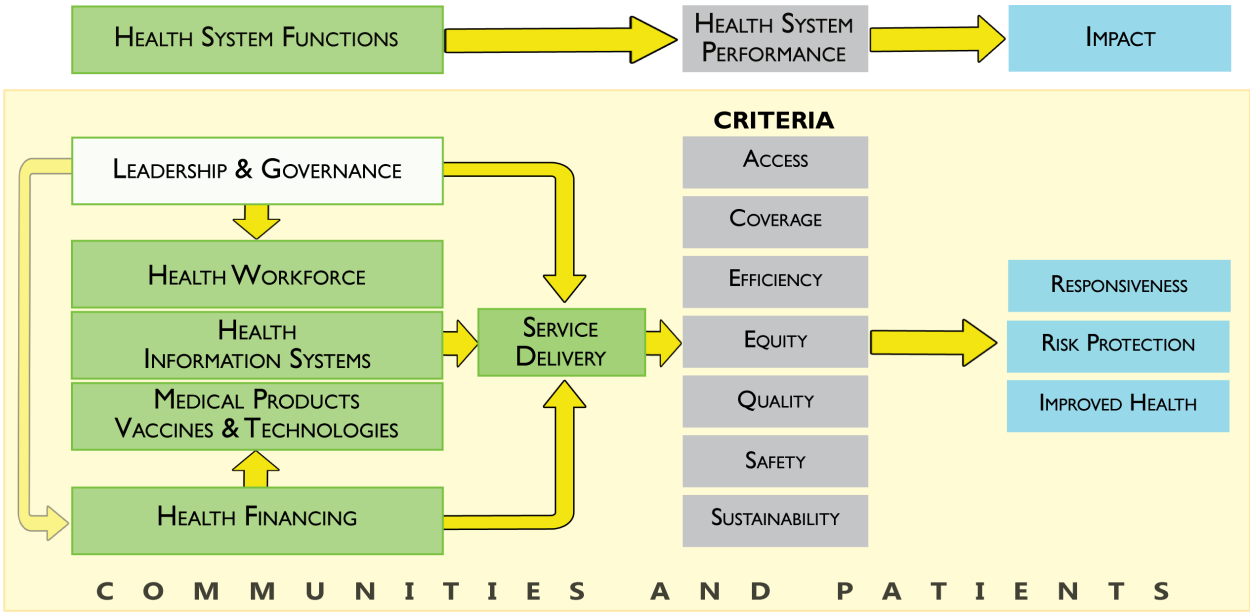
Module 2
Leadership and Governance

This module defines leadership and governance of the health sector, and offers an approach to identify what information is needed to assess governance as well as methods and sources for collecting this information.

FIGURE 3.2.1 IMPACT OF BUILDING BLOCK INTERACTIONS



Introduction

Evidence shows a positive relationship between governance indices and measures of health performance and outcomes (Lewis 2006); that is, effective health system governance – engaging and regulating both public and private sector actors – is crucial for achieving broader health objectives (Lagomarisino, Nachuk, and Singh Kundra 2009). The World Bank has led data collection and reporting on governance, and the indicators it developed are the basis for the HSA approach to the leadership and governance building block.

This module presents the leadership and governance components of the HSAA manual.

- Subsection 2.1 defines leadership and governance and its key dimensions, and summarizes an operational model for leadership and governance in the health sector.
- Subsection 2.2 provides guidelines on assessing leadership and governance for the country of interest.
- Subsection 2.3 presents the indicator-based part of the assessment, including suggested assessment questions.
- Subsection 2.4 guides the technical team member in how to summarize findings and develop recommendations.
- Subsection 2.5 contains a checklist of topics that the team leader or other writers can use to make sure they have included all recommended content in the chapter.

The indicators in this module differ from those in other building block modules in that they are mostly qualitative and descriptive rather than quantitative and measurable.

2.1 What is Leadership and Governance?

International donor partners and entities that work to improve health status recognize the importance of effective health governance. In 2000, WHO introduced the concept of health sector "stewardship," which is closely related to leadership and governance. It defined stewardship as "the careful and responsible management of the well-being of the population." WHO later refined its thinking on this building block, stating that leadership and governance "involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability" (WHO 2007).

USAID has described effective health governance as the process of "competently directing health system resources, performance, and stakeholder participation toward the goal of saving lives and doing so in ways that are open, transparent, accountable, equitable, and responsive to the needs of the people" (USAID 2006).

The quality of overall governance in a country–broadly defined as the set of rules and institutions by which authority is exercised–directly affects the environment in which the health system operates, as well as the ability of health officials to exercise their responsibilities and health providers to deliver quality services. This definition encompasses (1) the process by which governments are selected, monitored, and replaced; (2) the capacity of the government to effectively formulate and implement sound policies; and (3) the linkages, formal and informal, among citizens, private organizations, and the state that influence the interactions among them and the outcomes of those interactions.

Measures of overall governance are relatively well developed. As noted in the opening to this module, the World Bank has led data collection and reporting on governance, employing indicators on voice and accountability, political stability, government effectiveness, regulatory quality, rule of law, and control of corruption (Kaufmann, Kraay, and Mastruzzi 2006). The HSA approach uses these indicators as a foundation for assessing the governance building block of the health system. Effective governance should engage and regulate both the public and private sector. Mixed (public and private) health system stewardship mechanisms – including regulation, risk pooling, and purchasing–can offer incentives that align private health actors with public health system goals.

Health Governance: An Operational Model

Following from the definition of governance given above, health governance concerns the rules and institutions that shape policies, programs, and activities related to achieving health sector objectives. These rules and institutions determine which societal actors play which roles, with what set of responsibilities, related to reaching these objectives.

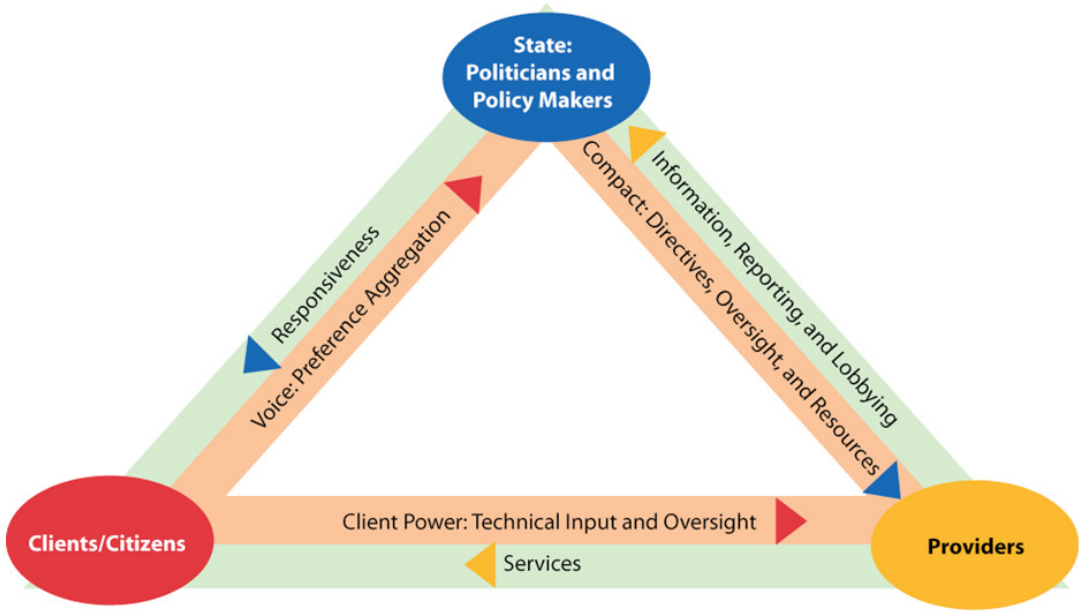
Health governance involves three sets of actors. The first set is state actors, which includes politicians, policymakers, and other government officials. The public sector health

bureaucracy –comprising the health ministry, health and social insurance agencies, public pharmaceutical procurement and distribution entities, and so forth –is central, but non-health public sector actors also play a role. These include parliamentary health committees, regulatory bodies, the finance ministry, various oversight and accountability entities, and the judicial system. The second set of actors is health service providers. This set comprises public, private, and not-for-profit individuals and groups that deliver health services, and organizations that support service provision: medical training institutions, health insurance agencies, the pharmaceutical industry, and equipment manufacturers and suppliers. The third set of actors contains beneficiaries, health service users, and the general public. This set can be categorized in a variety of ways; for example, by income (poor vs non-poor), by location (rural vs urban), by service (maternal and child health, reproductive health, geriatric care), and by disease or condition (HIV/AIDS, TB, malaria, etc.).

The linkages among these three categories of actors constitute the operational core of health governance. Figure 3.2.2 characterizes the key relationships among the various health system actors. These linkages exist at multiple levels in the system, depending upon the system's structure (see the discussion of decentralization in Subsection 2.2).

The particular features of these linkages –for example, their strength, effectiveness, and quality– influence the ability of the health system to meet the performance criteria elaborated in Section 1: equity, efficiency, access, quality, and sustainability.

Figure 3.2.2 Health Governance Model



Source: Brinkerhoff and Bossert (2008)

2.2 Developing a Profile of Leadership and Governance

TIP

Conducting the Assessment

- Select ONLY indicators that apply to the specific country situation.
- Conduct a thorough desk review of all available secondary data sources before arriving in country.
- In stakeholder interviews, focus on filling information gaps and clarifying issues.
- Coordinate stakeholder interviews with team members so all six modules are covered and avoid interviewing the same stakeholder twice.
- Look at all health actors – public, for-profit, and not-for-profit – involved in delivering health services.
- Tailor assessment questions to reflect the level of decentralization so the questions are relevant to the interviewee.
- Schedule team discussions in country to discuss cross-cutting issues and interactions.
- Finalize an outline for the assessment report early on so sections can be written in country.

Because there are few standardized, quantitative indicators to measure governance in the health sector, much of the information for this module will be qualitative and gleaned from both secondary sources and interviews. As the international community increasingly recognizes the importance of health governance, more quantitative survey-based information will likely become available over time, similar to the data generated for the general governance indicators used in the first six indicators of this module.

Because of the sensitivity of leadership and governance issues such as corruption, accountability, inclusiveness of all health actors, and system responsiveness, the HSA team must take considerable care in conducting interviews, in attributing information to sources, and in documenting results from the data collected. The technical team member in charge of governance will need to weigh the importance of documenting, sometimes for the first time, problems of patronage or corruption against repercussions that publication of such information could have on informants; often team members will need to ensure the anonymity for information sources and key informants.

Another potentially sensitive topic is the government's perspective and attitudes in working with non-state actors in the health system. Limited interaction between the public and private sectors and lack of understanding of what motivates private sector stakeholders, particularly the commercial's sector's need to earn a profit, creates suspicion and mistrust between the sectors. A key area to examine is the relationship between the public and private sectors, how willing the government is to working with the private health sector, and how inclusive the government is in policy and planning for the health sector.

Leadership and Governance and Decentralization

The extent of decentralization of the health sector will have a direct impact on the exercise of governance at various levels within the sector. If authority and responsibility are centralized, then subnational and local officials will not have the "decision space" to function as stewards with policy-making power (Bossert 2008). Nevertheless, they still have a positive role to play in improving leadership and governance through better management of resources, client-responsive services, or collection of quality health data. These actions contribute to making the linkages in Figure 3.2.2 functional and effective. In countries where the health sector is more decentralized, the HSA technical team member will need to assess the authority and responsibilities that exist at all levels – subnational and local levels as well as national – to ascertain whether programmatic resources to support stewardship in health should be directed at multiple levels.

Definitions of Licensure, Accreditation, and Certification

Licensure *is a process by which a governmental authority grants permission to an individual practitioner or health care organization to operate or to engage in an occupation or profession. Licensure regulations are generally established to ensure that an organization or individual meets minimum standards to protect public health and safety. Licensure to individuals is usually granted after some form of examination or proof of education and may be renewed periodically through payment of a fee, and/or proof of continuing education or professional competence. Organizational licensure is granted following an on-site inspection to determine if minimum health and safety standards have been met. Maintenance of licensure is an ongoing requirement for the health care organization to continue to operate and care for patients.*

Accreditation *is a formal process by which a recognized body, usually an NGO, assesses and recognizes that a health care organization meets applicable pre-determined and published standards. Accreditation standards are usually regarded as optimal and achievable, and are designed to encourage continuous improvement efforts within accredited organizations. An accreditation decision about a specific health care organization is made following a periodic on-site evaluation by a team of peer reviewers, typically conducted every two to three years. Accreditation is often a voluntary process in which organizations choose to participate, rather than one required by law and regulation.*

Certification *is a process by which an authorized body, either a governmental or NGO, evaluates and recognizes either an individual or an organization as meeting pre-determined requirements or criteria. Although the terms accreditation and certification are often used interchangeably, accreditation usually applies only to organizations, while certification may apply to individuals, as well as to organizations. When applied to individual practitioners, certification usually implies that the individual has received additional education and training, and demonstrated competence in a specialty area beyond the minimum requirements set for licensure. An example of such a certification process is a physician who receives certification by a professional specialty board in the practice of obstetrics. When applied to an organization, or part of an organization, such as the laboratory, certification usually implies that the organization has additional services, technology, or capacity beyond those found in similar organizations.*

Source: Quoted from Rooney and Ostenberg (1999)

TIP

Legal and Regulatory

Reviewing the legal and policy framework for health is a key component for understanding not only governance but also possible barriers in the other health system modules. Therefore, it is critical that the HSA team gather as many health laws, policies, acts, regulations, and guidelines as possible.

To facilitate this, the in-country logistics coordinator should visit the MOH Department of Policy and Planning and/or chief medical officer as well as all the MOH councils (e.g., physician and dentist, nurse, laboratories, pharmacists). The department and/or the chief medical officer will have all the guidelines for standards of care, facility licensing, health insurance, and so forth. The councils are particularly important because they can provide the health law or act, and regulations governing the respective health cadres.

TIP

PRIORITIZING INDICATORS

Team members constrained by limited time or resources should prioritize as follows:

- First, assess Indicators 1–6. Data for them are readily available from the Health Systems Database (http://healthsystems2020.healthsystemsdatabase.org).
- Second, assess the key Indicators 8, 9, 12, 20, and 21.
- Third, if possible, assess all remaining indicators to get a more comprehensive picture of health system leadership and governance.

2.3 ASSESSMENT INDICATORS

This section focuses on governance indicators – it shows the topical areas into which the indicators are grouped, lists data sources to inform the indicators, discusses how to deal with indicators that overlap with other building block modules, defines the indicators, and shows how to work with the indicators. Finally, the section identifies key indicators to which the HSA technical team member can limit their work, if time precludes their measuring all indicators.

TOPICAL AREAS

The indicators for this module are grouped into seven topical areas (see Table 3.2.1). The topical areas are based on Health Systems 20/20's health governance framework, which outlines the relationships between three sets of health system actors, the state, clients, and providers (Figure 3.2.2).

TABLE 3.2.1 INDICATOR MAP–LEADERSHIP AND GOVERNANCE

Topical Areas	Indicators
A. Overall governance	1–6
B. Government responsiveness	7–8
C. Voice: Preference aggregation	9–10
D. Client power	11–13
E. Service delivery	14–17
F. Information, reporting, and lobbying	18–19
G. Compact: Directives, oversight, and resources	20–23

DATA SOURCES

There are many sources from which the technical team member assigned to the governance chapter can gather data that will allow them to assess and analyze leadership and governance. The sources are organized into three main categories:

1. **Standard indicators:** Data are drawn mainly from existing and publicly available international databases. Data regarding Topical Area A (indicators 1–6) are available through the Health Systems Database (http://healthsystems2020.healthsystemsdatabase.org/). Further information is available on the following websites:
   - The World Bank, http://info.worldbank.org/governance
   - Transparency International, www.transparency.org

2. **Secondary sources:** Information for Topical Areas B–G should be gathered to the extent possible through desk review of health-related research and policy documents prior to travelling to the country (see box above for a definition of the different terms and types of relevant policies). Here is a suggested list of secondary sources that may be readily available.
   - Health laws and policies, health acts, and regulations governing scopes of practice, financing, professional and facility licensing, standards of care, and hospital autonomy
   - Safety and sanitary guidelines, for the safety and efficacy of pharmaceuticals, medical devices and equipment, quality of health provision (provider licensure and certification, facility accreditation), and dispensing of pharmaceuticals
   - Health sector planning and strategy documents and interviews with people who participated in their development
   - Reports on civil society engagement in policy formulation and legislation
   - Media reports of the policy development process, to identify organizations that influence health policy
   - Advocacy organizations' stated objectives, to determine which organizations publish their objectives, policy positions, and/or policy research
   - The MOH, for information on what the ministry and donors are doing to improve client feedback to providers
   - Project and ministry reports on client feedback mechanisms
   - Citizen scorecard reports, where they exist, for information on client power
3. **Stakeholder interviews:** Unlike the other technical modules, most information for governance indicators will be collected through discussions and interviews with key informants and other stakeholders. A key planning challenge is to balance the number of interviewees between the three health system actors – government, service providers, and client/consumers. Moreover, it will be important to get the private sector perspective from both the service delivery side and the consumer side.
   - MOH leadership, MOH planning and regulatory departments, Ministry of Local Government
   - Representatives of grassroots organizations, NGOs, and advocacy groups, including representatives of patient groups (such as people living with HIV/AIDS), underserved populations (women's groups, indigenous organizations), and civil rights leaders
   - Key public health facility staff (e.g., chief medical officer, head public health nurse, hospital administrator, district health manager)
   - Parliamentary health committee members, and other parliamentarians with an interest in health issues

- Representatives of the MOH staff of schools of medicine, nursing, and public health
- Representatives of the private health sector, starting with any sector-wide association representing all facets of the private health sector (e.g., Kenya Health Federation, Association of Private Health Facilities in Tanzania) and professional associations representing a range of health cadres (physicians, pharmacists, nurses/midwives, laboratory technicians). If these representative bodies do not exist, a selection of individual private health care business owners/managers could substitute
- Client-provider committee members and/or consumer groups
- Media outlets (TV, radio, newspaper)
- International donors active in the health sector
- Data users, including government policymakers, NGOs, private sector advocacy groups, and major health sector donors, particularly WHO, which typically assists with health data, infectious disease surveillance, and immunization

For each indicator the manual offers below illustrative questions and issues to explore – through information gathered using the above data sources – so that the team can assess the quality of the governance linkage. Because the questions seek qualitative information (rather than more measurable, quantitative data) the responses they elicit require careful analysis. The qualitative nature and lack of a clear means of benchmarking also makes it difficult to compare the HSA country "scores" with other countries unless the governance expert has experience with countries in the region or at a similar level of development. (The interviewer may be able to get a feel for this comparison by probing other donor representatives.)

Many of the other technical HSA modules also touch upon issues of leadership and governance. Table 3.2.2 lists how leadership and governance might overlap with the other modules. Depending on number of technical team members, the time available for data collection, and the specific interview schedule, potential overlaps can be handled in one of two ways: First, the governance expert could join his or her team member in some or all of the other technical module interviews, particularly with the leaders and directors in that health system area. Alternatively, the other team member could be asked to cover governance topics on behalf of the governance expert. In the latter case, the governance expert should provide the other team member the specific governance and leadership questions to ask, to ensure this information is captured.

Table 3.2.2 Overlapping Topics between Governance and Other Health System Technical Modules

Module	Areas of Overlap with Governance
Health financing	• Consistency of public sector resource allocation with stated health strategic plan • Administration of social insurance funds • Management of provider payment systems aimed at increasing accountability and transparency • Existence (or not) of informal payments,
Service delivery	• Clear, transparent, and equitable enforcement of facility accreditation • Updated and/or new standards of care • Feasible standards of care (e.g., task shifting to address human shortage, facility licensing linked to scopes of practice to address access issues, affordability for the government) • Government capacity (staff, resources, authority) to consistently and equitably enforce regulations
HRH	• Updated and/or recent health professions act (for each profession) • Absenteeism and other motivation issues associated with public sector health workers • Impact of dual practice on public health services • Unambiguous scopes of practice for key health professions consistent between public and private sectors • Consistent and enforced professional certification procedures • Existence of re-licensure policies and procedures for all health professions • Accreditation of private medical institutions
Medical products, vaccines, and technology	• Regulation of medicines especially importation of drugs, compliance of retail pharmacies, control of black market, counterfeit and expired medicines • Compliance or possible corruption in pharmaceutical procurement
HIS	• Complement of the "Information, Reporting, and Lobbying" topical area • Exchange and sharing of information between public and private health sectors

Detailed Indicator Descriptions

This section provides an overview of each topical area and then a table that gives a definition and interpretation of each indicator.

Topical Area A: Overall Governance

Overview

The scores for the six indicators in the Overall Governance topical area reflect the aggregate status of governance in the country, whereas the information collected for the six ensuing topical areas focuses on how governance relates specifically to the health sector. A high score on an Overall Governance indicator is not necessarily matched by positive findings for a corresponding indicator in the later areas. For example, the voice and accountability indicator as measured by the Worldwide Governance Indicators looks at the degree of political freedom and respect for rights and the rule of law, whereas voice and accountability in the health sector looks at stakeholder engagement and checks and balances directly related to health services and products. The ratings on the six Worldwide Governance Indicators characterize the institutional environment within which health governance is situated.

TIP

Helpful Resource!

For details on how the indicators in this section are constructed and measured, as well as for a user-friendly tool for preparing regional comparison charts of these indicators, visit the World Bank Governance and Anti-Corruption website:

http://info.worldbank.org/governance/kkz2005/

Overall Governance

Source for information on Indicators 1–6:
World Bank Governance Indicators, http://www.worldbank.org/wbi/governance/govdata/
The Health Systems Database includes both a point estimate and a percentile rank from the World Bank's Governance Indicators.

Indicator	Definition and Interpretation
1. Voice and accountability	Voice and accountability measures the extent to which a country's citizens are able to participate in selecting their government, as well as freedom of expression, freedom of association, and a free media. Thus, it is a measure of political, civil, and human rights. The topics included in this indicator are civil liberties, political rights and representation, and fairness of elections. For more information see Topical Area C: Voice: Preference aggregation.
2. Political stability	Political stability and absence of violence measures the perceptions of the likelihood that the government will be destabilized or overthrown by unconstitutional or violent means, including domestic violence and terrorism. Another indicator of political stability is the smooth transition between governments after an election. The political stability of a country has a direct impact on its ability to provide, manage, and fund health services.
3. Government effectiveness	Government effectiveness measures the quality of public and privately provided services, the quality of the civil service and the degree of its independence from political pressures, the quality of policy formulation and implementation, and the credibility of the government's commitment to such policies. Topics included in this indicator are administrative and technical skills of the civil service, transparency and openness, government stability, trust in government, and policy consistency. The effectiveness and quality of linkages between state, citizens, and providers, influences the ability of the health system to meet the performance criteria elaborated in Section 1: equity, efficiency, access, quality, and sustainability. See Indicator 8 (for example): The national government is transparent with regards to health sector goals, planning, budgeting, expenditures, and data. It regularly communicates with stakeholders in the health sector.
4. Rule of law	Rule of law measures the extent to which agents have confidence in and abide by the rules of society, in particular the quality of contract enforcement, the police, and the courts, as well as the likelihood of crime and violence. The existence of the rule of law creates an environment in which basic public health provisions can be enforced and regulated. This includes things like public safety, protection against hazardous waste disposal, safety regulations for workers, and traffic laws. See also Indicator 22: Health sector regulations are known and enforced in both public and private training institutions and health facilities.
5. Regulatory quality	Regulatory quality measures the ability of the government to formulate and implement sound policies and regulations that permit and promote private sector development. Topics included in this indicator are, for example, business regulations, taxation, trade and competition policy, and government market intervention. Regulatory quality can influence the frequency of malpractice occurring in a country as well as the licensing and accreditation of public and private practitioners. See also Indicator 20: The government provides overall direction to the health system through clear legislation, policies, and regulations.
6. Control of corruption	Control of corruption measures the extent to which public power is exercised for private gain, including petty and grand forms of corruption, as well as "capture" of the state by elites and private interests. See Indicator 23: Procedures exist for reporting, investigating, and adjudicating misallocation or misuse of resources.

The Worldwide Governance Indicators database "reflects the statistical compilation of responses on the quality of governance given by a large number of enterprise, citizen, and expert survey respondents in industrialized and developing countries" (World Bank 2006). The score for each indicator for a country ranges from –2.5 to 2.5, with higher scores reflecting better outcomes. Countries that score in the negative range on all indicators are unlikely to exhibit high-quality linkages among the actors in the health system (see Figure 3.2.2 above).

Topical Area B: Government Responsiveness to Stakeholders

Overview

This topic encompasses the organization and leadership necessary to convene and facilitate collaboration between government, private actors, and civil society, involving a broad range of stakeholders (including those not typically considered to be health related) to participate in identification of health priorities and in planning, budgeting, and monitoring health sector actions. This dimension of governance also considers the degree of the health system's responsiveness to the input of these multi-sectoral stakeholders.

Issues to Explore

In countries with little or no history of civil society participation in governing, government may be reluctant to include civil society stakeholders in the policy process. In these cases, civil society interviewees may be very passive and have low expectations, while government interviewees may be dismissive of the role that civil society can, does, or should play in the policy process or how responsive government should be to the recommendations of civil society.

In countries with heightened awareness of civil rights and increased citizen participation experience, however, both civil and government interviewees may have exaggerated demands and expectations for the space that the policy process allows for civil society input. The assessment team member in charge of researching governance will have to weigh information from all sides to formulate a balanced assessment of the state of government responsiveness to civil society concerns. Ask about recent elections – was health an issue and how was it handled?

Government Responsiveness

Indicator	Definition and Interpretation
7. What mechanisms are in place to ensure the participation of key stakeholders in the health policy agenda? Which groups are represented during these discussions?	Government and health provider organizations regularly solicit input from the public and concerned stakeholders (vulnerable groups, groups with particular health issues, etc.) about priorities, services, and resources. This indicator is complementary to Indicator 11 but focuses on the strength of consumer voice. It is necessary to determine whether key stakeholders are, either deliberately or inadvertently, being excluded from discussions on the health policy agenda. Additionally, decentralized structures may also have separate mechanisms for soliciting feedback from stakeholders that should be included in this indicator. Clear and frequent communication of objectives, performance targets, and financing are needed to evaluate progress and performance and for the MOH to be held accountable. It also is necessary to determine whether or not the government is responsive to external stakeholder input, and to look at how well stakeholder input has been included into the decision-making process and whether that input has been part of a participatory and inclusive process. Examples of possible mechanisms for tracking responsiveness include independent reviews of decision-making processes, and the presence of public input in national policy. Unless health officials incorporate citizen feedback into their planning and policy formulation, social participation has little meaning.
8. Mechanisms and strategies used by the government to engage all health stakeholders in policy and planning include workshops to discuss policies and develop strategic plans, and widespread distribution of policies and plans to all major health entities.	The national government is transparent with regards to health sector goals, planning, budgeting, expenditures, and data. It regularly communicates with stakeholders in the health sector. Not only look for the different types of mechanisms and strategies, but also assess how effective and inclusive these approaches are. Look for: number of mechanisms/strategies, frequency, and representativeness of participants. If there are established, active, and multiple forums and strategies that reach public, not-for-profit, and private sector, then the government is very inclusive and effectively engages the entire health sector. Another form of evidence is to review strategies and plans to determine if they include other sector perspectives and define roles and responsibilities for public and private actors.

Topical Area C: Voice: Preference Aggregation

Overview

This topic encompasses the ability of civil society, experts, and citizens to act as credible partners with government in improving health services: analyzing data from a variety of sources (including citizen feedback) and presenting that feedback to policymakers in ways that positively influence policy decisions. While Topical Area B, Responsiveness, deals with the actions of government in obtaining and responding to civil society input, this section considers the sophistication of external stakeholders in providing input into health policy.

This topic also examines the opportunities available to external stakeholders for influencing health policy. Whether non-state health providers are involved in policy and planning is the most important issue to explore. The media's influence on health policy through routine reporting, features, debate coverage, and opinion articles is also important in analyzing this component of leadership and governance.

Issues to Explore

Countries without a history of civil society participation are likely to have few or no organizations that are capable, or even willing, to perform an advocacy role. It is also possible that organizations in this context may be conducting limited advocacy, through participation in working groups or other mechanisms, without necessarily recognizing their actions as having an effect on health policy or legislation. It is important for assessment team members to ask about these avenues for including citizen voice into health policy.

Additionally, media outlets have a role in reporting and analyzing health policy debates so as to inform the public about ongoing debates, as well as reporting on public or civil society reaction to health policy. Media reporting, in this context, is voice, providing context and information to citizen and policymakers on the policy process.

Voice: Preference Aggregation

Indicator	Definition and Interpretation
9. The public and concerned stakeholders have the capacity and opportunity to advocate for health issues important to them and to participate effectively with public officials in the establishment of policies, plans, and budgets for health services.	Civil society organizations, private institutions, and other external stakeholders have an important role to play in the health system by advocating for the rights of their members. Individual citizens are able to petition their government, without the assistance of a formal organization. Additionally, the role of the media in reporting on health issues, policy debates, and activities is an important aspect of this indicator. Inclusion of civil society ideas into policy development shows both the strength of civil society in being a reliable source of information for government as well as government willingness to listen to civil society concerns. In order to address this indicator, interviews with a wide range of civil society, media, MOH, and private institutions, such as hospitals, insurance companies, or pharmacies, is necessary. Presenting this data will most likely require examples of how external stakeholders have affected policy, the types of tools they have used to do so, how sophisticated their analyses are, and their long-term experience with advocacy; therefore, it is important to obtain examples from interviewees.
10. Willingness of the public and concerned stakeholders to participate in governance and advocate for health issues.	This indicator can be measured by looking at the number of members of patient groups that are active, the amount of active participation of provider groups in lobbying government, and the number and sizes of health NGOs acting as watchdogs. Willingness to participate shows whether people feel empowered to advocate for certain issue and answers the question of how well evolved and how well supported civil society is in the country.

Topical Area D: Client Power: Technical Input and Oversight

Overview

Client Power is the ability of citizens, citizen groups, and watchdog organizations to monitor and oversee the actions of health providers, ensuring that health services are high quality, transparent, and follow accepted norms. The relationship between clients and providers can be strengthened through collective action, such as through facility-based health committees or civil society organizations that provide voice to otherwise marginalized clients. Participation in joint forums by both citizens and providers can also improve the voice that citizens are able to exercise. Additionally, markets may allow citizens to exercise power by providing choice and competition, improving provider accountability.

Issues to Explore

Structures, both community- and health facility-based, that allow or encourage providers to communicate with clients regarding issues of service quality, delivery, and transparency should be explored. Transparency of service utilization, available resources, and budgets are all key considerations as well. In countries with user fees or a strong private sector, transparency issues around user fees should be examined. Structures that allow clients to give direct feedback to providers should be examined and reported. Providers should have some knowledge of these structures, but it is also important to ask policymakers in the MOH what they are doing, on a national level, to improve how clients interact with health providers.

Client Power: Technical Input and Oversight

Indicator	Definition and Interpretation
11. Civil society organizations oversee health providers and provider organizations in the way they deliver and finance health services.	The existence and ability of non-state organizations to provide oversight of facility management, regardless of whether or not those facilities are private or public, is measured by talking to civil society organization that perform these roles, if any exist. Media often cultivate sources among these watchdog organizations and have a role in publicizing issues. Assessment team members need to examine if professional organizations, specialized health related NGOs, and the media exist and are capable of assessing if providers – public or private – follow protocols, standards, and codes of conduct in regard to medical malpractice, unfair pricing patterns, discrimination against clients, etc. Civil society organizations can be powerful watchdogs to supplement government oversight.
12. The public or concerned stakeholders (e.g., community members) have regular opportunities to meet with health care providers about service efficiency or quality.	This indicator measures the access that individual citizens have to health managers (directors) of health service organizations (hospitals, health centers, clinics) to raise issues. Interviews with citizen groups and facility-level staff are vital to understanding this indicator. The existence of client-provider committees or similar mechanisms is the first step toward ensuring that citizens have input into service delivery issues at the facility level. Second, these committees must help citizens play an active role in the management of their health facilities through facilitating interaction between citizens, facility managers, and providers.
13. There are procedures and institutions that clients, civil society, and other concerned stakeholders can use to fight bias and inequity in accessing health services.	This indicator is measured on two levels. The first is whether or not organizations that advocate for patients' rights and defend patients exist and what the capabilities of those organizations are. The second level measures the existence of an independent judiciary that adjudicates malpractice or discrimination claims without bias or undue influence. Key informant interviews with civil society groups and government are important to this indicator. The involvement of law enforcement and the judiciary in punishing bias and inequity in health services plays an important role in encouraging citizens to speak out and civil society to encourage whistle-blowing on malpractice.

Topical Area E: Service Delivery

Overview

This area examines the relationship and dynamics between health care providers and their clients in terms of transparency, incentives, and results-based services. In contrast, the Service Delivery module assesses the organization of health delivery services, the way that services are delivered, and the roles and responsibilities of each actor in the health system across the public and private sectors. Of particular importance to leadership and governance is the issue of continuity of care, understanding the health system from the perspective of patients accessing points of care at different places and times, and potentially moving between the public and private sectors.

As with the linkage from clients to providers, service delivery often contends with information asymmetries and power imbalances. Clients often view health providers as the ultimate health authority, and clients are unlikely to raise questions about quality. The ability of health care providers to bridge these gaps through transparent services and pricing, as well as positive communication with clients is a key issue in understanding and analyzing this linkage.

Issues to Explore

Structures, both community- and health facility-based, that allow or encourage providers to communicate with clients regarding issues of service quality, delivery, and transparency should be explored. Transparency of service utilization, available resources, and budgets are all key considerations as well. In countries with user fees or a strong private sector, transparency issues around user fees should be examined.

Structures that allow clients to give direct feedback to providers should be examined and reported. Providers should have some knowledge of these structures, but it is also important to ask policymakers in the MOH what they are doing, on a national level, to improve how clients interact with health providers.

SERVICE DELIVERY

Indicator	Definition and Interpretation
14. Health services are organized and financed in ways that offer incentives to public, NGO, and private providers to improve performance in the delivery of health services.	Resource transparency is difficult to foster, as the health system may not have disaggregated information at the facility level, where people actually receive services. Government regulations such as licensing and accreditation regulate quality at the point of entry, but do not incentivize quality service provision over the long term. Some countries require registration at regular intervals (yearly, bi-annually) including interviews with a medical board or professional association. Continuing education and recertification requirements are also ways that government can regulate the quality of health service provision. The other important element of incentivizing good performance is to enforce the standards and regulations set out in government policies.
15. Information on allocation and use of resources and results is available for review by the public and concerned stakeholders.	Resource transparency is difficult to foster, as the health system may not have disaggregated information at the facility level, where people actually receive services. Without detailed information on resources, citizens are unable to judge if they have been used well. In contrast, strong data that are shared with multiple stakeholders can lead to improved outcomes as more viewpoints and data are brought into the decision-making process. In order to understand the quality of health system information that is made available to the public, it is necessary to talk to the people in media and civil society who would use that information, as well as to the people who are making the data available, such as the MOH or facility managers.
16. Information about the quality and cost of health services is publicly available to help clients select their health providers or health facilities.	Civil society may have details about the level of knowledge that exists in the general population about user fees, while health providers should be able to provide anecdotal information on whether or not they have posted a fee schedule. Information on service quality can be more difficult to obtain, but it could come in the form of mortality data in the maternity ward of a hospital, malaria cases treated in the last month, or HIV counseling and testing uptake. The media also has a role in publicizing quality and cost information and could be a major player in ensuring that this indicator is met. One of the most basic pieces of information that can aid health system transparency is that clients understand the cost of the services they are purchasing. This simple step can reduce graft and corruption solely by giving citizens information.
17. Service providers use evidence on program results, patient satisfaction, and other health-related information to improve the services they deliver.	Do public and private providers have mechanisms in place to measure client satisfaction and do they use this to inform how they deliver services? The key question to answer in relationship to this indicator is how facility-specific activities are determined. For example, do they use surveillance data to track outbreaks and design activities to counter those outbreaks? Or are data not used when determining how to allocate resources? Other sources of information could be patient satisfaction surveys or program reports. In most cases, the private sector is very sensitive to client perception and therefore uses a wide array of tools to stay abreast of consumer behavior.

Topical Area F: Information, Reporting, and Lobbying

Overview

Reliable, timely information on trends in the health status of the population, health services, health care financing, and human resources in the health sector is needed to ensure an accountable health system, so that policymakers can assess health system performance and formulate appropriate policies. Information reported from health providers is critical if health policymakers are to formulate evidence-based health policy. This area also encompasses the influence that providers exert on health policy, including advocacy and other efforts. More in depth information on reporting systems can be found in the HIS module.

Issues to Explore

Talking to data producers is important, particularly at the facility level, where redundancies can occur. Data collection requirements for multiple vertical programs may affect the quality and timeliness of reporting and reveal a lot about the structure of routine information systems. Also necessary is to probe policymakers regarding their understanding of what information they should expect or demand and to what extent their expectations are met, including information from the private health sector.

Another important issue to investigate is information asymmetry. Service providers will always know more about health services than policymakers do. These providers have incentives to maintain and use these asymmetries for lobbying or other purposes. Lobbying activities from health providers to government may reflect this reality.

Another issue affecting the state actor-provider governance link is that of attribution. In a complex, multi-stakeholder health system, it is difficult to assess whose contributions made a difference, or whose efforts fell short. Health outcomes are the result of numerous factors, many of which are outside of the control or influence of providers or health ministries.

Country Story: Eastern Caribbean Countries

Poor relations between the public and private sectors can impede health sector reform. In several Eastern Caribbean countries, mistrust and tension has resulted in complete breakdown in communications and interactions between the sectors, making it nearly impossible for the MOH to lead efforts to strengthen health systems and/or pass reform policies with the support of all major stakeholders. In these cases, one of the Health Systems and Private Sector Assessments' principal recommendations is to resume dialogue, work out the grievances, and focus on the health system priorities.

INFORMATION, REPORTING, AND LOBBYING

Indicator	Definition and Interpretation
18. Public and private sector providers report information to the government.	This indicator looks at the quality of the data provided by health facilities to the MOH, as well as the use of that data and if they are used to formulate policy, plan health direction, and monitor health system performance. Examine what type of data are reported by which – public or private – providers to the government. While the HIS module goes into more depth in terms of the systems used to move information, the Leadership and Governance module studies information reporting, dissemination, and use in policy, planning and monitoring performance. Issues to examine are timeliness of reports, quality, and ease of use by policymakers. Also examine if the data and reports present data on the entire health sector, including non-state providers, to create a comprehensive picture of overall trends and performance.
19. Service providers use evidence to influence and lobby government officials for policy, program, and/or procedural changes.	This indicator measures the effect that providers and provider organizations, such as medical and nurses' associations, have on the policy process and planning processes. This indicator examines how providers engage and interact with the government in policy and planning processes. Providers often have access to information, knowledge, and power that citizens' groups do not; as a result, their lobbying efforts can be more influential than that other civil society organizations. It is also important to note that while citizens' and providers' interests often overlap, they do not always have common goals and purpose. Providers often have interests relating to reimbursement mechanisms, working conditions, facility licensing, and registration requirements that clients may not. Conversely, clients, especially in countries with significant user fees, are often concerned about pricing in a way that providers may not be.

Topical Area G: Compact: Directives, Oversight, and Resources

Overview

This dimension includes the process by which laws, policies, and regulations that govern the health sector are formulated. It also describes the capacity of the government for oversight of safety, efficacy, and quality; capacity for enforcement of guidelines, standards, and regulations; and perception of the burden imposed by excessive regulation. Compact also examines the ability of government to monitor health system performance and provide direction and guidance to the overall health system.

Issues to Explore

What mechanisms are in place to develop and enforce legislation, regulations, standards, and codes that support public health and health care services? Some countries are prone to passing new health laws and regulations frequently and may perceive this action as an accomplishment. The new laws and regulations, however, may be inconsistent and create confusion; furthermore, the government may fail to implement the laws. Is there adherence to "old" laws that prevent providers from exercising their practice? Other countries are extremely slow or reluctant to pass new laws or regulations, and reform must move forward with the existing legal framework.

How does the government provide direction to the health system? Is there a statutory framework for these activities? Is there an MOH unit that is directly involved with health planning and monitoring? Does the MOH engage all health system actors? Consistently? Or on an ad hoc basis? How willing is the MOH to work with non-state service providers?

COMPACT: DIRECTIVES, OVERSIGHT, RESOURCES

Indicator	Definition and Interpretation
20. The government provides overall direction to the health system through clear legislation, policies, and regulations.	This indicator is very broad in that in covers the main pieces of legislation that affect the health system, the regulations developed to guide the implementation of the legislation, and the most recent national strategies developed by the MOH to outline the strategy for enacting the goals of the legislation. In order to stay focused, try to identify the 3-4 main pieces of legislation that affect the health system, give a brief explanation of each, followed by a discussion of the national plan. How old are the laws (they can be upwards of 50 years old)? Are there serious contradictions between some laws or serious ambiguities? Such contradictions often happen when laws are passed to decentralize the health system. Does the national plan support the implementation of the legislation? How does implementation look in facilities? Does legislation define how health facilities, health providers, and other health system actors will be governed? Is there a clear inclusion of private actors in regulatory requirements in terms of reporting, service delivery, and/or facility management? Be sure to determine how health providers are licensed and accredited.
21. Government officials rely on evidence in policy and planning.	Formulating policies and regulations and planning health interventions that are based on evidence is a key function of the MOH. Strategic plans are normally produced every five years and describe priority area for health interventions and ways of achieving them. Operational plans address the specific activities for improving those priority areas. Does the MOH or other government agency review, evaluate, and propose revisions of laws, regulations, and policies to ensure that they reflect current scientific knowledge and best practices for achieving compliance? If they do not, they cannot serve as the basis for sound regulation of health sector actors. Interviewees at the MOH should be able to explain the process of creating these plans. Does the MOH include all key stakeholders – public, not-for-profit, commercial – in the analysis and design of polices and plans?
22. Health sector regulations are known and enforced in both public and private training institutions and health facilities.	This indicator is characterized by authorities with the capacity and mandate to enforce regulations (protocols, standards, codes of conduct, and certification procedures) through inspections, deterrents, and oversight. Possible constraints on this indicator are the lack of health sector regulations and poor enforcement due to capacity constraints. Additionally, service providers may not abide by the regulations, either due to the perceived lack of legitimacy of the regulations or because they are unaware of the regulations. Also, enforcement may not be consistent between the sectors (e.g., stricter enforcement in the private sector than in the public), or, as is often the case, non-existent for the private sector. Therefore, understanding how all providers respond to health system regulations is important to knowing how they are enforced. Each of these issues can be uncovered through interviews with service providers, regulatory authorities, and MOH officials. Important questions include: Do governmental regulatory agencies have the necessary resources (human, technical, financial) to enforce existing legislation and regulations? What attempts has the government made to support compliance with regulations? To what extent have these attempts been effective?
23. Procedures exist for reporting, investigating, and adjudicating misallocation or misuse of resources.	This indicator looks at the government regulations on corruption and malpractice in the health sector and how they are enforced. What are the policies in place for dealing with mismanagement? What opportunities exist for concerned citizens or health workers to report resource allocation problems, malpractice, counterfeit drugs? Is an impartial ombudsman available for investigating them? What laws exist to deal with mismanagement of health funds?

Key Indicators Table

Table 3.2.3 lists five key indicators for the health governance module. These indicators address the main components of the linkages in the health governance framework between different health system actors, with special emphasis on the role of citizens in providing feedback to the state and health providers and the methods by which government develops national policies and regulations that affect the health sector. The indicators are particularly useful to: (1) monitor service delivery improvements over time; and (2) guide a team with severe time constraints to focus on the most important measures of governance. Depending on the scope and time and resources available for a particular assessment, this list of key indicators can be modified.

Table 3.2.3 Key Indicators Table

No.	Indicator
8.	The national government is transparent with regard to health sector goals, planning, budgeting, expenditures, and data. It regularly communicates with stakeholders in the health sector.
9.	The public and concerned stakeholders have the capacity and opportunity to advocate for health issues important to them and to participate effectively with public officials in the establishment of policies, plans, and budgets for health services.
12.	Public and private sector actors, civil society organizations and other concerned stakeholders (e.g., community members) have regular opportunities to meet with managers (directors) of health service organizations (hospitals, health centers, clinics) to raise issues about service efficiency or quality.
21.	Government officials rely on research and evaluation studies and existing HIS when they formulate laws, policies, strategic and operational plans, regulations, procedures, resource allocation decisions and standards for the health sector.
22.	Health sector regulations (protocols, standards, codes of conduct, and certification procedures) are known and enforced in training institutions and health facilities.

2.4 Summarizing Findings and Developing Recommendations

Section 2, Module 4, describes the process that the HSA team will use to synthesize and integrate findings and prioritize recommendations across modules. To prepare for this team effort, each team member must analyze the data collected for his or her module(s) to distill findings and propose potential interventions. Each module assessor should be able to present findings and conclusions for his or her module(s), first to other members of the team and eventually in the assessment report (see Annex 2.1.C for a suggested outline for the report). This process is iteractive; findings and conclusions from other modules will contribute to sharpening and prioritizing overall findings and recommendations. Below are some generic methods for summarizing findings and developing potential interventions for this module.

Analyzing Data and Summarizing Findings

Analysis should take place in three steps. First, the desk-based review should give the interviewer some idea of the main issues of health governance, and guide interview questions. Second, interviews should clarify the issues uncovered in the desk review and give the interviewer more viewpoints to consider. Third, common themes that were evident between interviewees should be identified and findings should be developed based on these themes. The steps are discussed in more detail in the following paragraphs.

Documents such as the national health strategy, relevant legislation, and other health assessments are useful in determining governance challenges in the country, and informing the interviewer's questions. As has been mentioned above, because the leadership and governance module relies much more on qualitative data than do the other technical modules, the in-country interviews are particularly important in clarifying issues and refining findings – in addition to possibly leading to new issues and findings. By asking similar questions of a range of public and private sector health system actors, the interviewer gets multiple viewpoints and a broad understanding of the health system. For example, a public health provider may have a different perspective on facility licensing requirements than a private health care provider.

Table 3.2.4 provides an easy way to summarize and group findings. (This process is part of Step 4 for summarizing findings as described in Section 2, Module 4.) It organizes each building block module by topical area. Rows can be added to the table if additional areas are needed to accommodate the HSA country context. In anticipation of working with other team members to put findings in the SWOT framework, each technical team member can label each finding as a strength, weakness, opportunity, or threat. (See Section 2, Module 4. for additional explanation on the SWOT framework.) The "Comments" column is used to highlight links to other modules and possible impact on health system performance in terms of equity, efficiency, access, quality, and sustainability. Examples of system impacts on performance criteria are summarized in Annex 2.4.B. Additional guidance on which indicators address each of the WHO performance criteria is included in Table 3.2.6.

TABLE 3.2.4 TEMPLATE SUMMARY OF FINDINGS–LEADERSHIP AND GOVERNANCE MODULE

Indicator or Topical Area	Findings (Designate as S=strength, W=weakness, O=opportunity, T=threat.)	Source(s) (List specific documents, interviews, and other materials.)	Comments

[a] List impact with respect to the five health systems performance criteria (equity, efficiency, access, quality, and sustainability) and list any links to other chapters.

Table 3.2.5 shows the completed Leadership and Governance SWOT table from the Guyana HSA 2011.

TABLE 3.2.5 GUYANA HSA LEADERSHIP AND GOVERNANCE SWOT 2011

	Equity	Access	Efficiency	Quality	Sustainability
Strengths and opportunities	• Civil society is strongly represented in the CCM, involved in activities relating to HIV, and it offers some strong voices on other health issues.	• The MOH has a good relationship with the media and uses them effectively to convey strong health promotion messages to the public.	• Flexibility of GPHC and Region 6 to innovate, including task shifting and incentive programs.	• Existence of health management committees in Region 6 that provide feedback on service quality issues. • Momentum behind the formation and continued strengthening of RHAs.	• Strong political and senior-level ministerial leadership on health systems issues.
Weaknesses and threats	• Few CSOs have the capacity to advocate on non-HIV-related health issues. Only rarely is a variety of viewpoints expressed relating to other health issues.	• Disease-specific forums such as the CCM and National AIDS Committee offer CSOs limited ability to provide input into broader health policy.	• Few forums exist for the MOH and other stakeholders, including regions, development partners, other ministries, and NIS to discuss specific topics of common concern. • Inflexibility of government processes, including the hiring system, funding, and task shifting.	• Health management committees do not exist outside of Region 6.	• Continued reliance of the RHA on RDC funding in Region 6, and for RHDs in all other regions.

Source: Health Systems 20/20 and Guyana Ministry of Health (2011)

After obtaining this stakeholder input, the HSA governance expert must analyze the information to identify common themes. These themes often involve relationships between and coordination of public and private stakeholders, enforcement of policies and regulations across sectors, and degree of decentralization. They can cut across the linkages found in the health governance framework, or even across modules. The common governance themes should be woven throughout the assessment report, where appropriate, in order to understand how issues relate to one another. For example, poor coordination at the subnational level could negatively impact reporting, service quality, facility oversight, and citizen involvement in health decisions. All impacts must be explained in their respective modules. As discussed in Section 1, WHO's health system performance criteria can also be used to examine the strengths and weaknesses of the health system. Table 3.2.6 summarizes the leadership and governance indicators that address each of the five WHO key performance criteria: equity, efficiency, access, quality, and sustainability (WHO 2000).

TABLE 3.2.6. SUGGESTED LEADERSHIP AND GOVERNANCE INDICATORS ADDRESSING THE KEY HEALTH SYSTEM PERFORMANCE CRITERIA

Performance Criterion	Suggested Leadership and Governance Indicator
Equity	7. Government and health provider organizations regularly solicit input from the public and concerned stakeholders (vulnerable groups, groups with particular health issue, etc.) about priorities, services, and resources. The government is responsive to external stakeholder input.
Efficiency	11. Private associations and/or civil society organizations (including professional organizations, specialized health-related NGOs, the media) oversee health providers and provider organizations in the way they deliver and finance health services, and follow protocols, standards, and codes of conduct in regard to medical malpractice, unfair pricing patterns, discrimination against clients, and so forth.
Access (including coverage)	16. Information about the quality and cost of health services is publicly available to help clients select their health providers or health facilities.
Quality (including safety)	21. Health sector regulations (protocols, standards, codes of conduct, and certification procedures) are known and enforced in training institutions and health facilities.
Sustainability	14. Health services are organized and financed in ways that offer incentives to public, NGO, and private providers to improve performance in the delivery of health services.

Source: Health Systems 20/20 and Guyana Ministry of Health (2011)

Developing Recommendations

Finally, recommendations that address the findings should be developed. Just as findings often link to other modules, so do recommendations. Section 2 Module 4 suggests an approach for doing this in general. This section focuses on common governance challenges and possible solutions. Table 3.2.7 lists typical governance recommendations that an HSA team might be able to use or adapt to its context.

The governance recommendations must be discussed with the other technical team members to make sure they align with the other modules; no recommendation should be repeated. For example, a recommendation for poor coordination at the subnational level could include setting up regular stakeholder meetings where representatives from providers, citizens, civil society, and government can discuss ways to improve service quality or reporting standards.

Table 3.2.7 Illustrative Recommendations for Governance Issues

Health System Gap	Possible Interventions
MOH planning capacity is weak.	Build policy and planning capacity through structural changes in the MOH (e.g., creation of a new planning entity, elevation of the planning entity in the organization, or creation of new job titles and job descriptions for key planning personnel) and training of key planning personnel.
Coordination or communication between the different health actors, including other government agencies, executive branch and the legislature, and non-state providers is weak or nonexistent.	Create an ad hoc intergovernmental committee with strong leadership to establish dialogue among branches of government, private sector representatives, and other key stakeholders. Consultation with project staff of any general governance project that may be present in country can be useful in identifying interventions that have been successful in other sectors.
Donor coordination is weak.	Help establish a donor coordination committee and provide support for setting up and helping the committee to function effectively for an initial period, until it is generally recognized as being useful and therefore becomes self-sustainable. Ensure donor funding aligns with government health priorities.
Government has limited capacity to engage non-state actors in policy and planning.	Build MOH private sector capacity through structural changes in the MOH (e.g., creation of a public-private partnership unit or private sector adviser) and training of MOH staff.
Coordination and dialogue with the private sector is weak or sporadic.	Establish committees or consultative working groups to bring private sector representatives together for purpose of soliciting inputs on their concerns, such as regulations, taxation, business opportunities, and potential barriers to private participation in the health sector.
Conflicting legislation exists.	Provide technical assistance to pinpoint inconsistencies and formulate clarifications. Ensure private sector participation in process to clarify legislation.
Regulatory agencies lack resources to enforce legislation or regulations.	Identify funding sources, beginning with reallocation of MOH resources, to ensure proper enforcement of safety and quality standards.
No system exists for accrediting health professionals.	Provide technical assistance to develop accreditation bodies, standards, and processes. Ensure private sector participation in the process.
Public documents are not being published or disseminated.	Bring this problem to the attention of policymakers to help identify sources of funding to ensure that information regarding patient rights, fee schedules, health entitlements, and other issues are made available to the general public. Provide funding to produce and disseminate widely changes in policies and reform to all actors, particularly private sector providers.

Health System Gap	Possible Interventions
Government officials are less responsive to citizen concerns and ideas, once voiced.	Set up independent mechanisms for tracking decision-making processes and the level of public input into policies can be set up.
There is lack of citizen participation in the definition of health needs and services.	Encourage citizen participation through civil society participation in health planning forums, town halls, or workshops.
Civil society participation is weak or absent.	Assist in the formation or strengthening of professional organizations and advocacy and watchdog groups (including consumer defense bodies) through establishment of organizational development grant programs, which may be either donor funded or funded by a combination of donor, government, and civil society resources.
Stigmatized groups (such as organizations of people living with HIV/AIDS) are excluded from the health policy dialogue or if the government is not responding to citizen input.	Introduce special provisions, such as new bylaws, for inclusion of these groups in intergovernmental committees and other organizations. Donor organizations can be helpful in identifying such gaps and writing requirements for inclusiveness for countries to qualify for donor funding (vis-à-vis the Global Fund to Fight AIDS, Tuberculosis and Malaria, and requirement for involvement of civil society groups in the Country Coordinating Mechanism).
The press is not covering important health policy issues	Train media and establish media liaisons in key positions.
Oversight or regulation of health services is weak.	Set up or strengthen independent oversight boards or citizen groups to provide clients with feedback mechanisms for health providers. These structures would need a mandate to fight bias and inequity, unfair pricing patterns, and discrimination, and to help providers to follow existing protocols and standards.
Citizens have no opportunity to meet with health providers.	Organize client provider committees that represent the voices of clients. Additionally, joint forums that include citizens, providers, civil society, and local government provide an opportunity for client power to be exercised.
Health facilities are not actively communicating health financing or service information, such as resource allocation or utilization, to citizen's groups.	Set up committees or forums that facilitate communication. If facilities are not transparent with regard to user fees, or pricing structures are unfair, publically posting user fee schedules could alleviate this problem. Recommend this area be coordinated with those under the Service Delivery module.

2.5 Assessment Report Checklist: Leadership and Governance

- **Profile of Country Leadership and Governance**

  A. Overview of Leadership and Governance (can include):

  a. Look at quality of leadership and governance

  b. Understand the operational model of governance

  B. Level of decentralization:

  a. Examine whether linkages in Figure 3.2.2 are functional and effective

  b. Assess the authority and responsibilities that exist at the national, subnational, and local levels

- **Leadership and Governance Assessment Indicators**

  A. Overall governance

  B. Government responsiveness

  C. Voice: Preference aggregation

  D. Client power

  E. Service delivery

  F. Information, reporting, and lobbying

  G. Compact: Directives, oversight, and resources

- **Summary of Findings and Recommendations**

  A. Presentation of findings

  B. Recommendations

Notes