Good Governance for Health

Department of Health Systems

World Health Organization
Geneva
Good Governance for Health
This document is not issued to the general public, and all rights are reserved by the World Health Organization (WHO). The document may not be reviewed, abstracted, quoted, reproduced or translated, in part or in whole, without the prior written permission of WHO. No part of this document may be stored in a retrieval system or transmitted in any form or by any means - electronic, mechanical or other - without the prior written permission of WHO.

The views expressed in documents by named authors are solely the responsibility of those authors.
Table of Contents

Good Governance for Health: an introduction .................................................. 1

Human Development, Health and Governance in the Indian State of Kerala ........... 5

Governance and Sri Lanka's Universal Child Immunization Programme ...................... 9

The Role of Governance in the Legalization of Midwifery in a Canadian Province ....... 14

Good Governance Practices in a Malaysian Hospital ............................................. 19

Glossary of Governance-related terms .................................................................. 22

Recommendations for Further Reading on Governance .......................................... 24
Good Governance for Health: an introduction

Health systems in crisis

Health systems in many countries across the world are in a state of continuing crisis. Inadequate human, technical and financial resources, inaccessible and inequitable services, and dissatisfied health service users and providers are just some of the problems encountered - particularly in the developing world.

Developing countries carry 90% of the global burden of disease, yet it is these countries whose health systems are in greatest disarray. The difficulties faced by the most vulnerable groups in the developing world are compounded by the inability of governments and health care providers to adequately run and maintain even the limited health delivery infrastructures which have been established. Scarce resources are used inefficiently: an excessive proportion of funding is allocated to maintaining bureaucracies while programmes and services at delivery level are often critically underfunded. Unresponsive administration, bureaucracy, lack of accountability and transparency, and corruption are but a few examples of obstacles to the efficient management and functioning of the health systems of many countries.

The gradual decrease of public sector capacity can be added to this list of problems. Many developing countries have experienced a quantitative and qualitative decline in their public sectors, accompanied by rapid growth of the private sector. Clients of many public institutions are met with indifference and inefficiency: public servants have lost the ethos of "serving" and of being accountable to the client. While the role of public sector incentives for improved service provision goes unexamined, private clinics flourish. This is not necessarily because they are able to provide better quality care, but because their success depends on their responsiveness to the needs of the client. And yet the State fails to take advantage of the opportunities presented by the private sector: despite the ongoing reduction in funding of the public sector, responsibility for costly services such as tertiary care services continues to reside with the State. In this context, the symbiosis between private and public sectors must be more clearly defined. Suggestions have been made to pass the greater measure of responsibility for curative care over to the private sector and to redefine the role of the public sector as primarily regulatory. However, developing countries whose public sectors are in a state of decline are actually least capable of fulfilling this regulatory role.

Problems at the Community Level

Joint and complementary action between the health sector and communities has been increasingly advocated to achieve health gains and improvements in health care quality. Community organizations seek to understand whether current health care reforms will lead to greater community control over health. They note that health not only derives from the health sector, but from a broad range of community concerns: employment, housing, sanitation, etc. Community organizations across the developing world are attempting to place the community in the centre of health decision-making and to ensure that the highest possible standard of care is available to the community. There are, however, major barriers to the full involvement of communities and to the efficient running of community health service, some of which can be traced to the general crisis in health systems.
The state of disarray in which the public sector finds itself has limited the contribution of communities to the functioning of local health centres. In addition, the public sector has failed to link with the rapidly growing private sector and exploit potential synergies through a judicious public-private mix. There are no policies or guidelines for community participation in the private sector except that exercised through the market: ie, customers choosing their provider.

The poor working conditions in most public sector settings have been noted before. The frustration of the staff is exacerbated by the inability of staff to improve their own performance or to play a meaningful role in the running of the hospital or health centre. As long as the health sector itself lacks the mechanisms for constructive communication between staff and meaningful worker participation, it is unrealistic to attempt to develop meaningful community participation in the running of health services.

Attempts made to involve the community in priority setting and decision making have been stymied by the existing power structures that favor professional associations and higher level government authorities. The agenda is set by the more articulate and well established interest groups.

**Governance**

While a significant measure of the crisis in health systems, as manifested at the community level, is attributable to budget constraints, poor governance practices are also responsible. There is a poor or ill-defined relationship between the private and public sectors, one in which the public sector is forced to compete against the private sector for staff and for clients, and in competing, lose most times. The public sector itself, already suffering from a shortage of staff, equipment and resources, is fraught with personnel problems. There is poor communication between different levels of staff, no mechanism through which staff can express their grievances or have those grievances addressed, and little opportunity for staff to take part in decision making and therefore limited scope for personal career satisfaction. There is little community participation.

These problems of management, staff development, communication and participation are all related to governance - or a lack thereof. From reviewing national level consultations with community representatives, to redefining the relationship between local authorities and hospital boards, to meeting the needs of the individual client: addressing the crisis of the health sector involves addressing issues of governance.

In responding to this crisis, the tendency has been to treat the symptoms of the problem rather than its source. Yet treating the symptoms provides only short-term, and often costly, solutions. The predicament of these health care systems is much more complex than each symptom in isolation suggests. To address the source and systemic nature of the problem and to work towards fundamental and lasting reform, it is necessary to take a much broader approach by examining governance practices in the field of health care.

The United Nations Development Programme (UNDP) defines governance as "(T)he exercise of political, economic and administrative authority in the management of a country's affairs at all levels. Governance comprises the complex mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal
rights and obligations". While this broad definition places governance in the context of social development in a democratic society, a more specific definition is required when discussing good governance in the context of health.

In relation to Health for All in the Twenty-First Century, good governance has been described as "the system through which society organizes and manages the affairs of these sectors and partners in order to achieve its goals". This is helpful, but it requires some amplification. Good governance for health is the enabled participation of those concerned in the formulation and deployment of policies, programmes and practices leading to equitable and sustainable health systems. It involves supporting and developing the right institutions, groups or individuals for effective administration, consultation and service delivery. Good governance places clients, rather than providers of care, at the centre of the health care system.

Wide-ranging collaboration, which is part of good governance, involves a broad range of actors. The government, the private sector, non-governmental organizations, civil society, and health service users and providers are among the potential players in governance for health. As health development is a part of overall socio-economic development, it is not dependent on the activities of the health sector alone: individuals and groups associated with other sectors may also be involved in good governance for health. For example, improvements in education inevitably lead to improved health status: the relationship between increased female literacy and decreased infant mortality has been clearly established. Thus while much of the action to improve the health status of populations lies outside the control of the health sector, the health sector can support health promoting behaviour through broad participation and multi-sectoral collaboration.

While the responsibility of ensuring good governance for health often appears to fall on the Ministry of Health, it must be emphasized that the Ministry is just one of many players in this game: good governance implies much more than good government. Although it is the Ministry of Health which ultimately determines health policy, it relies on the involvement and expertise of other groups in developing and implementing these policies and providing services. Collaboration with these groups should be based on accountability and transparency in decision-making, decentralization and delegation of authority, and instilling all concerned with a sense of 'ownership' in the process. It must be emphasized that collaboration for its own sake is not productive: the energy and resources of these disparate groups must be constructively channelled.

Transparency, accountability, participatory decision-making, consensus-orientation, and a client-centred approach: the elements of good governance are many and varied. This document examines the role of good governance in health systems through a series of case studies. The objective is to illustrate how some of the elements of governance described above have been successfully handled. Good governance practices can be employed at all levels of the system, whether it is in developing health legislation, implementing a programme, or managing an institution. It is hoped that lessons of good governance will be learned and disseminated - that the principles of good governance will be derived from practical experience rather than theory.

---


The following four case studies describe good governance practices at work. They are organized to illustrate how good governance is practised at all levels of the health system, from the operation of an entire public health sector serving 30 million people, to the management of an individual health care institution. The first study is a description of a government's commitment to adopting a socio-developmental and equity-based approach to health in the Indian state of Kerala. The second, an examination of Sri Lanka's Universal Child Immunization Programme, outlines the significance of political commitment to successfully implementing and sustaining an initiative. The importance of broad participation in consultation and decision-making is explored in the third study on the development of midwifery legislation in Canada. The fourth and final study of an award-winning hospital in Malaysia explores the importance of a client-centred approach to managing a health care institution.
Human Development, Health and Governance in the Indian State of Kerala

Introduction

In 1951, India became the first country in the world to undertake an official Family Planning programme. This was part of a national initiative to stabilize the country's population at a level consistent with the needs of national development. Since that time, India has significantly reduced its national birth rate and improved the health of women and children. While the programme is presently two thirds of the way towards achieving the goal of replacement level fertility, it has not been equally successful in all Indian states: some states have made only limited progress, while others have achieved highly satisfying results. One state which has been very successful in reducing the population growth rate and improving the health of its women and children is Kerala. The success of the Family Planning programme in Kerala can be attributed to the egalitarian or socialist nature of the state and its adoption of a socio-developmental approach to health. Many of the principles associated with this approach can be seen in the light of good governance.

Good governance is most frequently associated with democracy, due to its emphasis on broad participation in decision-making. Yet it is not exclusive to democracy: it can flourish in an authoritarian state. Good governance involves coordinating the diverse interests and roles of different sectors and actors to maximize their contribution to the development and implementation of sound policies and practices, and ultimately to the improved health status of the population. A State which manages the work of all sectors - health, education, trade, etc, - is well-placed to synthesize the activities of these diverse sectors in order to achieve a social goal. Good governance is the means of achieving an equitable and sustainable health system. This orientation towards equity is a guiding principle shared with the socialist ideology. In examining the success of the Family Planning programme in the state of Kerala, the socio-developmental approach of this egalitarian state and related elements of good governance are revealed.

Kerala and its Economy

The state of Kerala is located in the Southern Peninsula on the West Coast of India. Established in 1956, it was the first socialist state in India. In 1991 its population was estimated at 29.1 million, or roughly three percent of the national population. Kerala is distinctive for its remarkable achievements in social and economic equity. Despite the socio-developmental advancement of the state, Kerala can be described as economically backward. In 1987-1988, Kerala's GDP was only 1,416 rupees per capita compared to a national per capita GDP of 1,910 rupees. This 'backwardness' is partly attributable to the policies of successive governments in Kerala in promoting egalitarianism: in the year 1987-1988, only 16.9% of the population of Kerala was living below the poverty line, compared to a national figure of 29.2%. Kerala spends more on social welfare programmes than any other state in India. It may therefore be said that it is not economic but political factors which have lead to the high level of social development in Kerala.
Employment and Environment

Factors contributing to the emergence of an egalitarian society in Kerala include the implementation of land reforms, establishment of a minimum wage in agriculture and industry, and better working conditions. There has been continual improvement in the habitat and environment of both the rural- and urban-dwelling people of Kerala. The State has seen improvements in housing and sanitation, increased access to electricity, and improvements in the quality and accessibility of safe drinking water. Environmental factors such as these play a significant role in the health of the people: there is a positive correlation between the availability of electricity and piped water and a reduction in crude death rates³.

Education

Kerala provides its population with universally accessible education. The State has invested heavily in both primary and secondary education, with great success. While the literacy rate for the Indian population as a whole was 51.5% in 1991, the literacy rate for Kerala at that time was 90.5%. Ensuring the people access to education has not only resulted in an increasingly skilled and employable workforce, it has ensured a steady flow of suitably trained and locally available medical and health care personnel.

Kerala has been particularly active in promoting the education of girls and women. In 1991, 86.17% of women in Kerala were literate, compared to a national average of 39.21%. In 1989, 35% of employees in the organized sector in Kerala were female, compared to a national figure of 12%. In addition to presenting employment opportunities for women, the education of girls and women - most importantly at the secondary level - has lead to an improved understanding of matters associated with health and hygiene.

As women are the primary educators in most families, this has had a significant impact on the health of the population. Educated women are better able to assess the risks to their own health and that of their children and have a better understanding of the value of health-promoting behaviours. Moreover, educated women are more likely, and better able, to seek and obtain health care when necessary. There is a correlation between increased rates of female literacy and reductions in maternal, infant and child mortality. In 1991, female life expectancy in Kerala was 71.1 years, compared to a national figure of 59.1 years. In 1996, the infant mortality rate in Kerala was 13 deaths per thousand live births, as opposed to a national average of 72 deaths per thousand.

An educated woman is also more likely to delay marriage, and therefore childbearing, than an uneducated woman. In 1981, the average age of marriage for Keralite women was 21.9 years, compared to a national average of 18.3 years. In a culture which generally encourages girls to marry in their teens, the trend in Kerala to delay marriage by several years reduces the risk to the health of women and children. More mature women are less likely to encounter complications during childbirth and tend to be more capable of caring for their children.

³ In 1996, Kerala had a crude death rate of 6.2 per thousand, and a sanitation availability rate of 49.46%; the Indian state of Uttar Pradesh, in contrast, had a crude death rate of 10.2 per thousand and a sanitation availability rate of only 7.44%.
And perhaps most significantly, women who have had access to education are more likely to practice family planning than those who have not. There is a correlation between increased levels of female literacy and decreased fertility rates. The Family Planning programme in Kerala has succeeded in assisting couples in achieving their desired family size. The state has achieved the greatest reduction in fertility rates in all of India: between 1951 and 1991 the population growth rate in Kerala fell from 2.08 to 1.31, compared to an increase in the national population growth rate from 1.25 to 2.11 over the same period. Although the increase in the national population growth rate is partly attributable to the improved health status of the Indian population, the comparative success of Kerala is nonetheless significant. In addition to limiting the number of children a woman has, family planning has allowed Keralite women to extend the period of time between pregnancies, resulting in lower levels of maternal, infant and child morbidity and mortality. Kerala has achieved remarkable success within the mandate of the national population policy and Family Planning programme goals set by the government of India. In 1994, Kerala had a contraception prevalence rate of 51.5% - 6.1% higher than the national rate.

The egalitarian nature of the society and the high priority assigned to the education of women and girls in Kerala has provided women and girls with a high status not accorded to them elsewhere in the country. Perhaps the most striking evidence of this is Kerala’s sex ratio: in 1991, there were 1,036 females for every 1000 males, compared to a national average of 927 females for every 1,000 males. Elsewhere in India, the tendency to favour males over females has resulted in an unnaturally low number of females in the population.

**Summary so far**

The sound social development policies of the government of Kerala have played a major role in the favourable demographic changes in the state and in the subsequent success of the Family Planning programme. As the policies and goals of the national Family Planning programme were the same in every state, the remarkable success of the programme in Kerala can be attributed to the state’s ongoing commitment to health and education programmes and the allocation of resources for their effective implementation. The commitment of the political executive to the implementation of welfare policies and social development programmes through efficient administration has been a central element of this success. The egalitarian nature of the society, high status of women, rise in female literacy, and increase in age of marriage have all combined to produce an enabling environment for the success of the Family Planning programme in Kerala. Increased Family Planning awareness and acceptance among the Keralite people created a demand for efficient delivery of services which were accessible and of high quality. Political guidance has secured sustained popular support for the promotion of the health, education and welfare of the people.

The state of Kerala is people-oriented, committed to equitable and universal access to services, has adopted a multi-sectoral approach to health, and exhibits political will to support health initiatives. These factors, which were integral to the success of the Family Planning programme in Kerala, can be seen as elements of good governance for health.
Challenges to the health system

Although the commitment of Kerala to human development has contributed enormously to the improved health status of the population, the financial burden of maintaining such a costly social welfare system is now resulting in serious financial problems for the health system. For although the Kerala health system was intended to be equitable, it was not sustainable.

Kerala has a long history of organized health care. When the State was founded in 1956, the foundation for a sound health care system had already been laid. Thereafter there was remarkable growth and expansion of government health services. The number of beds in government hospitals rose from 13,000 in 1960 to 38,000 in 1996. The annual compound rate of government expenditure on health during that period was higher than the compound rate of total government expenditure and higher than the annual compound rate of growth of the state domestic product4.

Despite an intense period of growth in the health sector following the creation of the state of Kerala, funding for the health sector has gradually diminished since the mid 1980's due to growing financial pressures. The inadequacy of funds has lead to a severe decline in the quality of medical care in government hospitals. This has lead to substantial growth in private, for-profit health care.

Private health facilities are now more numerous than government health facilities, providing more beds and employing more staff than government facilities. The private sector has been particularly successful in providing facilities for sophisticated tertiary care. This can be attributed to both the government's inability to provide these costly services and to the need for the private sector to focus on the most commercially profitable services. The public sector has been reduced to such a degree that many government-run primary health centres do not provide any curative services. Other than immunization and sterilization, most of the population's health needs are met by the private sector. This has lead to an increase in the cost of medical care to the people. Meanwhile, the government has been unable to establish effective mechanisms or policies to regulate or oversee the activities of the private sector and private sector facilities.

The ongoing decay of the public sector and the growing imbalance in the public/private mix must be addressed in order to ensure that the Keralite health system is equitable and sustainable: in order to restore 'primacy' to primary health care. Although the original system was intended to increase equity in access to health care, its inability to sustain itself has resulted in an increasingly inequitable health system. While the egalitarian social system which shares some of the guiding principles of good governance created an environment which enabled the improvement of the health status of the population, it is good governance practices which are required to address the growing crisis in Kerala's health system.

4 Compound rate of growth of health expenditure was 13.04% in this period, compared to compound rate of growth of total government expenditure of 12.45% and annual compound growth rate of state domestic product of 9.81%.
Governance and Sri Lanka's Universal Child Immunization Programme

Introduction

Good governance comprises many diverse factors. In the context of health, it involves the creation of an environment which promotes active and constructive participation by all concerned in the formulation and implementation of initiatives and policies leading to equitable and sustainable health care. It involves supporting and developing the right programmes or institutions for effective administration, consultation and service delivery. Most important, good governance places people, rather than providers of care, at the centre of the health system.

The Sri Lankan health care system relies on a variety of actors to provide care to the people: the Government, private sector and NGO's are all responsible for health service delivery. Issues of good governance are therefore highly relevant, not only to the efficient functioning of the Sri Lankan health care system in its totality, but to the success of individual health initiatives at all levels. The Universal Child Immunization Programme was one such initiative whose success can be considered in terms of good governance practices.

An enabling environment

The Universal Child Immunization Programme was established in 1985. Its success can be seen as a part of the continual improvement of the socio-economic and health status of the Sri Lankan people. In fact, the success of the programme can be partly attributed to this trend.

Since the late 1940's, Sri Lanka has seen a steady improvement in literacy rates and education. It has strengthened its national infrastructure, experienced growth in rural income, and seen increased social mobilization. Since this time, Sri Lankans have experienced tremendous improvements in their health status in relation to this overall social development. Evidence of this includes an 80% reduction in infant mortality\textsuperscript{5}; a 76% reduction in maternal mortality\textsuperscript{6}; a 52% reduction in the crude birth rate\textsuperscript{7}; and an increase of 33.6 years and 25.6 years in the life expectancy of women and men respectively\textsuperscript{8}.

The initiation of the UCI programme was preceded by a long history of immunization against preventable diseases:
1886 Introduction of smallpox vaccination;
1949 Introduction of BCG vaccination;
1962 Introduction of triple vaccination against diphtheria, whooping cough and tetanus;

\textsuperscript{5} Between 1950 and 1995, the infant mortality rate fell from 82.3 per 1000 live births to 16.5 per 1000.
\textsuperscript{6} Between 1946 and 1995, the maternal mortality rate fell from 15.5 per 1000 live births to 3.6 per 1000.
\textsuperscript{7} Between 1950 and 1995, the crude birth rate fell from 40.4 per 1000 to 19.3 per 1000.
\textsuperscript{8} Between 1946 and 1991 life expectancy at birth rose from 41.6 to 74.2 years for females and from 43.9 to 69.5 years for males.
1962 Introduction of oral vaccination against polio;
1963 Introduction of BCG vaccination for newborns;
1969 Introduction of tetanus toxoid vaccination for pregnant women;
1978 Launch of the Expanded Programme on Immunization;
1984 Introduction of measles vaccination.

The ongoing socio-economic development of Sri Lanka, the continual improvement in the health status of its people, and a longstanding dedication to vaccinating children: these factors created an environment conducive to the implementation and subsequent success of the Universal Child Immunization Programme.

As a consequence of Sri Lanka’s commitment to vaccination and the specific role of the Universal Child Immunization programme, target diseases such as poliomyelitis, diphtheria and whooping cough have today almost disappeared. Incidence of tetanus has fallen 92%⁹, incidence of tuberculosis has fallen 70%¹⁰, and incidence of measles has fallen 95%¹¹.

**Political support**

Right from the time of its launching, the UCI programme enjoyed a very high level of political commitment. This political support was spearheaded by the Prime Minister at the time, Mr Premadasa, who in 1989 became President and until his death in 1993 provided his personal backing to the UCI programme. Given this leadership, political support at all levels was forthcoming: from Cabinet Ministers, to the Ministry of Health, to the Provincial Councils¹² - all the way down to local government institutions. In several instances, political support was provided irrespective of differences of political leadership at different institutional levels. This widespread and enduring political support was a significant factor in ensuring the continued availability of financial resources for the duration of the programme's operation.

**Infrastructure support and human resources**

At the time of the UCI programme's implementation, Sri Lanka already had a delivery system for immunization services. It had been built up over the years through the several programmes which were implemented over time. Therefore, instead of attempting to establish a new system or infrastructure to support immunization service delivery, the UCI programme focussed on strengthening, expanding and modifying the existing system. It made use of a system which had already proven itself to be adequate and sustainable. Moreover, the infrastructure support system was organized on the principle of taking the service to the people rather than expecting a family to travel in search of service for their child. Immunization centres were strategically chosen to cover a large area and to be easily accessible by public transport.

---

⁹ Between 1960 and 1995, incidence of tetanus fell from 14.5 per 100,000 population to 1.1 per 100,000 population.
¹⁰ Between 1960 and 1995, incidence of tuberculosis fell from 106.3 per 100,000 population to 31.5 per 100,000 population.
¹¹ Between 1960 and 1995, incidence of measles fell from 31.5 per 100,000 population to 1.5 per 100,000 population.
¹² The system of Provincial Councils, a basis for a devolved political system, was instituted through a 1987 amendment to the country's constitution.
As the UCI programme adapted the existing service delivery structure, the basic supply of human resources was already in place. All that was required was to minimally enhance the cadres at different levels and in different locations. Given the degree of political commitment to the programme, funding of such enhancement was not an insurmountable obstacle. In using the existing service delivery system and workforce, the programme avoided unnecessary expense and the duplication of certain services.

**Organization of service delivery**

Organization of the UCI programme was based on an existing organizational system, the functioning of which was already familiar to the Ministry of Health. Under the leadership of the Secretary of the Ministry of Health, delivery of the UCI programme was placed under the Directorate-General of Health Services. The Epidemiologist of the Directorate-General, supported by the Family Health Bureau, functioned as a manager of the programme. Management of the programme was further supported by the World Health Organization and UNICEF.

Under the direction of this management team, Regional Directors of Health Services were responsible for implementing the programme in their respective regions. The primary service delivery points in each region were: hospitals, run by Medical Officers; central dispensaries and maternity homes, run by Assistant Medical Practitioners; and field teams, run by Medical Officers.

Using the existing organizational structure recognized the time-bound nature of the programme, avoiding the creation of structures which would become redundant at the end of the programme.

**Public awareness and social mobilization**

A significant feature of the UCI programme was the marketing of the programme through the creation and enhancement of public awareness. In addition to the standard health education programmes, a multi-media campaign geared to the needs of the programme was launched. It involved the use of radio, television, newspapers, posters, printed publicity material and puppet shows in its efforts to communicate its message. Publicity meetings and Maternal/Child Health clinics were also held. The public awareness campaign was continually revised and updated to meet arising challenges, and was quite successful in generating support for the programme.

Given the highly rural nature of Sri Lankan society, social mobilization was considered a key factor to the successful implementation of the UCI programme. Capitalising on the influence of religious institutions in Sri Lankan society was identified as a means of achieving social mobilization. At national level, conferences with religious leaders on issues of child welfare and development were organized. This mobilized different religious organizations to generate community support for, and involvement in, the programme. To the same end, field staff at local level took advantage of opportunities to speak with local Buddhist monks, members of the Christian clergy, leaders of Hindu temples and clerics of Muslim mosques. This was a culturally appropriate approach to social mobilization which made use of existing social structures and lines of communication to achieve the programme's objective.
The Ministry of Health also sought and maintained the assistance of non-governmental organizations, civil society organizations and volunteers at national, district and grassroots levels. These groups facilitated the implementation of the programme through the creation and operation of public awareness campaigns and mobilization of human resources.

The UCI programme placed great importance on issues of public awareness and social mobilization. This was a means of empowering the public and reinforcing the people-centred nature of the programme.

**Monitoring and evaluation**

The Universal Child Immunization Programme engaged in an intensive process of monitoring and evaluation. Collection and analysis of immunization data from the field formed the base of the monitoring and evaluation activity, but in addition, senior officials at the Ministry of Health held quarterly review meetings with field staff. At these meetings ongoing immunization coverage levels were reviewed against possible constraints to immunization coverage. At one point it was recognized that, although immunization levels were increasing, it was not at a sufficient rate for targets to be achieved on schedule. The rate of implementation was therefore increased, allowing targets to be met on time. Quarterly review meetings not only ensured that problems were recognized and addressed in a timely manner, they reassured field staff of senior level commitment to the programme.

**Challenges**

While implementation of the UCI programme was highly successful, it was not without its challenges. These hurdles included both civil and cultural factors.

During the operation of the UCI programme, Sri Lanka was experiencing civil disturbance as a consequence of youth insurrection in the south of the country and ethnic insurrection in the north and east. This resulted in a lack of motivation for field staff, who had to carry out their tasks in a stressful and sometimes dangerous environment. In the face of this challenge, the Ministry of Health employed a motivational strategy and began awarding trophies to health teams performing at optimal capacity. This paid significant dividends in motivating field staff and building a team ethic.

A cultural hurdle to the successful implementation of the UCI programme was the deep-rooted socio-cultural perception of certain diseases as relatively harmless and necessary childhood illnesses. Diseases such as measles are often perceived as illnesses bestowed by the gods and warded off only through divine protection and the use of a protective amulet. Given this cultural and religious context, the UCI programme took the innovative approach of presenting the measles vaccine as a form of protective amulet. The Ministry of Health went so far as to offer gold amulets to 'lucky' infants selected by draw from those who were duly certified as immunized against measles. This very creative approach to the problem was met with great enthusiasm and had the intended effect of bolstering public support for, and faith in, the programme. Challenges to the success of the Universal Child Immunization Programme were met with innovative thinking which generated creative yet appropriate solutions to arising problems.
**Equity**

The UCI Programme employed good governance practices to ensure equitable service delivery. Commitment to people-centredness ensured that immunization services were physically accessible to the largely poor rural population, and broad consultation with religious institutions ensured that all members of the population, irrespective of religious orientation, were and encouraged to make use of immunization services.

**Summary**

The Universal Child Immunization Programme was a highly successful health intervention. Governance-related factors which contributed to its success included a high level of political commitment; use of existing infrastructure and human resources; client-orientation; and dedication to public education, public awareness and social mobilization. The programme achieved all of its objectives and was a major contributor to the near eradication of target diseases and the overall improvement of the health status of Sri Lanka's children.
The Role of Governance in the Legalization of Midwifery in a Canadian Province

Introduction

In 1993 the government of the Canadian province of Ontario\textsuperscript{13} passed legislation which admitted midwifery\textsuperscript{14} into the Ontario health care system as an autonomous, self-regulated profession. The Act encompassed a vision of midwifery and of community health which had been advocated by interested parties, including consumers and the midwives themselves. In order to understand the governance structures which enabled the participation of all concerned in the development of this legislation, the process leading to the inclusion of midwifery into Ontario’s health care system must be examined.

Governance

Governance is the interaction of a variety of actors in order to reach a decision, manage a system, institution or programme, or design and implement a policy. In the context of health, governance may include the government, the legal and judicial system, the public sector, the private sector and civil society organizations. When developing a new health policy or designing health legislation, one very significant element of governance is the process of participation and consensus building among all concerned. This participation informs the government, complements its public or democratic mandate, and ensures that policies are people-centred. Good governance is good decision-making. To understand governance, we must ask who makes the decisions and how they are made.

An enabling environment

Canada practices socialized health care: government agencies are involved in most aspects of policy-making, regulation, and implementation. Government-run health care is led and implemented by the province and receives supplementary funding and standard-setting from the federal level. It involves medical insurance programmes, hospital construction, fiscal policies, laws and enforcement, medical education and so on. At a time when Canada was seeking innovative ways of reducing the significant cost of running this comprehensive national health system, midwifery, and specifically the practice of midwife-assisted home-births, presented a cost-efficient alternative to hospital deliveries. A 1986 study by a joint committee of the Canadian Nurses Association and the Canadian Medical Association indicated that in Canada, savings would be at last $8.2 million (Canadian) a year\textsuperscript{15}.

\begin{footnotesize}
\begin{enumerate}
\item The province of Ontario is located in central Canada, sharing its southern border with the United States. With approximately 10 million inhabitants, Ontario is home to roughly one third of the Canadian population.
\item Midwifery is defined by the Act as "the assessment and monitoring of women during pregnancy, labour and the post-partum period and of their newborn babies, the provision of care during normal pregnancy, labour and post-partum period and the conducting of spontaneous normal vaginal deliveries".
\item Midwifery Issue: the newsletter of the midwifery task force of Ontario, Number 9, October 1985 and Number 11, April 1986.
\end{enumerate}
\end{footnotesize}
A national and international movement to strengthen community health services occurred in the wake of the World Health Organization's so-called Ottawa Charter of 1986. One of the goals of the Ottawa Charter was to reorient health services away from a focus on acute care, hospitalization and the use of technology. Midwifery services fell in line with this proposed reorientation by providing a service which reduced dependence on technological intervention and was generally not hospital-based.

The nature of the Canadian health care system, the financial pressures upon that system, and a national and international move away from hospital-based health care: these factors contributed to the evolution of a supportive environment, an environment which enabled the integration of midwifery into Ontario's health care system.

The process

Although efforts to legalize midwifery practice go back several decades, the process began to gain momentum in the 1980's. In 1983 a consumer lobby group known as the Midwifery Task Force of Ontario was formed. In 1985 the jury of a coroner's inquest recommended that midwifery be legally recognized in Ontario and incorporated into the health care system, and a year later the Health Disciplines Review Committee recommended the legalization of midwifery. Later in 1986 the Minister of Health announced government intention to incorporate midwifery as part of the regulated health care system. In 1989, design of a university curriculum for a midwifery programme was undertaken. In 1991, the Minister of Health and Minister of Colleges and Universities announced that Ontario would offer a degree programme in midwifery and a pre-registration programme for experienced midwives. In 1993, three Ontario universities began a four-year baccalaureate programme in Midwifery. Later that year, The Regulated Health Professions Act and the Midwifery Act were proclaimed law, legalizing the practice of midwifery in Ontario. A College of Midwives was established and changes to the Public Hospitals Act were implemented to allow privileges to midwives in cooperating hospitals. In 1994, experienced midwives who had completed the integration programme became the first in Ontario to practice as licensed midwives. And finally, in 1996, more than a decade after the process began in earnest, the first midwives to graduate from university programmes began to practice midwifery.

Government

The changing attitude toward midwifery was not based on political distinctions. The process described above was carried out during the tenure of three different governments, encompassing a broad spectrum of political beliefs. The different governments were able to carry the initiative forward due, in part, to strong public support for the change. Yet cooperation between the various ruling parties was also required: the endurance of legislation despite changing governments relies on a set of established rules and conventions on how legislation passes from one government to another. It is through the acceptance of these rules on how decisions are made that new initiatives can continue through the public sector system.

Institutions

It is also important to note how the state interacted with other institutions, particularly the medical establishment, in shaping the direction of health care reforms. The opposition of the medical
establishment to midwifery served to delay its acceptance into the health care system, yet state intervention in the form of multi-party consultations ensured that the medical institution adapted to, and ultimately accepted, changes in the health care system. The medical establishment’s eventual acceptance of midwifery was eased by the institutional form the new profession took - one which clearly paralleled its own. This new profession actually reinforced the established structures of the medical establishment, which was obviously less threatening to the medical establishment than having a highly visible alternative practice outside any formal institution.

The legal system

Legal mechanisms are a pervasive and decisive force in the restructuring of health care. In the case of midwifery, the state, under the federal Criminal Code, has the power to prosecute birth attendants in cases of professional negligence or wrongdoing. While individual prosecutions are one form of legal control over midwives and other health care practitioners, a coroner’s inquest is another. Coroner’s inquests are quasi-criminal proceedings which are conducted by a criminal prosecutor and a crown attorney with clear recognition of the potential for criminal charges to be laid. The medical establishment is almost exclusively in control of a coroner’s inquest, and has, in the past, made exceptionally effective use of inquests to discredit midwifery. For example, although existing data supports the improved outcomes of midwife-attended births whether at home or in hospital16, the coroner’s inquests have not reflected that reality. Of the eight inquests held into infant deaths in Ontario between 1982 and 1989, six involved midwifery care and/or home births. By determining who will be called as a witness and who is qualified to participate, the Coroner has wide powers to set the agenda and the outcome of the inquest. As an apparently ‘alternative’ practice, whose service providers - and certainly users - are female, midwifery suffered considerable prejudice and resistance from the established medical community.

Despite this bias in favour of the medical establishment, it was an inquest which eventually contributed to a shift in the way midwifery services were viewed in Ontario. The 1985 inquest into the death of a baby delivered by two Ontario midwives resulted in a set of recommendations for incorporating midwifery into the health care system. These recommendations were made despite opposition by the Coroner, and were the combined result of consumer pressure, international testimony and support, and solid research. Thus the legal system can be a catalyst for change.

Civil society organizations

The process leading to the integration of midwifery services in Ontario not only involved the participation, views, and needs of those concerned - it actually depended on it. Consultation and the participation of civil society occurred in a number of fora, including the Health Disciplines Legislative Review process; the Task Force on the Implementation of Midwifery in Ontario; the Interim Regulatory Council on Midwifery and its subcommittees; university training programmes, and coroner’s inquests.

Extensive consultations with civil society organizations occurred throughout the process. This instilled the public with a sense of ownership regarding the process. The consultation process and ensuing media attention resulted in a gradual and favourable change in the public's initially suspicious attitude towards midwifery. The consultation process allowed some of the more controversial aspects of midwifery to be publicly debated and allowed research to be examined and myths dispelled. For example, the public learned of the reduced morbidity and mortality associated with midwifery care\(^\text{17}\). The public began to feel that midwifery services were not only acceptable, but necessary.

The strong movement on the part of the recipients of midwifery care ensured that the issue did not drop from the agenda: clients and supporters of midwifery were encouraged to join the Midwifery Task Force. The growth of membership encouraged broad participation in the process and ensured the financial stability of the organization.

Such extensive consultation necessarily led to the exposure of views and needs which might not otherwise have come to light. Through consultations, regulatory bodies were able to respond to the concerns of various diverse groups and thereby incorporate a broad perspective into the process. A good example of an issue which came to light as a result of the participatory process was the issue of midwifery services for women in Canada's northern and particularly First Nations communities. As a result of consultation with First Nations groups and with the support of the Equity Committee of the Interim Regulatory Council on Midwifery, changes were made to the midwifery legislation. These changes allowed First Nations communities to independently design, manage and regulate the culturally appropriate practice of midwifery on First Nations Reservations. The voices of ethnic and cultural minority groups were heard, and their needs addressed.

Submissions made by various groups throughout the process became the backbone of the legislation. The groups' abilities to write briefs and negotiate with the Review Committee paved the way for the development of models for Ontario midwifery legislation. Extracts from some briefs were actually incorporated verbatim into the final legislation. Without the high quality work undertaken by these groups it is unlikely that the initiative would, or could, have moved forward.

**Equity**

The legalization of midwifery, and the process leading to its legalization, can be seen as a step toward more equitable health service provision. Women and cultural minorities were empowered to play a greater role in their own health care. Official recognition of a traditional, non-hospital-based and female-dominated practice was a move towards restoring balance to an otherwise technology-oriented and male-dominated medical community.

\(^{17}\) Midwifery care has been shown to reduce the rates of prematurity and therefore decrease the amount of intensive care needed for the newborn, with lower rates of brain-damage and subsequent institutionalization: 1.5/1000 in Sweden vs. 5.4/1000 in the US (Stewart, D. 1981. "Home: The Traditional Safe Place for Birth." In Steward D. (ed.) *Five Standards of Safe Childbearing.* Marble Hill, Missouri: NAPSAC, 117-135).
Challenges

Although legalized midwifery in Ontario is now a reality, its course was not without its challenges. Many of the greatest challenges arose from the process of integrating currently practising midwives into the new system. Many midwives were excluded from the initial accreditation process despite outcries from their clients and supporters. In some cases, there were accusations that the reason for non-integration was political. One highly experienced and respected midwife who had been involved in well-publicized debates over the proposed content of curricula met with opposition when she later attempted to enroll in the programme. Authorities claimed she was denied admittance due to professional incompetence. Although she was eventually admitted after a series of legal battles, such exclusion suggests that ensuring objectivity in the integration process was problematic.

One major hurdle ahead is the imposition of severe financial constraints on Ontario's health care system. These constraints have led to hospital closures. Some of the hospitals scheduled to close are those with which midwives have successfully negotiated access to hospital privileges. And of course a few additional challenges may arise. The possibility that the Coroner will call an inquest questioning the validity of midwifery services cannot be eliminated. Moreover, issues of training, medical back-up, hospital support, and inter-professional conflict have not yet been fully resolved.

Summary

Despite these actual and potential difficulties, the legalization of midwifery can be viewed as a highly successful health initiative. The midwifery model of care now offered to Ontarian women has been an important health achievement. A number of broad characteristics allowed this initiative to succeed, including an enabling environment; appropriate structures and institutions; and most importantly, extensive consultation with many different actors. With an understanding of the myriad ways in which different players interact, we can begin to develop effective policies for health care reform: policies which are truly people-centred.
Good Governance Practices in a Malaysian Hospital

Introduction

Even before the Alma Ata declaration of 1978 which presented the vision of Health for All, Malaysia had established a health care delivery system based on the principles of Primary Health Care. Malaysia's health care system embraces the philosophy of the Alma Ata declaration, employing practices which can today be seen as elements of 'good governance'.

Good governance involves many diverse elements, including the creation of an environment which promotes the active and constructive participation of all concerned; the development of a health care system which places people at its centre; and the promotion of collaboration and consultation between the government, non-governmental bodies, the private sector and users and providers of health care services.

The most successful providers of services in the Malaysian health care system employ these good governance practices. The Ministry of Health, actively promoting quality improvement initiatives, identified a number of hospitals and health centres which merited recognition for excellence in the quality of the services provided and the satisfaction of service users, service providers and hospital managers. One such institution was the Kuala Krai hospital, which in 1996 was recognized for its high standard of service provision and its sound managerial practices.

An enabling environment

The Kuala Krai hospital has achieved great success in providing high quality services, yet this degree of success would not have been achieved were it not for the supportive environment in which the hospital operates. This supportive environment includes factors at the national level such as a stable economy and political system and a very active Ministry of Health.

The Ministry of Health is a strong presence in the Malaysian health care system, providing clear leadership and embracing health care reform. The Ministry has established broad policies on quality assurance in service provision and effectively promotes widespread participation in a variety of health initiatives. As a means of motivating service providers to constantly strive to provide the best possible care, the Ministry of Health promotes open competition and has established a system for recognizing and rewarding optimal service provision. Moreover, government-run hospitals are highly accessible, provide an adequate range of services, are appropriate to the needs of the population, and are heavily subsidized and therefore operate at very low cost. As a general principle, the Ministry of Health strives to empower both the individuals who provide care and the communities they serve.

These practices, among others, have allowed the Malaysian Ministry of Health to create a supportive environment: a health care system which enables individual service providers such as the Kuala Krai hospital to perform at the highest possible level.
**Good governance practices**

The Kuala Krai hospital has maintained a high standard of care and succeeded in satisfying the needs and desires of its clients, staff and managerial team by effectively employing the organizational and managerial principles of good governance. It is well known in its field for having a positive and vibrant operational culture, which is the result of a combination of factors.

**Client orientation**

Kuala Krai is people-oriented: client satisfaction is incorporated in the hospital's mission statement. The client is at the centre of decisions made at all levels, from the hospital waiting room to the highest level of management. The hospital encourages active community participation and has established a Board of Visitors for outside consultation on a variety of issues.

The hospital regularly conducts client satisfaction surveys. The results of these surveys, both positive and negative, are publicized. Client feedback has contributed to numerous innovations and improvements in service provision, including the provision of health education materials in the hospital waiting room and at various service points and, most notably, a reduction in outpatient waiting time. Transparency in publicizing survey results enhances the credibility of the hospital: results have indicated an overall client satisfaction rate of approximately 70%.

Kuala Krai has proven itself to be accountable to the client, thereby empowering the people and increasing confidence in the hospital.

**Managerial practices**

The managerial team at Kuala Krai is headed by a dynamic and visionary leader. It engages in a participatory style of leadership and has an open-door managerial policy. This encourages the involvement of staff and others in the decision-making process. Managerial efforts to build team spirit and instill a sense of pride at the hospital include innovations such as the creation of a hospital flag and slogan.

The management team displays an ability to effectively manage conflict, delegate responsibilities, coordinate tasks, and set clear objectives. Strategic planning at Kuala Krai is carried out by a team consisting of the director and unit heads, and staff support for proposed plans and programmes is sought. Furthermore, the hospital engages in health systems research to ensure that it is fully informed of developments and innovations in the field.

Efficient, participatory management such as this creates a cooperative work ethic and instills staff with a sense of ownership in the overall running of the hospital, encouraging them to embrace changes as and when they arise.

**Human resources development**

Kuala Krai is committed to staff training and development. It has a comprehensive staff training programme which covers pertinent health care issues and addresses information or training
requests by staff. In keeping with its overall objective of instilling staff with a positive attitude towards their work, the training course incorporates a culturally appropriate religious dimension. Every member of staff must attend at least three training sessions per year.

Staff training is complemented by conferences and visits to model institutions, and is supported by a library run on the honour system, a journal club, and the operation of a 'Speak English' campaign. Study tours of the different units of the hospital are conducted to provide staff with an understanding of the role of the different units and of the overall functioning of the hospital.

Equally as important as the skill enhancement initiatives are the regular staff performance appraisals which are conducted at Kuala Krai. Performance appraisals allow for the timely identification of strengths, weaknesses and problem areas, and provide staff members with feedback on how to improve their performance. An additional and significant means of ensuring the delivery of high quality care is the use of the National Indicator Approach to quality assurance, as well as the use of hospital-specific indicators of quality.

In the day to day operation of the hospital, healthy competition is encouraged, motivating staff to perform to their fullest professional capacity. Staff members are not restricted by a rigid and prescriptive style of supervision: they are encouraged, within reason, to take an innovative approach to their work. Innovations tend to arise from teamwork, particularly when an element of competition between teams is introduced. Furthermore, every staff contribution is recognized by small rewards and verbal or written expressions of appreciation.

In addition to assuring that high quality care is offered, this investment in human resource development is a way of giving something back to the staff - of recognising their contribution and demonstrating commitment to optimizing their professional competence and ensuring their personal career satisfaction. Commitment to staff development results in a skilled and motivated workforce and a culture of mutual respect and appreciation. This, in turn, results in an increasingly skilled staff and a reduction in staff turnover.

**Challenges**

The effective and efficient running of the Kuala Krai hospital has not been without its challenges, but these challenges have been faced with innovation and determination. The most significant hurdle has been constraints of human and financial resources due to the relatively small size of the hospital and the correspondingly low density of the population it serves. These constraints necessitated the amalgamation of available resources and optimization of their use. Consequently, the hospital closely examined its existing practices and the result was actually increased efficiency.

**Summary**

The success of the Kuala Krai hospital is the result of a variety of factors associated with good governance. It is people-centred; involves a variety of actors in the decision-making process; has a dynamic leader and participatory style of management; encourages cooperation and teamwork; conducts regular reviews and evaluations to ensure that a high standard is maintained; is accountable and transparent; and is innovative and forward-looking. The Kuala Krai hospital is a model health service provider, setting the standard to which other hospitals and health centres may aspire.
Glossary of Governance-related terms

Accountability
Accountability of a government, agency, organization or group is the ability of the client to hold the body responsible for decisions made and actions taken; and the body's acceptance of that responsibility.

Capacity building
Capacity building in a government, sector or organization is the development of capability or potential for enhanced performance, the standard of which is sustainable.

Civil society
Civil society is the collective of organizations, groups and individuals - organized or unorganized - representing different interests and concerns and acting in the political, economic and social realms.

Consensus-building
Consensus-building is the process of negotiation and discussion to reach a decision which is not objectionable to any stakeholder.

Equity
Equity is fairness or social justness. It is the fair treatment of all people, regardless of their socio-economic status, sex, race, ethnicity, religion, age, or geographic location, and regardless of the privileges or disadvantages associated with these factors. Equity in health care requires: equity in the way health care resources are allocated; in the way services are received; and in the way individuals are required to pay for services. Equity in health means reducing unnecessary and unjust gaps in the health of different social groups and in the determinants of the health of these groups.

Governance
Numerous definitions of governance are currently in circulation. Our Global Neighbourhood (Oxford University Press, 1995) defines governance as "the sum of the many ways individuals and institutions, public or private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and co-operative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest". For the purposes of this paper and in the context of health, the following definition is proposed: "good governance for health is the enabled participation of those concerned in the formulation and deployment of policies, programmes and practices leading to equitable and sustainable health systems". Some elements of good governance common to most definitions are: people-centredness, accountability, transparency, broad participation and consultation, and regular monitoring and evaluation.
Health sector
The health sector includes the range of government ministries and departments, social security and health insurance schemes, voluntary organizations and private individuals and groups, which provide health services. Taken from *Health for All: a glossary of terms* (WHO/PLL/TRA/CTT/94.5)

Health services
Health services are the institutions, individuals and technologies which provide care for, and strive to improve, the health of the population. Health services may be oriented towards, for example, prevention of illness or disability, promotion of health, or treatment and cure of illness or disability.

Health system
A health system is the complex set of interrelated elements which contribute to health in homes, educational institutions, the workplace, public places and communities, as well as the physical and psychosocial environment and the health and related sectors. Taken from *Health for All: a glossary of terms* (WHO/PLL/TRA/CTT/94.5)

Public sector
The public sector is the range of government-operated and publicly-funded health services.

Private sector
The private sector is the range of health services which are privately-operated and -funded and are therefore market-driven or for-profit in nature.

Sustainability
Sustainability of a system, organization, programme or reform is its ability to maintain itself in the future: its ability to continue to operate at the same or higher standard without exhausting resources or becoming dependent on outside assistance.

Transparency
Transparency is the ability or willingness of an organization or body to act openly and directly, ensuring that information on its management, functioning and decision-making processes is accessible to all stakeholders.
Recommendations for Further Reading on Governance

United Nations Development Programme, Governance for sustainable human development: a UNDP policy document (New York: United Nations Development Programme, 1997) This is a comprehensive document, examining public and private sector management and decentralization of key authorities and functions of government. It outlines the importance of multi-sectoral partnerships and of mobilizing civil society to encourage people to play a role in their own development.

United Nations Development Programme, Sub-group on capacity development for governance: ACC Task Force on an Enabling Environment for Economic and Social Development (UNDP document, 1997) This report attempts to define the parameters of governance, while presenting the various definitions of governance which are currently in circulation. It outlines the interests of other UN agencies in the area of governance.


United Nations Development Programme, Capacity development for sustainable human development: conceptual framework and operational signposts (UNDP document, 1995) This document describes the need to direct development support to country level institutions and the creation of national expertise in order to achieve sustainability and reduce dependence on outside assistance. It emphasises the need for capacity development to be internally driven and involve a broad range of actors and civil society.


World Health Organization/Cassels, Health sector reform: key issues in less developed countries (WHO document WHO/SHS/NHP/95.4, 1995) This document examines the need to understand the political, economic and institutional context of a country in order to be able to assess the need or potential for reform. It discusses the elements of reform and the role of managed competition as an incentive for increased efficiency in the public sector.

Hancock, Trevor, Creating healthy and sustainable communities: the challenge of governance (London: The British Council, 1994) This publication examines the role of local governments in creating environments which are conducive to good health. It outlines the need for a holistic approach to health, drawing on community action and the empowerment and participation of the people for socially sustainable development.

The Case Studies: Unabridged*
The impact of the Family Welfare Programme in the States of Kerala and Uttar Pradesh in India, by Usha Vohra
The role of governance in the integration of midwifery in Ontario's health care system, by Julie Delahanty, The North South Institute

Governance and health: the experience of Sri Lanka, by Shelton Wanasinghe

The role of good governance in sustainable health care reform: experience of Malaysia, by Abu Bakar Suleiman

* Case studies available from the Department of Health Systems, WHO

This document was put together by Allison L. Edwards, Consultant, Department of Health Systems, World Health Organization.