SECTION 5

CONTEXT CONSTRAINTS

TOPICS

The setting in which your governing body works influences not only the needs and challenges that it faces, but also the scope and nature of its effectiveness. This section describes how governing bodies can best assess the context in which they work and embrace actions that can help improve the effectiveness of their work in various contexts.

THE CHALLENGE

Tensions between competing political parties in Tanzania make it difficult to establish a wise set of health sector plans and programs. Because politicians frequently force a change in health ministers, investments in the health sector for needed health professionals and basic health centers are inadequate and inconsistent. What can those who lead and govern health systems do to improve the political and economic stability and vitality of their health sectors? What is the social, economic, and political case for stronger health systems, and how might effective governing bodies best make this case to the country's political leaders?

SCANNING THE ENVIRONMENT HELPS YOU TO GOVERN

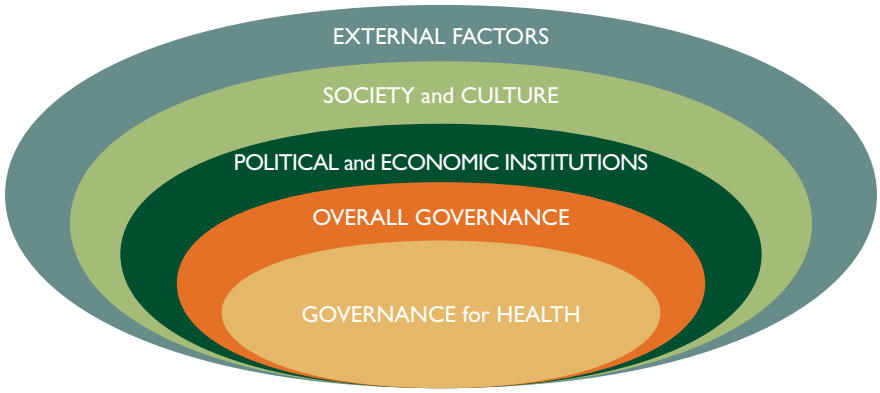
Governing health sector organizations in low- and middle-income countries (LMICs) is not easy, for three interrelated reasons:

1. Pervasive poverty: Improving the health status of people and communities that face persistent and pervasive high levels of poverty and low levels of education is very difficult.[1] It demands the management of many societal factors not directly within the control of ministries of health.[2]
2. Need for health systems strengthening: To secure strong health outcomes, the health sector must have organizations that are built for strong performance and strong sustainability. Unfortunately, in most LMICs, policymakers and managers have weak mastery of the principles and practices for health systems strengthening.[3] They also face challenging shortages of needed health workers[4] and unstable sources of funding that depend on out-of-pocket spending from poor families and weak health insurance arrangements.[5]
3. Political instability: Governing health systems, ministries of health, and public and private health services organizations need clear and stable strategic plans. In many LMICs, this stability is threatened due to frequent changes in health sector leadership, fragile political institutions, and disruptive tensions among terrorist groups and religious extremists.[6]

Figure 5.1 depicts the context of governance for health.

1. World Health Organization (WHO), *Improving Health Outcomes of the Poor: The Report of Working Group 5 of the Commission on Macroeconomics and Health* (Geneva: WHO, 2002). Available at: http://whqlibdoc.who.int/publications/9241590130.pdf
2. WHO, *Social Determinants of Health: Report by the Secretariat* (Geneva: WHO, 2012). Available at: http://www.who.int/social_determinants/B_132_14-en.pdf
3. For a review of factors essential for stronger health systems and greater health impact, please see these resources: WHO, Health Financing for Universal Coverage (Geneva: WHO, 2015). Available at: http://www.who.int/health_financing/en/ and the classic review of the essential building blocks for strong systems: http://www.wpro.who.int/health_services/health_systems_framework/en/
4. For the challenges of shortages of health workers, see WHO, "Strengthening Health Workforce to Strengthen Health Systems (Geneva: WHO, 2015). Available at: http://www.who.int/hrh/resources/strengthening_hw/en/. For regional action plans, see: WHO, "Health Workforce: Governance and Planning" (Geneva: WHO, 2015). Available at: http://www.who.int/hrh/governance/en/
5. WHO, Community-Based Health Financing (Addis Ababa, Ethiopia, 2006). Available at: http://www.afro.who.int/en/clusters-a-programmes/hss/health-policy-a-service-delivery/features/2233-community-based-health-financing.html
6. See USAID assessments and strategies here: USAID, "Fragile States Strategy" (January 2005). Available at: http://pdf.usaid.gov/pdf_docs/PDACA999.pdf. For insights from the UK Department for International Development (DFID), see Claire Mcloughlin, "Topic Guide on Fragile States" (Birmingham, UK: University of Birmingham, Governance and Social Development Resource Centre, 2012), chapter 7. Available at: http://www.gsdrc.org/go/fragile-states/chapter-7--dfid-guidance-on-working-effectively-in-fragile-states. See also USAID work on Political and Economic Assessments at: http://pdf.usaid.gov/pdf_docs/pbaaa891.pdf

FIGURE 5.1 Context matters. Society, culture, and political and economic institutions determine the overall governance of a nation, of which governance for health is a part.



In your local district, county, or province you will understand these issues in a much more personal manner. Your ability to confront and minimize these frustrations, however, will be a function of how your leadership group evaluates, defines, and frames the scope and nature of the problems. A poorly-defined problem is unlikely to be solved. Your governing body would be wise, therefore, to conduct a careful assessment of its operating environment by using one or more of these assessment tools:

- the Management and Organizational Sustainability Tool (MOST) from Management Sciences for Health (MSH)[7]
- the World Health Organization's District Assessment Tool[8]
- the USAID-supported Health Systems Assessments[9]
- the USAID Political and Economic Assessment resources[10]

You can also conduct a series of focus group meetings within your region with community health leaders, politicians, health workers, media, employers, and religious and economic leaders to answer these five questions:

1. How should we define the characteristics of a well-run health system, hospital, maternal-child health center, or HIV & AIDS program?
2. What do we see as the greatest obstacles to achieving these desired characteristics?

7. MSH, *Management and Organizational Sustainability Tool,* 3rd ed. (Medford, MA: MSH, 2010). Available at: http://www.msh.org/resources/management-and-organizational-sustainability-tool-most
8. Luis G. Sambo, Rufaro R. Chatora, and Simone Goosen, *Tools for Assessing the Operationality of District Health Systems* (Geneva: World Health Organization Regional Office for Africa, Brazzaville, 2003). Available at: http://www.who.int/management/district/assessment/assessment_tool.pdf
9. Health Systems 20/20, *The Health System Assessment Approach: A How-To Manual Version 2.0* (Bethesda, MD: HSAA Project, Abt Associates, 2012). Available at: http://www.healthsystemassessment.com/health-system-assessment-approach-a-how-to-manual
10. Molly Anders and Jeff Tyson, "USAID to launch new political economy analysis tool" (Washington, DC: DevEx, October 2014). Available at: https://www.devex.com/news/usaid-to-launch-new-political-economy-analysis-tool-84666

3. What types of services, health workers, medicines, and facilities will we need to achieve our desired health system within the next three to five years?
4. How can we build in incentives for our health workers and health programs and organizations to strive for optimal levels of performance in the coming two to three years?
5. How can we best measure, monitor, and report our health organizations' progress against plans?

EPIDEMIOLOGY MATTERS

Experienced governing bodies and their leaders ensure that the mission they are promoting and protecting is directly focused on the critical health issues of the community, country, district, province, or nation as a whole. How can your governing body make judgments about what are the most important health issues to address? Most rely on studies of the epidemiological dimensions of health problems in the area.[11] These usually include:

- the demographic structure (e.g., age, sex) of the population;
- threats to sexual and reproductive health from weak human rights;
- climate and weather risks;
- water and food security problems;
- sanitation risks;
- threats from war and conflict;
- workplace safety risks;
- poorly enforced or corrupt enforcement of health protection regulations and policies.

Governing body members also need information about the burden of specific diseases that cause people to seek health services and about the trends in these data. Is the country progressing in fighting the major causes of mortality? Which areas are most affected by particular diseases and conditions?[12]

For example, Table 5.1 shows the leading causes of premature death in Nigeria. Analysis of these factors, all of which affect infants and children, reflect Nigeria's major health issues. These are not just major diseases such as malaria and HIV & AIDS but also maternal, newborn, and child health—and the related area of family planning and reproductive health. See Table 5.2.

11. For key issues and indicators, see, for example, the Demographic and Health Survey for your nation, at: http://www.dhsprogram.com/; and the annual WHO World Health Statistics reports. Available at: http://www.who.int/gho/publications/world_health_statistics/en/
12. For behavioral risks and burdens of noncommunicable diseases, see WHO, *Noncommunicable Diseases Country Profiles 2014* (Geneva: WHO, 2014). Available at: http://apps.who.int/iris/bitstream/10665/128038/1/9789241507509_eng.pdf?ua=1. For environmental risks and disease burdens, see A. Prüss-Üstün and C. Corvalán, *Preventing Disease through Healthy Environments: Towards an Estimate of the Environmental Burden of Disease* (Geneva: WHO, 2006). Available at: http://www.who.int/quantifying_ehimpacts/publications/preventingdisease.pdf.

TABLE 5.1 Major causes of premature death, Nigeria, 2010

Indicator	Deaths	Percentage
1. Malaria	24,149	23.2
2. HIV & AIDS	8,598	8.3
3. Lower respiratory infections	8,034	7.8
4. Neonatal sepsis	6,596	6.4
5. Diarrheal disease	5,854	5.7
6. Road injury	4,488	4.3
7. Preterm birth complications	4,396	4.3
8. Protein-energy malnutrition	4,353	4.2
9. Meningitis	3,674	3.6
10. Neonatal encephalopathy	3,164	3.1

Source: Institute for Health Metrics and Evaluation (IHME), "GBD Profile: Nigeria," in Global Burden of Diseases, Injuries, and Risk Factors Study 2010 (Seattle, WA: IHME, 2010).

TABLE 5.2 A snapshot of maternal, newborn, and child health in Nigeria, 2013

Indicator	Statistic
Total fertility rate	5.5 children per woman
Use of modern contraception by married women (15-49)	15%
Skilled birth attendance	38%
Maternal mortality ratio	545 per 100,000 live births
Under-5 mortality rate	128 per 1,000 live births
Infant mortality rate	69 per 1,000 live births

Source: *Nigeria Demographic and Health Survey 2013*

What can governing bodies do about these complicated health risks and challenges? Good leaders who govern can consider taking these three key actions:

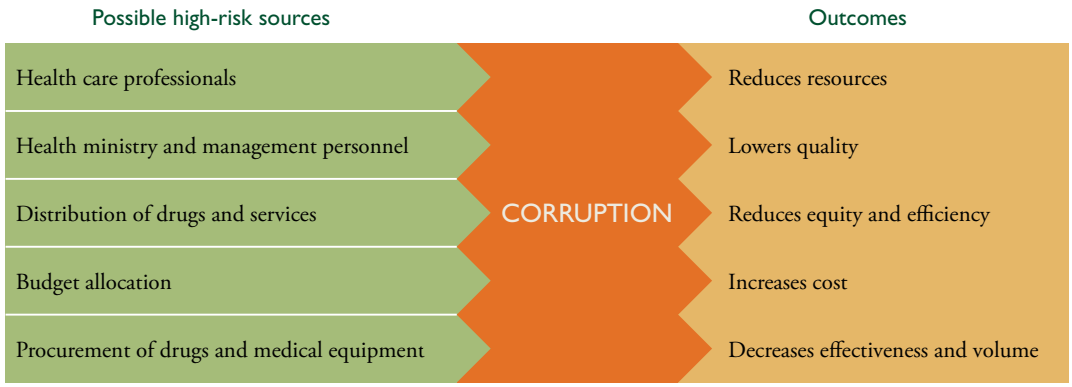
1. Ask local health officials, NGOs, or international donor-supported assistance groups for a careful study and documentation of the major causes of death in your area, and post these numbers as easy-to-understand charts in and around your community and your health services organization.
2. Convene groups of your most at-risk populations to meet with your health workers to define the causes of these deaths and illnesses, and develop specific short-term actions to change individual and institutional behaviors and environmental risks. Further, create plans, including who will implement these activities, how, by when, and with what resources. Many of the challenges will require action from many organizations and types of people in order to realize health gains that are both significant and sustainable. (This is often called "collective action"[13] or "collaborative governance."[14])
3. Post these in and around your community and organization for all to see and help monitor progress of plans. CARE International uses "Community Score Cards" for this purpose.[15] Convene community groups and media representatives to publicize how the progress of your collective action is strengthening the health of your population and the vitality of your organization's finances and performance.[16]

13. See International Centre for Collective Action, "Our Collective Action Services" (Basel, Switzerland: Basel Institute on Governance). Available at: http://www.collective-action.com/
14. See examples of collaborative governance here: John Donahue, "On Collaborative Governance," Corporate Social Responsibility Working Paper No. 2 (Cambridge, MA: John F. Kennedy School of Government, Harvard University, March 2004). Available at: http://www.hks.harvard.edu/m-rcbg/CSRI/publications/workingpaper_2_donahue.pdf.
15. CARE Malawi, "The Community Score Card (CSC): A Generic Guide for Implementing CARE's CSC Process to Improve Quality of Services" (Atlanta, GA: Cooperative for Assistance and Relief Everywhere, Inc., 2013). Available at: http://www.care.org/sites/default/files/documents/FP-2013-CARE_CommunityScoreCardToolkit.pdf
16. For examples of how to promote community health, see the resources here: Centers for Disease Control and Prevention (CDC), "CDC's Healthy Communities Program: Tools for Community Action" (Atlanta, GA: CDC, 2014). Available at: http://www.cdc.gov/nccdphp/dch/programs/healthycommunitiesprogram/tools/.

CORRUPTION STEALS RESOURCES, UNDERMINES MORALE, AND THREATENS LIVES

Studies by the Department for International Development (DFID) remind us that tackling corruption in the health sector is essential for achieving better health outcomes (see Figure 5.2). The section that follows comes from Karen Hussmann, "How-to Note: Addressing Corruption in the Health Sector."[17]

FIGURE 5.2 Corruption in the health sector: risk areas and consequences. The health sector is vulnerabe to corruption and has several high-risk areas; the consequences can be grim.



Source: Taryn Vian and Carin Nordberg, "Corruption in the Health Sector" (Bergen, Norway: Chr. Michelsen Institute, 2008), U4 Anti-Corruption Resource Center, Issue 10. Available at: http://www.u4.no/publications/corruption-in-the-health-sector-2/

Corruption in the health sector can be a matter of life and death, especially for poor people in developing countries. In China, an estimated 192,000 people died from using counterfeit drugs in 2001 alone. An International Monetary Fund (IMF) study across 71 countries showed that countries with high incidences of corruption have higher infant mortality rates, even after adjusting for income, female education, health spending, and urbanization.[18]

Corruption in the health sector can have severe consequences on access to and the quality, equity, and effectiveness of health care services. For example, unofficial user fees discourage the poor from using services or lead them to sell assets, driving them further into poverty.[19] Bribes to avoid government regulation of drugs have contributed to the rising problem of counterfeit drugs, which can lead to increased disease resistance and death.

17. Karen Hussmann, "How-to Note: Addressing Corruption in the Health Sector" (London, UK: Department for International Development, Nov. 2010), pp. 2-3. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67659/How-to-Note-corruption-health.pdf. This section contains public-sector information licensed under the UK Open Government Licence v3.0. Please see https://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/.
18. Sanjeev Gupta et al., "Corruption and the Provision of Health Care and Education Services," Working Paper No. 00/116 (Washington, DC: International Monetary Fund, 2000).
19. Taryn Vian and Carin Nordberg, "Corruption in the Health Sector" (Bergen, Norway: Chr. Michelsen Institute, 2008), U4 Anti-Corruption Resource Center, Issue 10. Available at: http://www.u4.no/publications/corruption-in-the-health-sector-2/

Globally, 10% of all drugs are believed to be fake, while in some African countries, the figure can amount to 50%. An estimated 10% to 25% of public procurement costs for drugs are lost to corruption.[20]

In addition, corruption in financial management has a direct negative effect on access to and quality of care. A study of 64 countries found that corruption lowered public spending on education, health, and social protection. In Chad, the regions received only one-third of the centrally allocated resources; in Cambodia, 5% to 10% of the health budget was lost at the central level alone; in Tanzania, local or district councils diverted up to 41% of centrally disbursed funds; in Uganda, up to two-thirds of official user-fees were pocketed by health staff.[21] Finally, corruption in the health sector erodes the legitimacy of and public trust in government institutions. Corruption can lead to the freezing of donor funding to the sector and the interruption of lifesaving services.

Ultimately, corruption in the health sector has a corrosive impact on the population's level of health. Evidence shows that reducing corruption can improve health outcomes by increasing the effectiveness of public expenditure (Dellavalade 2006). Tackling corruption in the health sector is essential for achieving better health outcomes.

Governing body leaders would be wise to follow initiatives defined by DFID as important for governing bodies to address in their governance work. Addressing corruption may seem daunting, but experiences from around the world have shown that local governing bodies can leverage their work to combat corruption by defining and working within clear ethical standards and a code of conduct. (See Section 11 on how to create a culture of accountability and transparency.) The international donor response can also reinforce the effectiveness of these local initiatives by considering these factors (DFID 2010):

- What is deemed to be corruption and what constitutes an appropriate response will vary from country to country.
- Systematic analysis of vulnerabilities to corruption or abuse is necessary to identify problems, select priorities, and sequence interventions in a sector-wide approach.
- A political economy analysis of the sector can help you be selective, opportunistic, and realistic when trying to influence the overall situation.
- Mitigating strategies should focus on preventing corruption by strengthening transparency, enforceable accountability, and stakeholder participation in the health sector. These must be linked to measures to detect abuse and apply sanctions.

20. Kari K. Heggstad and Mona Frøystad, "The Basics of Integrity in Procurement" (Bergen, Norway: Chr. Michelsen Institute, 2011), U4 Anti-Corruption Resource Center, Issue 10. Available at: http://www.u4.no/publications/the-basics-of-integrity-in-procurement
21. C. Delavallade, "Corruption and Distribution of Public Spending in Developing Countries," *Journal of Economics and Finance,* 2006; 30(2). Available at: http://link.springer.com/article/10.1007%2FBF02761488#page-1

- Tackling corruption in health must be linked to broader governance reforms, including public finance, public administration, and external oversight reforms. Both supply- and demand-side reform measures need to be supported, taking into account government's commitment and implementation capacity, as well as the capacity and environment for civil society engagement.
- Strategies to address corruption can be systematically integrated into health sector plans using the WHO health systems strengthening model.
- Implementation of mitigating interventions can be monitored through sector reviews and external evaluations.
- In the absence of an integrated, sector-wide anti-corruption approach, health advisors should actively look for opportunities to address corruption and unethical behavior in specific subsectors (e.g., medicines) or systems (hospital management, payroll management, etc.).