SDC's Approach to Governance

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SDC NETWORK
Democratisation, Decentralisation and Local Governance

Part 3

Governance in health – a practical guide

This guide is one in a series to support SDC staff in integrating governance in the SDCs' priority themes – in this case health. It outlines key governance issues regarding the health sector and how these can be integrated into the design, implementation, monitoring and evaluation of cooperation strategies and projects. This guide is part of the *SDC's Conceptual and Practical Guidance to Governance* (available here).

Introduction

The enjoyment of the highest attainable standard of health is one of the **fundamental rights of every human being**. This right is enshrined in the Constitution of the World Health Organization (WHO) [1] and the International Covenant on Economic, Social and Cultural Rights[2] as part of the International Bill of Human Rights. Health is central for poverty reduction and plays an important role in ensuring social security, peace and economic stability.

The 2000 Millennium declaration includes eight Millennium Development Goals, three of which are dedicated to health. This has triggered unprecedented interest and investment in global health issues. Much has been achieved in improving people's health and lowering the burden of disease. Nevertheless, huge challenges remain, particularly inequalities in access to health resources, a dramatic increase in non-communicable diseases and fragmentation and poor quality of health services.

Consequently, universal access to quality health services, sustainable health financing and disease prevention and treatment remain high on the sustainable development agenda and are targets under Goal 3 of the 2030 Agenda.[3]

Achieving these targets and the health related goals will require substantial improvements in the governance of the health sector in order to improve its performance and outcomes. This ranges from allocation of resources for health, mechanisms for accountability and oversight, coordination between different tiers of the health system and stakeholders as well as evidence-based policy processes. Multi-level and multi-stakeholder governance approaches that promote accountability and participation are critical for health systems in order to deliver quality and people-centred health services which leave no one behind. These aspects are reflected in the **WHO approach to governance in health** which defines leadership and governance as one of the six building blocks of a health system. This understanding emphasises the importance of steering and regulation of the health system and promotes collaboration with other sectors, including the private sector and civil society, the establishment of transparent and effective accountability and the participation of the population in an inclusive manner to promote population health[4].

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1 The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States, and entered into force on 7 April 1948.

2 Adopted by the UN General Assembly on 16 December 1966 and entered into force on 3 January 1976. It has been ratified by 164 states as of November 2016.

3 Cf. SDC Health Policy (2013) and WHO (2012) Governance for Health in the 21st century http://www.euro.who.int/__data/assets/pdf_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf (accessed on 2 November 2016).

4 See also http://www.who.int/healthsystems/topics/stewardship/en/ (accessed on 23 November 2016)

The SDC recognises that addressing governance in health is critical for achieving the SDC's overall goal in health which is to improve population health with a specific focus on poor and vulnerable groups. The **SDC approaches governance in health** by a) integrating gender and governance in all SDC health activities, b) placing a focus on **strengthening health systems** to extend universal coverage[5] and c) engaging in health governance dialogue at global level.

A health systems strengthening approach includes a thorough assessment and monitoring of political, economic and social processes and encompasses aspects of health financing, governance and management of the health sector and key constraints related to the health workforce, quality and availability of health resources (infrastructures, medical products, technologies, information) in order to inform health programming. Activities must refer to a human-rights based approach and promote citizen participation and empowerment, social protection and (social) accountability mechanisms to extend truly universal health coverage.

More generally, a human rights approach to health refers to international human rights law to identify rights, freedoms and entitlements of rights-holders as well as obligations of duty-bearers to realise these rights and ultimately strives for the elimination of all forms of discrimination. The fulfilment of the right to health is closely linked to the **improvement of the underlying determinants of health**[6] especially in the areas of livelihoods, nutrition, education and access to water and sanitation, which is an important aspect of the SDC's approach to health.

Equally important are **aspects of health services, goods and facilities**, such as their **accessibility** (affordable, reachable, non-discriminatory), their **availability, acceptability** (for different population groups) and their **quality** – also referred to as the **AAAQ** framework. Along with freedoms (e.g. from non-consensual treatment) and entitlements (e.g. to essential medicines) of right-holders they constitute an important pillar of a rights-based approach to health.

Global Health recognises the "impact of global interdependence on determinants of health, transfer of health risks and the policy response of countries, international organizations and the many other actors in the global health arena,"[7] which determine access to health across different regions of the world. The SDC aims at **strengthening global health governance** through efficient coordination **between multilateral organisations** at global level[8]. The policy impact hypothesis is that a stronger normative and coordinating role of the WHO, multi-sectoral collaboration for health between multilateral organisations, as well as coherent Swiss policy messaging will foster the coordination between these organisations and reinforce their efficiency and effectiveness. Switzerland is host to a range of key institutions for global health, both multi-lateral (WHO, GFATM[9], UNAIDS etc.) and private sector (pharmaceutical companies), but also research institutions and NGOs (MSF, ICRC). Consequently, Switzerland is well positioned to assume a key role in improving international governance standards for the planning, implementation and monitoring of technical and political action in health.

Health outcomes are however not only rooted in the health sector, but are strongly influenced by other sectors and their respective policies. This includes the economy, education, water and sanitation, the

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5 *Strengthen health systems to extend universal coverage* is one out of three priority themes in SDC's Health Policy (2013). *Universal health coverage* (UHC) has been defined by the WHO as the desired outcome of health system performance whereby all people who need health services (promotion, prevention, treatment, rehabilitation and palliation) receive them, without undue financial hardship. http://www.who.int/entity/healthinfo/universal_health_coverage/UHC_Meeting_CivilSociety_Jan2014_Report.pdf?ua=1accessed on 23 November 2016).

6 Determinants of health include the general socio-economic, cultural and environmental conditions that affect a person's individual health status as part of a social group or community. They include education, nutrition, access to water and sanitation, human security, employment and income, labour conditions, gender roles, environmental conditions etc. and are ideally resources for good health. The Health SDG 3 cannot be achieved without addressing the determinants of health beyond health services.

7 Kickbusch, I. (2002) Global Health - A definition. Yale University.

8 SDC Global Programme Health, Strategic framework 2015-2019

9 The Global Fund to fight Aids, Tuberculosis and Malaria

environment and food systems. The concept *health in all policies* recognises these sectoral interdependencies by addressing and mainstreaming health in all sector policies.

While the concept of governance in health is well established and researched, concrete methods and approaches to address governance aspects in health remain few. The following chapters aim at providing concrete guidance on **how to address governance in health projects**, both at global level, through multi-lateral partnerships, and at national level through bi- or multi-lateral health projects.

Key governance challenges and implications

Common governance challenges across the components of health systems can be analysed along three different dimensions: **1) governance structure, 2) governance processes and 3) key actors.**[10]

The following table identifies governance challenges within the health sector and outlines some of the implications for health outcomes:

Dimension	Governance challenges and implications[11]
Governance structure: policies, strategies, laws and institutional setup	- **Unclear roles and responsibilities within the health sector**: leads to inefficient use of resources and heavy bureaucracy; leads to fragmentation of health system and services; prevents clear accountability relationships leading to weak enforcement of health policies and strategies. - **Scarce finances** for health but also other sectors: leads to non-availability of essential medicines and equipment, regional disparities in health delivery, high out-of-pocket expenses as well as discrimination and weak inter-sectoral collaboration on health because of inter-ministerial competition for resources. - **Lack of** systems (policy, laws, institutions) to ensure **transparency and equity** in the allocation and use of resources for health. - **Weak regulation of the private sector** which is generally profit oriented: results in exclusion of the poor from service delivery and lacks accountability mechanisms. - **No functional separation between health provider and purchaser**[12]: this weakens accountability, leads to unclear responsibilities and impedes performance and cost effectiveness of the health system.
Governance processes: adherence to good governance principles	- **Poor health information systems** (and management): limits the ability of oversight institutions to track progress toward meeting health targets and to make adjustments as needed; information gaps impede health officials' capacity to identify and respond to demand for improvements in health service delivery (e.g. patient-centred care) and to inform policy design (e.g. for pro-poor prioritisation) – this is a particular risk in correlation with a highly centralised system. - **Weak accountability systems**: lead to little transparency, a lack of sanctions and high level of corruption by state institutions in

[10] For more specific information and guidance on how to address particular sub-themes of governance, e.g. gender, fragility, public sector financing, please refer to the examples in: Governance as Transversal Theme: a practical guide to integrating governance in the SDC priority themes/sectors.

[11] Also compare Mikkelsen-Lopez, I. (2014) Health System Governance in Tanzania: Impact on service delivery in the public sector. http://edoc.unibas.ch/34099/1/IML%20thesis%20May%2014th%202014.pdf (accessed on 2 November 2016).

[12] Many mandatory health insurance schemes are funded and managed by the state, which consequently assumes a double role of providing health services and financing them from the general state budget.

	procurement and distribution as well as in treatment (requests for informal fees/bribes from patients). - **Lack of coordination and collaboration** to design and implement health policies: health policies are not defined in a participatory and inclusive manner, and health services delivery does not build on partnerships for efficiency (with the private sector, NGOs, communities), leading to low quality and low responsiveness of health policies to local needs and low levels of implementation. - **Limited coordination of donor and development partner inputs** into the national health system: lowers effectiveness of aid and contributes to fragmentation of the health system. - **Non-inclusive and not responsive health planning** (e.g. at sub-national level) combined with scarce resources: leads to selective and inadequate prioritisation of health issues, inadequate budgeting and reinforces inequitable access to health and discrimination.
Key actors: power, capacities and interests to shape the governance system and processes	- **Weak technical capacities** of health professionals and systemic incentives fostering unethical behaviour lead to weak health outcomes and low public trust in public health systems. - **Lack of political willingness** to address equity issues and work with non-governmental stakeholders leads to limited outreach and quality of health services. - **Focus** of health service providers **on treatment and cure** to the detriment of health promotion and disease prevention leads to low health literacy levels in the population, limited awareness of rights and persistence of underlying determinants of health. - **Asymmetry in patient-health provider relationship** leads to healthcare not being responsive to people's needs, to potential discrimination and stigmatisation (e.g. AIDS patients and vulnerable groups), low patient compliance with treatment and poor health outcomes. - **Few incentives to enhance performance** because of unattractive working conditions in the health sector (low salaries, no supportive supervision, few opportunities for professional advancement, little security, high workload) and prevalence of nepotism and non-merit based appointments: results in high staff turnover, absenteeism in public institutions, brain drain and unethical behaviour.

Key recommendations for integrating governance in the health sector[13]

SDC activities in health encompass health systems strengthening approaches with support to sector policy reform, continuum of care (from promotion, prevention to curative and rehabilitative/palliative services), capacities for health (incl. for research), financing for health e.g. for pro-poor schemes or budget support, support to health information systems, and support to global health governance (also refer to the examples in the next chapter). The following are some key considerations and recommendations on how to best integrate governance in health programming:

[13] Also compare: Governance as Transversal Theme: a practical to integrating governance in SDC priority themes/sectors, (Chap. 2.2), which provides a comprehensive analytical framework.

Governance structures	Recommendations for programming
Policy framework	• Analyse the existing health policy framework (constitution, laws, regulations, strategies) concerning the following aspects *Does it correspond to people's health needs and the national context? Does it commit to universal health coverage and equity? Is it inclusive? Does the policy framework clearly regulate roles and responsibilities, including those of private sector actors? Is an updated national health strategy and action plan in place with clear goals, targets and SMART indicators (disaggregated for equity monitoring)? Are strategies and plans matched by adequate funds?* • Support responsible state institutions (MoH, parliamentary committees) in reviewing and adapting policies and strategies and promote multi-stakeholder dialogue (including civil society organisations, private sector, patient organisations, professional associations etc.). • Look into other sectors such as education, nutrition, water and sanitation *Do these policies address important social determinants of health and are they operationalised? If not, consider addressing social determinants in other sectors in your programming (see example from Tanzania in the next chapter)*
Decentralisation architecture	• Assess how functions, financial and decision-making powers are assigned at different levels (central, sub-national, local) within the ministry of health (including related public institutions such as health insurances) and other ministries involved in health issues (education, agriculture, etc.). *Are functions shared or not across levels? Do the available resources match the assigned functions and needs at all levels? What is the potential for own source revenue generation?* • Support clear definition and assignment of roles and responsibilities with corresponding human and financial resources at different government levels. • Define a system of shared responsibilities between the ministry of health (MoH), private health providers, medicine and technologies providers, insurance schemes and professional associations, NGOs and community groups and support the establishment of clear communication and information channels, both vertically and horizontally *Do sub-national platforms exist where health stakeholders can agree on priorities and allocation of resources? How are the roles of professional associations, NGOs, community groups and private sector providers defined and how do they play out in reality?*
Governance processes	**Recommendations for programming**
Effectiveness and efficiency	• Strengthen effective and efficient public resource management processes in the health sector by focusing on informed planning (based on evidence from health providers), public financial management, performance monitoring and control, public information and consultation.

	What is the MoH's performance in achieving its operational and strategic targets? How effective and efficient is the management of public resources at central (MoH, MoF) and local level (e.g. capacities and role of local governments in public finance management) considering the decentralisation architecture in place? • Foster sector coordination among key stakeholders at various levels and across different sectors. *How effective and efficient is collaboration within the MoH (vertical coordination) and across different sectors and non-state health actors (horizontal coordination)?*
Accountability architecture[14]	• Strengthen the overall accountability architecture by supporting accountability actors (such as parliamentary committees, CSOs, ombuds institution, office of the controller and auditor general) as well as accountability processes (by promoting public access to health programming, steering and monitoring, budget information and outcomes), partnerships for accountability (e.g. platforms for CSOs) and sanctions and redress mechanisms and promote measures against corruption. *What is the role of parliament, audit institutions, judiciary and media/civil society in overseeing health sector budgets, performance and applying sanctions? How do these actors collaborate? Can citizens hold district authorities accountable? Is there a mechanism to address complaints by patients and sanction professional misconduct? How could the project address widespread corruption in the health sector?*
Participation	• Strengthen and establish spaces for inclusive participation and improve the quality of participation *Does a coordination forum exist where all stakeholders of the health sector (and other sectors) have a voice? How is civic participation at local level organised? What local groups exist and how are the interests of vulnerable groups represented? What is the role of the local governments/district authorities in providing spaces for health-related decision making? Are citizens or their representatives (patients' associations, CSOs) able to influence district planning for health promotion activities? What are the competences and capacities of involved stakeholders to contribute meaningfully*? • Strengthen the role of professional associations in advocacy, policy development and promotion of quality standards *How are health associations governed, managed and financed? What are their capacities to influence planning, steering and monitoring within the health sector? How do they network with other interest groups, CSOs and professional associations and liaise with legislative and regulatory bodies?*

[14] The domestic accountability architecture includes the practices and measures of state authorities and other responsible actors to explain and justify their actions towards the public; the ability of civic and public oversight bodies to demand accountability, monitor performance and denounce corruption; measures by state institutions to sanction and correct non-compliant practices (e.g. combat corruption).

Equality and non-discrimination	• Address power relations that lead to inequality and discrimination and encourage health providers to promote specific measures to enhance gender equality and social inclusion. *What groups are mostly excluded from accessing promotional, preventive and curative health services? What are the patterns of exclusion? Are pro-poor and insurance schemes available (including informal ones)? Are the interests and needs of vulnerable groups (children, pregnant women, the elderly, people with disabilities) represented in national and sub-national decision making processes? How equitable is access to health services for vulnerable groups? Are provisions in place such as pro-poor funding, local language, female health staff and transport? Are effective mechanisms in place to prevent social stigmatisation e.g. of HIV/AIDS or patients with a mental disability?*
Rule of law	• Address weaknesses in the legal and regulatory system and build capacities within the judiciary on health sector specific issues *Is a legal framework in place that effectively regulates the provision of health services and medicines, procurement of drugs and technologies and health financing and provides re-dress mechanisms? Do courts have specialised benches that deal with public health and health insurance issues? Is the justice system accessible to all?*
Transparency	• Promote platforms for information sharing and management information systems *How does evidence from the field feed into policy design? How is public health research organised? How is information collected, analysed and used to inform both practitioners at field level and policy makers? Do health authorities and institutions continuously inform the public and other concerned actors about key decisions and their related decision-making process?*
Key actors	**Considerations and recommendations for programming**
Power, incentives and motivations	• Identify incentives that can trigger policy and practice/behavioural changes and empower relevant actors for enhanced health governance. • Identify disincentives that impact negatively on performance (e.g. working conditions) and propose remedial action. *Are relations between key health stakeholders defined by domination or collaboration and alliance, strong, weak or conflict relations? Which actors/key institutions enjoy most trust and legitimacy (e.g. midwives traditional healers)? Which actors are the most powerful (e.g. in terms of financial resources, but also position, power or networks)? What are health staffs' grievances and satisfaction levels regarding their employment and workplace conditions?*
Human resources capacities	• Strengthen the capacities of health stakeholders (nurses, doctors, community workers, public health staff etc.) to perform their duties. *Are skills (knowledge, competences and ethics) of health providers sufficient to fulfil assigned duties? What are the capacities of MoH staff to inform health policy development? What qualification systems are in place for (continuous) medical education and training? Are training curricula for different health career options standardised and do they*

	comply with international standards? Is the professional staff management system fair and motivating? Does supportive supervision exist in the health system? How is it perceived by the health workers?
Advocacy	• Strengthen the role of advocacy work in promoting health and support platforms for multi-stakeholder and multi-level exchange. *Is sufficient information available to key stakeholders to advocate for specific health issues, including the right to health for all and to evaluate the system's effectiveness and performance? Does the administrative and political set-up promote effective, inclusive and affordable healthcare, does it protect the most vulnerable and empower the disadvantaged and is it responsive to feedback and complaints? Are civic organisations (CBOs, interest groups, professional associations) capacitated and empowered to advocate for social health promotion?*

SDC best practice: implementing governance as transversal theme in projects

The following examples from SDC health portfolios illustrate how governance can be effectively integrated into the health domain. The selection aims at highlighting both a domain level approach to governance (the example of Tanzania) as well as different aspects of governance that are at the core of individual projects.

A comprehensive and systemic approach to health in the cooperation with Tanzania

The Tanzania Health Portfolio (Swiss Cooperation Strategy 2015-2019) is a good example of a comprehensive and systemic approach to health that places considerable emphasis on governance aspects at different levels within and beyond the health sector. The portfolio includes projects addressing aspects of health policy, financing for health including public finance management, decentralised health administration, community participation in planning, managing and reporting on health services, and other determinants of health (e.g. water and sanitation). To monitor progress at country level, indicators that refer to national and district audit reports and national financing for health including equity concerns are included.

Addressing the underlying determinants of health: Water and Sanitation Governance for Health in Tanzania. Water and sanitation (WASH) is one of the most important underlying determinants of health. Whereas the legal framework and policy guidelines on water management do exist in Tanzania, water management committees in some areas are not fully functioning and in many cases ownership and roles and responsibilities for water management are not clearly defined. Upon the request of regional authorities, the SDC is upgrading water supply and sanitation systems in 100 primary health facilities in order to reduce the high risk of infection transmission and improve the quality of care in health facilities. Communities are capacitated to ensure participatory and sustainable operation and maintenance of the water supply and sanitation facilities, and knowledge of hygiene amongst health workers, patients and visitors is improved. As part of the gender and social accountability mainstreaming, women's representation in water governance structures is increased (through management and leadership skills training) and their specific hygiene needs addressed. Citizen report cards are introduced to assess citizens' access and satisfaction with WASH services and inform the dialogue between citizens and district authorities.

Health systems strengthening to improve the efficiency, accessibility, acceptability and quality of health services: the *Health Promotion and System Strengthening project* (HPSS) in Tanzania works both on the demand (health promotion, health insurance, community health funds) and the supply side (drug procurement; health technology maintenance) to improve health services. The project applies a

social health protection approach and supports the development of corresponding public finance mechanisms to protect people against health risks (pro-poor funding). The existing rural insurance community health fund has been reformed in order to increase coverage, include the poor and simplify payment to health facilities. A mechanism of pooled procurement at the regional level through a public-private partnership has been set up in order to secure drug availability in health facilities (medicines management through a 'prime vendor system'). The communities' awareness of their health needs is strengthened and they are empowered to take action to improve their health and influence health promotion activities at district level. A maintenance system for existing health equipment and technologies in the health facilities contributes to improved quality of health services.

Public sector financing for quality care at all levels[15]: In 2015, Switzerland played a central role in coordinating the health sector budget support in Tanzania. Concretely, Switzerland contributed to reforming the *Health Basket Fund* (HBF) which is a joint financial mechanism used by international donors and the Tanzanian government (ministries of finance, decentralisation and health), that makes additional resources available to districts to reach their health objectives. The HBF encompasses a performance element to foster the quality of care. It is part of a wider public finance reform and contributes to effective decentralisation by devolving the most pertinent financial competences to the district level.

The HBF enables coordination with other stakeholders and donors resulting in an aligned and harmonised approach to promoting health-sector reforms informed by evidence from other activities, such as the Health Promotion and System Strengthening project.

Addressing governance from different angles: examples from SDC health portfolios

A rights-based approach to health

The SDC approach to the right to health typically strengthens accountability for health by building capacities and competences amongst duty-bearers to fulfil obligations and to empower rights-holders to claim their rights:

A non-discriminatory and adapted approach: addressing the health needs of specific population groups: in Moldova, the SDC supports a national programme that provides *Youth Friendly Health Services* (YFHS) across the country. YFHS includes counselling on sexual and reproductive health and rights, pre- and postnatal education and the provision of qualified medical, psychological and social assistance. The programme works both with duty bearers by strengthening the capacities of medical staff, social workers and school staff and right-holders by empowering and enabling young people to acquire the knowledge, skills, attitudes and values necessary to make informed decisions about their sexuality and health. The inclusion of the most vulnerable groups (Roma, drug users, people with disabilities) is emphasised and social support services and legal services ensure the safeguarding of young people's and vulnerable groups' health rights and wellbeing.

Empowering citizens to claim their rights: in Mozambique, the *Strengthening Social Accountability for Health Services project* complements the SDC's health sector budget support by empowering citizens to claim accountability and transparency in public spending and better quality of service delivery. The project both engages civil society organisations and citizens, with a focus on women's and children's rights and combines a human-rights based approach to health with a local governance perspective that seeks to establish functional accountability and transparency mechanisms between citizens, local CSOs, community based organisations and district health providers. Not least will the evidence generated at local levels be used to inform and influence national health policies.

Public finance management competences for health

[15] Also refer to the more detailed description of the Tanzania HBF in: Governance as Transversal Theme: a practical guide to integrating governance in the SDC priority themes/sectors (Annex 1).

In **Kyrgyzstan**, a Sector Wide Approach (SWAp) aims at strengthening the capacity of the MoH in areas where **institutional weaknesses** have been identified, i.e. financial management (introduction of a new fiduciary risk assessment) and the implementation of **public finance management** reforms in the health sector, specifically to ensure that the MoH and the mandatory health insurance fund are capacitated to take an active part in the budget processes in conjunction with the ministry of finance. This includes support in financial reporting, procurement, contract management and the use of the medium-term budget framework. Accountability is strengthened through a comprehensive and explicit joint statement between the Kyrgyz government and the donors. The SWAp allows greater harmonisation and division of labour in development partners' activities.

Capacity development for improved health provision at decentralised levels

In Kosovo, where the responsibility for the delivery of primary healthcare services is decentralised to the local level (including decision-making, financial and managerial authority), municipal governments are key partners in health which often lack the necessary managerial and professional capacities to fulfil their functions, leading to low quality of health services and low trust of people in the system. In order to improve the skills of health managers at both municipal and facility levels for improved health provision, a management training system has been developed with support from the Affordable Quality Health Care for Kosovo (AQH) project and will be anchored with a partner institution to facilitate scaling up and sustainability. The system is aligned to national health development strategies and will foster a change in attitude and practice from a system based on a simple control mechanism to internal quality auditing procedures that help managers to identify areas for improvement and engage in continuous quality improvement (CQI) activities. This includes facility and service management, basic health technology management, planning, financial management and budgeting, HR, communication, and leadership. Implemented through a continuous professional development programme and other on-the-job training programmes, the clinical and professional skills of health providers in selected municipalities with a high share of vulnerable communities will be strengthened leading to more efficiency, quality and responsiveness of primary healthcare provision at decentralised levels.

An adapted and conflict sensitive approach to health in fragile contexts

Myanmar has been affected by conflict and civil war since independence in 1948. As a result, a parallel system of social services provision has developed in territories controlled by non-state armed groups (NSAG). As is the case with state-run facilities and services in Myanmar, the quality of health provision is very low and is marked by extremely scarce public funding, insufficient numbers of qualified staff, lack of infrastructure and equipment, and language and cultural barriers. This situation is exacerbated in NSAG-controlled areas that only have the most basic facilities, equipment and medicines and staff. Through the Primary Health Care (PHC) project, the SDC provides support to government as well as ethnic health systems in Kayin/Karen State, a conflict-affected state of southeast Myanmar. Applying a conflict-sensitive and adapted approach, the project engages in state and non-state controlled areas with different implementing partners that enjoy the trust of local stakeholders. Both state and ethnic health department-run facilities receive equal support to improve the provision of basic health services. In line with the ongoing peace negotiations between government and ethnic armed groups, the project facilitates coordination between ethnic and government health systems and discussions for a future potential convergence of the two systems (use of the same training curriculum for community health workers; recognition of accreditation). The project also takes into account the expected return of IDPs and refugees to resettlement areas in the project region and prepares accordingly. This is particularly important from a conflict-sensitive perspective.

Important aspects for monitoring and evaluation (M&E)

- ✓ **Anchor health governance at cooperation strategy level:**
  - Design **domain outcomes** that include governance considerations (legal framework, state of decentralisation, performance and interaction of responsible actors in public sector management processes compared to good governance principles, power dimensions, personal

interests, incentives/disincentives and available capacities of key stakeholders) both at the level of people and institutions.

- Include a specific field of observation/indicator in the health domain to measure progress in **improving governance in the health sector.** A list of key outcome indicators is available on the Health Shareweb (from March 2017).
- Include changes in aspect of governance in the Risks and Assumptions part of the Cooperation Strategy.
- Include governance-relevant **country development indicators** (e.g. linked to accountability, transparency and oversight mechanisms and equity concerns or based on the AAAQ framework) in the health domain.

✓ **Anchor health governance at project level:**

- Include key questions on health sector governance in terms of reference for health sector assessments, reviews and evaluations to inform project design and adaptions in action strategy and result frameworks of ongoing projects.
- Establish individual project outputs and outcomes for pertinent governance issues, linked to health governance structures (e.g. improved policies for health governance), processes (e.g. clear functional assignment of roles and responsibilities) and key actors in health (e.g. individual/group behaviour changes).
- **Equity monitoring** can help to monitor inequalities in health **between different sub-population groups**, e.g. the richest and the poorest quintile. Combine health outcomes with at least one 'equity-stratifier' such as gender, wealth quintile, ethnicity, culture, age and place of residence to measure progress in reducing health inequalities (outcome: citizens have improved access to affordable primary health services. **Indicator 1:** percentage of infants who received *post-natal care within 2 days of childbirth*, **broken down by gender and vulnerable population groups**). Because health inequalities are often multi-dimensional, (e.g. more pronounced amongst poor, rural women) multiple equity-stratifiers should be considered.
- Address persistent social determinants within other sectors through specific activities (e.g. in water and sanitation) and monitor and evaluate their relevance for health governance systems and processes.

✓ Keep in mind to not only include line ministry actors and their respective sources of verification in your M&E framework but also communities, unions, (formal and informal) insurance companies/schemes, technology/medicine suppliers, professional associations, patients' associations, umbrella organisations, other sector actors and international partners' performance.

✓ Keep in mind that health indicators need a reliable source of information such as a quality health management information system, or certified/reliable surveys.