact that the dashboard actually provides information to the CCMs that they didn’t have before. There is actually the case where in a lot of countries, they weren’t receiving any information and in other countries, they are actually deluged with the information. So, it’s finding that happy medium of information which is presented through the dashboard that enables them to make informed decisions.

In many cases, they are getting a five-page packet of visually displayed information which would allow them to make informed decisions. With the board what happens, and people have worked in my office before know this, there are thousands and thousands of pages which come out before every single board meeting and between those board meetings, there are hundreds of pages which come out for the committees as well. What you see is that the representatives on the board come and go, but you need to have that continuity there to be able to digest that volume of information. It’s like drinking from a fire hose.

What we try to do by sharing information on how two different delegations on which I have served, the US government delegation and developed country NGO delegation is to share with the African board delegation the quantification of how many person hours, days, weeks that you need to actually digest that volume of information and then to make sure that there is a professional cadre of people who are providing support to the delegations to be able to go through that information and not just translate it from one language to another, which is an issue obviously with having Anglophone-Francophone-Lusophone representation, but also to have informed analyses of the decisions that are to be made, and to actually come up with decision papers so that the person sitting in the seat feels like he or she has a firm handle on the issues at hand.

Jim: Thank you very much. Let’s go to our audience for some questions. I’ll first turn to Medford, and then we’ll take one here in the Arlington office, and then by then, some of you in the field will have framed and shared with us in a short typed note a question.

Again, as I mentioned, we will probably have more questions than we can realistically deal with in this webinar. We will however respond back to everybody that has registered and show the questions and the answers, as well. I am first turning to Medford. Is there a question for our panelists?

Pat: Hi. Jim, can you hear me?

Jim: Yes, we can. Introduce yourself, please Pat.

Pat: Hi, I am Pat Nicholan [phonetic 00:41:47] in Medford. Thank you so much for the panel. I am with the Global Partnerships Marketing Communications. This is for Dr. Shukla. You mentioned on your slide that it takes time to translate governance
improvement to improve health system performance. My question in Afghanistan, how much time did it take?

Mahesh: Sure, Pat. People are able to gain knowledge of the practices of good governance, say in two orientation sessions of three days. Changing practice takes a while. If there is commitment, weeks or months and changing outcomes, in terms of health system performance and health outcomes, it might take several months to a year, or maybe a couple of years.

As far as we’re able to see, their governing practice improve. Then we’re able to see, in the period of change we see management improves, service delivery improves and finally, health outcomes improve. So, it’s a long process.

Jim: We should be patient but sometimes our clients and donors aren’t patient for the results. So, that’s the challenge we face. Is there a question here in the Arlington office? We’ll take on here in Arlington, and then we’ll come back to Medford, and Meredith, I’d like you to pick one from the field that are coming in. Ian, if you’d introduce yourself and raise your question, please.

Ian: [Inaudible 00:43:38]

Jim: Speak up.

Ian: Sorry. Ian Flannigan. First, really interesting discussion. Thanks very much. My particular question relates to Jim’s discussion of the hospitals. One thing that occurs I think to most of us is that hospitals tend to be the first of many places for patients. They are also very political institutions, very visible and tend to attract resources and of course, what we seek to do is try to contain cost of hospitals and try to move resources to lower levels of the health system so that we can support primary care, in pursuit of universal health coverage. I am very interested to hear what observations you may have about how board strengthening, which is absolutely necessary in a hospital affects that dynamic.

One of the priorities, number four, I think, was increasing service volumes and another was to make sure there was strategic planning of the community, and there is obviously a tension between those two. I am wondering if you could speak to those issues and what we’re seeing.

Jim: Yes. I believe people in the field heard the question. It is the dynamic tension in governing a hospital which is in most countries the largest consumer of resources and how to balance that with the need we know that is at primary care area.

There are three things that these governing bodies need to have the discipline and the encouragement to do. First of all, it is to acknowledge that they aren’t the center of
universe. This is very difficult, because so much of their work is defined by clinicians that are trained in hospitals, and so that one is an attitudinal adjustment, which can be improved through education about where the great returns come from investments compared to primary care versus hospital care.

The second thing that needs to be done is that we need, all of us, in our practices and technical assistance to encourage these governing bodies not to plan in an isolation, that they must open their strategic thinking and planning process to invite the community in, because it’s more difficult to say, “No, we can’t use some of these resources in the more remote or the more decentralized, or the more primary care setting,” when you’re sitting side to side and face to face with those individuals.

The third thing that needs to be done is that we need to make sure that their governance decision making is driving toward a preparation for the challenges of performance based pay, which is going to not just be paid on the number of people that are admitted or days of service they provide, but increasing the payment for packages of service that include primary, secondary and tertiary hospitals.

That’s easy to talk about, more difficult to do, as we know. So, that’s a quick response of what they are struggling with in Nigeria but in all hospitals.

Meredith: We have a question from [inaudible 00:46:52]. She writes, “The most important thing in governance is to reduce corruption. Has any of the panelists assessed how much the governing academy is practiced in the resource stewardship?”

Jim: An excellent issue. I would just preface before we turn to Jason and to Mahesh that the LMG project did a study over a year ago about the scope and nature of corruption in health sectors, and we were a little timid about asking the questions but we were surprised, I suppose, that within hours after the survey was posted, people from around the globe were weighing in, talking about one, this is a big problem, two, it won’t go away unless we talk about it and address it, and that this not only is at the policy level, but it must occur in the governing bodies. We must have policies to try and mitigate against conflict and interest and to avoid it, but it is difficult to do if you don’t have transparent decision making and if you don’t have reporting of results and transparent monitoring of the procurement and construction, and posting issues, which were all important elements of corruption.

So, it is a big issue. People from the field would understandably frame this. How does corruption get addressed at the Global Fund and CCMs Jason, and Mahesh, in your experience, how are these governing bodies going to have to deal with corruption? We’ll take quick responses and then we’ll go to another question. So, Jason first, corruption, how is it dealt with at all levels of the Global Fund system?
Jason: I think most importantly, the Global Fund did make a fundamental decision that its very start is to establish an independent office of inspector general which has responsibilities for finding and addressing corruption at any level of the organization.

Some of you might remember a few years ago, there were a series of reports on four different small countries in terms of corruption that we saw, which led to some changes in Global Fund board governance, and I think that both the confidence that was inspired originally by the office of inspector general and the fact that the Global Fund board has been very decisive in its actions. I think that the board itself has undertaken a process of developing an ethical code of conduct and the one question around that was around conflict of interest, be it perceived as real conflict of interest and making sure that you are able to mitigate that.

What I would say is you want to make sure that people are continuing to try to represent the interest of their organizations. They wouldn’t be members of the board if they didn’t have interest, but the people are open and transparent about declaring those interests. When we’ve had cases of corruption, the Global Fund has acted very decisively in terms of making sure that principal recipients or recipients were paying money back, or in the case of suppliers, we saw and issue with bed nets.

Most recently, they were barred from being a supplier to the Global Fund and there is actually a fine or a donation that’s made in response to what’s happened.

Jim: The GF has challenge of representing an interest versus representing the collective fiduciary responsibilities of the board. That is an issue not just in multisectoral boards but others. We’ll come back to that. I want to finish this discussion on corruption. Mahesh, your response of what advice you see on corruption, and then we’re going to go to a question from Jamal in Ethiopia and then back to Medford.

Mahesh: Thank you, Jim. Indeed, in good governance, stewarding the resources is one of the practices of good governance. Ethical use of resources and efficient use of resources are two hallmarks of responsible stewardship. When the members of governing bodies at these various levels, they discuss and deliberate this and at the same time, they are acutely aware of corruption issues in their health system. At the same time, spending their [inaudible 00:51:14] capacity is also one of the aims of this exercise of governance orientation or governance education.

As a result of emerging stakeholders, they are able to better engage with councils and committees at various community levels or district levels. So, problems come to their notice very quickly and these committees, they want to do something about corruption. For example, one of the provinces set up a committee on financial transparency on their own volition, like we didn’t ask them to do this or that but then, this committee, they
introduced two employees or two workers to criminal prosecution. So, they want to reduce corruption in their system. They are interested in it.

Jim: Thank you. We are going to go to some other questions. I would just say that in the discussions we had around this issue in Nigeria, in my previous work, it’s not enough to talk about it. You must have a written policy. It should be read and signed by every board member every year, and the board chair person should be the key keeper of that in partnership with the managing director and chief executive.

It gets a bit awkward though if it’s the board chair person that’s involved in the corruption. However, this is an ongoing challenge that the MSH and our project will continue to focus on.

I want to just do one quick comment/question here. I believe this came from Catherine Severo. She properly tees up this tension between representing your constituency and representing the full fiduciary of the board. I’ll turn for a short response please on that issue from you Jason, and then I am going to go to Medford. Was it Stephanie that had a question or is there still another question?

Female Speaker: Yes. Stephanie has had to leave. I have a question that is still on the table.

Jim: We will come to you in a moment, and then after, we do Jamal. Quick response on the tension of representation versus the fiduciary for the whole organization.

Jason: I mentioned this ethical code of conduct and there is actually some pushback from the civil society delegations in particular on the issue or representing your own constituency interest versus the interest of the Global Fund overall. I think that in the end, it’s in the eye of the beholder, and I think that you have to make sure that people have the ability to speak their peace on what’s going on that when they are actually representing their constituency’s interest, they believe that’s also in the interest and not set up a false dichotomy between the two.

That being said, if there is any potential for personal family or organizational gain out of anything that’s going on or if you are using your board representation to exert undue influence upon the Global Fund secretary or inspector general, obviously that’s problematic and we’ve set up measures to address that.

Jim: Thank you. We are going to turn to our colleague in Addis Ababa, Ethiopia. Jamal, you have a question. Please, if you can be un-muted. Jamal, I see that you typed in, “How can we conclude with the work on the governing board looking at the changes necessary to improve access and quality? It’s great to have those as policies
of a governing board, but in Ethiopia," Jamal is asking, "What can be done to try and do something about that?"

I will respond briefly to that, Jamal. It is a key question. There is three levels that are quite important. One is the board must establish and clear policy and they must become educated about the factors that influence quality. If we're dealing with quality in the hospital, often times it's medication errors, it's post-surgical infections, it's challenges around maternal delivery, and there are a number of materials available now from a wide number of groups that help governing bodies become more educated about this.

It's usually helpful to at least in perhaps two meetings a year, that the board invite in the clinicians to talk about what is being done and what should be done, and what role they can play to enable the work of the workers that are involved at the clinical level and administrative levels to make sure that you're reporting quality, monitoring it, celebrating good results and making sure the materials are available to help deal with it. It is heavy lifting and a challenging journey, Jamal, but it must be started with those kinds of considerations.

We're going to turn to Medford for a quick question. Barbara Tobin, we have four minutes left.

Barbara: Thank you. Actually, we have the next meeting standing outside the door, waiting to come in. I am not sure there is time for this. I noticed in your description of your governance academy slide the priorities that have been set and I am wondering how much that academy deals with differentiating roles of the governing board and committees. Some actually had functions in the management of the hospital that are to make sure that those roles are fairly delineated and that there are clear lines in between and actually take over. I wonder if that's covered in the governance academy.

Jim: Yes, thank you. Barbara from our Medford office raises one of the top three issues that governing boards identify that they need help to deal with and that is differentiating between their role and the role of management. In talking with managers, they say they want to guard against the board being overly-enthusiastic and slipping into micro-management, and the board however wants to make sure that they get fair and accurate information from management, so they can in fact stay at the strategic level.

It is a very important element to build into the learning experiences, which we're referring to as governance academies. If like corruption and conflicts of interests is not easy to chip away at, it must be continually paid attention to and that's where creating a culture of clear roles and understandings can contribute to that.
We are going to need to bring this to a close. We thank everybody for your attention. This is the first of three learning experiences. Please, direct any additional questions to us and we will respond in writing to them. Thank you very much for your interest in how good governance can be made stronger so that it can in fact enable the good work of those that deliver and those that manage health services. Thank you.

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