P08 / Collaborative Governance and Health Inequities: Perspectives from Low- and Middle-Income Countries

Topic : HEALTH POLICY

Chair : Sara Van Belle (Institute of Tropical Medicine/London School of Hygiene and Tropical Medicine)

GENERAL OBJECTIVES, RESEARCH QUESTIONS AND SCIENTIFIC RELEVANCE

Background
With the SDG of Universal Health Coverage, captured by "leaving no one behind", there is a renewed impetus to work collaboratively at the local level. Public and private providers could work jointly to improve the performance of fragmented urban health systems and to improve referral for maternal care. Collaboration across sectors may, for instance, attenuate the triple burden of disease and contribute to implement tobacco control policies at district level. Collaboration between health facilities and the police may to strengthen integrated service networks for victims of sexual violence. Schools and youth services working together may deliver stigma free health services for adolescents. Community-based organisations and health managers and providers may engage in joint priority-setting and better align health services to citizens' and communities' needs.

Research question
How do collaborative governance arrangements impact on existing health inequities in LMIC?

Objectives
This session aims at showcasing examples from recent empirical fieldwork in LMIC of a renewed impetus in improved collaborative governance within the broader goal of achieving universal health coverage and to explore how these formal and informal governance arrangements and practices at the level of the local (health) system might impact on accountability towards the poorest or most vulnerable groups (indigenous groups, socially excluded, single households, people with disabilities, the poorest,..), who cannot easily claim nor enforce accountability.

Scientific relevance
Any policy, programme (or applied research) intervention to advance universal health coverage has to pass the litmus test of its impact on health (and broader) inequities. The aim is to explore empirical examples and then discuss, on the basis of the papers, which mechanisms are at work, in which context and why. The panel will end with making the case for innovative research methods (such as realist evaluation, qualitative comparative analysis,…) which allow for the building of causal pathways.

CALL FOR PAPERS

Papers expected: exploratory case-studies of innovative policy, programme or research interventions; empirical testing of (often HIC-developed) collaborative governance theories in LMIC settings; use of innovative research methods to explain the interaction between governance mechanisms and LMIC contexts, e.g. challenging operational settings; exploration of possible pathways linking micro and meso level collaborative governance arrangements to 'macro' structural drivers of (health) inequities and effects on vulnerable groups and /or poorest (indigenous groups, socially excluded, single households, people with disabilities, the poorest,..)

Research question: How do collaborative governance arrangements impact on existing health inequities in LMIC?

Hypotheses: To achieve universal health coverage, specific measures will need to be taken to ensure that those "who are left behind" are included. Collaborative governance mechanisms could either attenuate or reduce health inequities through amplifying feedback loops that reduce social exclusion and accountability failures vis à vis vulnerable groups or through disrupting feedback loops which maintain the status quo.

We invite papers that present exploratory case studies of innovative policy, programme or research interventions; report on collaborative governance theories applied in low- and middle-income settings; use innovative research methods to explain the interaction between governance mechanisms and LMIC

contexts, e.g. challenging operational settings; explore possible pathways linking micro- and meso-level collaborative governance arrangements to macro-level structural drivers of (health) inequities and effects on vulnerable groups and /or poorest (indigenous groups, socially excluded, single households, people with disabilities, the poorest,..).

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Session 1Collaborative governance and health inequities: perspectives from low- and middle-income countries: intersectoral responses

Thursday, June 27th 08:00 to 10:00 (MB S1.435)

Collaborative governance in a multi-sectoral programme: a policy landscape analysis of Tobacco control programme in India

Shinjini Mondal (McGill University)

Sara Van Belle (Institute of Tropical Medicine/London School of Hygiene and Tropical Medicine)

Antonia Maioni (McGill University)

Background:

Collaborative forms of governance are well known to bring public and private stakeholders in collective partnerships within public agencies to engage in decision making and action. In health policy, the thrust on collaborative governance can be well studied through its mandate to promote Multi-sectoral action (MSA). MSA has been a long-standing priority in global health, where the objective is to improve health status and health equity through policy decisions and organizational practices. The tobacco control policies and programmes promote MSA in their policy formulation and implementation. Through a descriptive and explanatory case study design, we map, understand and explain the processes of implementation and governance of tobacco control policies at the national and state level in India.

Methods:

To investigate this case study, we use a policy mapping and landscape analysis approach. This kind of analysis provides a map and aids us with an analysis of policies, actors, institutes and their roles. We conducted a document review exercise, reviewing 30 documents, comprising of policy and plan documents, acts, bills, grey literature, meeting reports/minutes. This was followed by key informant interviews, with government officials (decision-makers, administrators) civil society organizations, health system actors and others (academics, private sector), who are engaged in tobacco control policy development and have insider knowledge of the subject. Findings from the document review and interviews were thematically analyzed, and supported by a summary matrix.

Results:

In decentralized health systems, effective ISA is dependent on multi-level (and poly-centric) action. The national tobacco control programme was able to provide a structure and a platform for collaborative work through establishment on national and state level multi-sectoral committees, and simultaneously providing the financial support. These factors supported face-to-face dialogue, trust building, and the development of commitment and shared understanding. Political leadership and presence of policy entrepreneurs provided the force to drive and steer the process. Civil society organization participated during the phases of agenda setting, implementation, and monitoring and provided critical support. The fact that tobacco consumption threats health and well-being of populations provided a strong narration among other public agencies to provide the support and join the cause. Though despite these positive factors, challenges were observed in forming a collaboration, as the creation of structures for multi-sectoral participation was not enough in itself, it required constant follow-up from the health sector. Health sector also reported a change in their role, as not only being implementers but as brokers between other department requesting their support for implementation, moving away from a top-down to a more collaborative form of governance. This also posed a challenge in terms of determining the accountability structures within the programme, as the success rested on how collaboration was working together.

Conclusion:

The implementation of multi-sectoral interventions in addition to achieving a consensus around a common

goal requires identifying the strengths of each sector and preserving their autonomy. Building adequate structures for decision-making, attaining a clear leadership and legitimizing support from government and participating institutions as necessary conditions for steering the process of collaboration.

Collaborative governance and implementation of Intersectoral policies: A meta-narrative Synthesis

Shinjini Mondal (McGill University)

Sara Van Belle (Institute of Tropical Medicine/London School of Hygiene and Tropical Medicine)

Antonia Maioni (McGill University)

Background: The importance of collaborative governance in health has been reinforced in the age of the Sustainable Development Goals, to achieve health and societal goals. Such an approach mandates working across different sectors beyond health and calls for joint action with participating sectors. This working across sectors, intersectoral action (ISA), has been a long-held objective in the health sector. Nevertheless, ISA for health remains a challenge and requires more knowledge and a better understanding of the policy processes across all levels of governments. The concept of ISA spans across several research traditions and learning from other disciplines can contribute to bridging the knowledge gap of the application of ISA in health. We use innovative conceptual knowledge synthesis to explore the concept and application of ISA across health, environmental sciences, public administration & management sciences, thus sourcing knowledge beyond the health sector. To this date, there has been no synthesis regarding lessons learned from other research traditions.

Methods: We used a meta-narrative synthesis approach (Greenhalgh et al 2005, Wong et al 2013, Otte-Trojel & Wong 2016) as it “helps make sense of heterogeneous evidence about complex interventions applied in diverse contexts and ways to inform policy”. This review method also allows to explore conceptual approaches, different ways of its application, identify commonalities and differences, and inform and share learning to strengthen intersectoral practices in health policy research. We used keyword searches, in the database of Scopus, resulting in a selection by a multidisciplinary panel of 80 articles. We present a PRISMA flow diagram and use the RAMESES guidelines (Wong 2013) for the review.

Results: The review identifies key approaches on how different traditions conceptualize and apply ISA. The results of the review confirm the complexity of the issue, specifically, in generating political will, building capacities and common dialogue for policy change. The challenge of ISA runs parallel with the challenge of implementing policy across institutions, essentially multi-level governance and is both technical and political in nature. More attention has been given in health policy to technical aspects of implementing/operationalizing ISA. However, the politics and strategic issues of ISA in health require a better understanding of accountability structures, political mandates, values, and associated conflicts, as these have been mostly ignored in health research. Environmental sciences literature highlights adaptation of global policy to local implementation contexts and emphasizes collaborative governance, decentralization, and systems adaptation. The literature on public administration and management elaborates a continuous struggle to find an adaptive balance between (the virtues of) specialization on the one hand and coordination between institutions on the other, and the relevance of an enabling institutional architecture, such as distributive decision-making mechanism. This review also highlights the need for a better understanding of the implementation context, accountability mechanisms and of different institutional styles/modes of coordination and integration practices.

Conclusion: This review highlights and summarises the over-arching and conceptual understandings of ISA across different research traditions, which contribute to better understanding and devising an appropriate solution for the multifaceted challenge of ISA in heath.

Can Collaborative Governance Approaches Strengthen State Capacity and Improve Service Provision? Evidence from a Case Study of Multi-Sectoral Nutrition Programming in Senegal

Ashley Fox (Rockefeller College, University at Albany)

New forms of collaborative multisectoral public policy networks— networks of actors that cut across established political and sectoral boundaries—have been applauded for their potential to democratize governance mechanisms, but less attention has been paid to how multisectoral networks operate to shape policy in low- and middle-income country (LMICs) settings. Collaborative and networked multisectoral arrangements have become a popular mode of delivering public goods, especially in the context of the

“new” public management and when addressing so-called “wicked” problems. Supported by UNICEF, the Scaling Up Nutrition (SUN) movement is a country-led effort aimed at engaging a multi-sectoral and multi-stakeholder space to effectively work together to promote nutrition in LMICs. As part of their obligations as participants in the SUN movement, countries are required to adopt a multisectoral nutrition governance plan with a goal of raising government attention to prioritize nutrition and advance nutrition programming to a national scale, which bridges global and local networks. This paper explores a case study of Senegal, a country considered to be a relative success case in multi-sectoral nutrition programming, to analyze the politics of multi-sectoral nutrition governance. This paper first reviews the evolution of the public health literature on multi-sectoral nutrition planning. The article then reviews the public management literature on collaborative and network governance and multisectoral planning that provides important insights into improving service delivery and coordinating multisectoral action in low- and middle-income countries. Through in-depth interviews with policy actors (N=30), network mapping of ties and activities among actors and document review, the study identifies several challenges specific to scaling up multi-sectoral policies in emerging economies in the context of weak state institutions as well as several opportunities for multi-sectoral governance to further scale-up attention and funding to nutrition. Even within a relatively committed country with a higher than average degree of state capacity, a number of barriers to effective collaboration within networks remain. These include the relative power of non-state actors casting a “shadow of hierarchy,” duplication of efforts and a lack of incentives for multisectoral collaboration across different sectors within government. Lessons for other countries in the process of scaling up multi-sectoral nutrition programs are discussed.

Collaborative governance towards an integrated health sector response to intimate partner violence: Findings from a recent study in Sri Lanka

Vathsala Illesinghe (Toronto Metropolitan University)

Sepali Guruge (Ryerson University)

Intimate partner violence (IPV) is a violation of human rights and a significance cause of short- and long-term mental and physical health problems for women worldwide.[1] The healthcare sector plays a significant role in providing IPV-related services to women.[2] From a policy analysis perspective, the health sector response to IPV in low middle income countries (LMICs) has mostly been examined using the multiple streams approach(MSA).[3] Some critics of the MSA point to its limitations in settings where there is high interdependence between the problem, politics, and policy streams and the lack of attention to formal institutions role within them.[4],[5]

Based on interviews with women who had experienced IPV, surveys among nurses, midwives, and doctors providing care to such women, and document reviews, this paper presents findings of a recent study aimed at understanding the health sector response to IPV in Sri Lanka - a LMIC in South Asia. The collaborative governance structure which formalized the integration of health and non-health sector services is examined from an institutional perspective.

The aim of this paper is to discuss how institutional frameworks can influence collaborative governance structures, make them ineffective, and attenuate inequalities in women’s ability to access and benefit from IPV-related services in this setting.

Prior to the formal institutionalization of a gender-based violence prevention policy by the Ministry of Health in Sri Lanka, healthcare providers relied on informal arrangements to refer women to non-for-profit agencies outside of the hospital for services such as emergency shelters and legal aid. An integrated service model which aimed to formalize this process not only increased the burden and demanded more accountability from the non-for-profits, but also disproportionally reduced their access to funds and resources. Formal governing arrangements can fail to support existing or new feedback loops that were mutually-beneficial to partners when they are driven by top-down institutional policies rather than collaborative governing structures. The implications for designing integrated IPV-related care in LMICs such as, breakdown of partnerships and loss of local community trust in the program are discussed.

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Enhancing Coordination of Multisectoral Actions for Health in Low and Middle Income Countries: Perspectives and Propositions from Social Science Theories

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Sara Van Belle (Institute of Tropical Medicine/London School of Hygiene and Tropical Medicine)

Freddie Ssengooba (Makerere University)

Background and objectives: The Sustainable Development Goals (SDG) agenda underscores development challenges (such as urbanization, food insecurity, social exclusion and climate change) that have far reaching health effects. Responsibilities to solve such global “wicked”– socially complex problems are never within the remit of one single organisation or sector. However, achieving coherence in policy and practice requires mechanisms to facilitate coordinated and interdependent collaborative multisectoral actions. Despite the consensus that coordinating multisectoral efforts is critical, enhancing coordination among multiple actors is a chronic governance challenge. Therefore, it is important to explore how and why coordination mechanisms for collaborative efforts for health get developed and implemented at both central and local government levels. Whereas social science scholarship has advanced several theoretical perspectives pertaining to collaborative governance for multisectoral action in general, the relevance and implications of these perspectives to multisectoral action for health has not been fully explored. This paper analyses social science theories, summarises relevant empirical findings on their utility and considers their practical and methodological implications for the study of coordination of multisectoral efforts for health.

Methodology: Social science literature was reviewed to identify theories relevant to the study of how and why coordination mechanisms for collaborative efforts evolve overtime. The review focused on political economy (PE), organisation theory and transaction cost economics (TCE) theories. Several propositions were derived from these theoretical perspectives as hypotheses that can be tested empirically as plausible explanations for evolutionary pathways of multisectoral coordination mechanisms.

Preliminary findings: From the PE perspective, coordination mechanisms evolve as a result of a political (contested and negotiated) process influenced by how the different actors conceive their motivations and balance multiple sets of interests and maneuver through a complex power context. According to the TCE perspective, the consideration of the costs of exchange relationships and the need to reduce these costs are the main drivers of decisions on coordination mechanisms. The organizational theory perspective (organizational sociology) posits that evolution of coordination initiatives can be explained by decisions of actors influenced by the organizational structure and modes of operation of the public sector.

Scientific Relevance: This study advances the argument that collaborative efforts to advance health objectives should be contextualized within broader social science theory (such as organizational theory (sociology) and political economy (political science/economics)) and draw on scholarship from political science to understand challenges and opportunities in public sector management.We propose that using the different perspectives in a complementary manner is critical for understanding coordination of multisectoral actions for health as a complex phenomenon such as coordination can only be explained through a multifaceted approach. This work is expected to inform efforts within the public health domain focused on adoption and implementation of appropriate coordination mechanisms for collaborative efforts to advance health improvements.

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Session 2Collaborative governance and health inequities in low- and middle-income countries: private sector engagement and views on public accountability

Thursday, June 27th 10:30 to 12:30 (MB S1.435)

Private Sector participation in India's journey towards UHC through Ayushman Bharat: Implications on Accountability

Deepika Saluja (Oxford Policy Management)

Despite being one of the primary justifications provided for increased private sector participation, the idea of accountability (Blanchett & Tolley, 2001) has not been clearly defined in the literature. Being confused with terms like responsibility, answerability, governance, responsiveness, regulation, and control, it remains 'a complex and chameleon-like term' (Mulgan 2000) and an elusive and much-contested concept (Bovens et al. 2014). In this paper, we attempt to probe understanding of this term by studying the design of the health financing component of India's recently launched Ayushman Bharat (National Health Protection Mission). The programme is labeled as a public-private partnership model with public financing and private provisioning. The Government pays the premium on behalf of the beneficiaries and healthcare services are provided by a network of empaneled public and private insurance companies, hospitals, third-party administrators. Evaluation studies on Rashtriya Swasthya Bima Yojana (Ayushman Bharat's predecessor) have shown mixed results in terms of outcomes like enrolment rate, utilization rate and out-of-pocket expenditures specifically (Das & Lieno, 2011; Gill & Shahi, 2012; Patel et al., 2013; Selvaraj & Karan, 2012, Ghosh, 2017, 2018). Some unintended consequences of the scheme such as increasing hysterectomies, a high percentage of claims towards preventable illnesses have been found (Desai, 2009). Additionally, ineffective IEC (Information, Education & Communication) activities, poor grievance redressal and delays in claim settlement have also been brought up as the major issues hindering the implementation (Trivedi & Saxena, 2013). Thus, in a way, the evidence points toward the need for a greater and serious role of government in holding the respective stakeholders accountable for their tasks.

Following Wettenhall (2013), we argue that bringing external private partners into the system potentially complicates the dynamics and leads to horizontal relationships in addition to the existing vertical chain of control and responsibilities Thus the nature of accountability in the system becomes multi-level and more interactive, thereby making the individual level conceptualization of the phenomenon incomplete and potentially misleading (Frink et al. 2008).

Pointing to the nature of complexity in the understanding the term and its arrangements, we attempt to unpack the different dimensions of accountability and its relationships amongst different actors in the governance and design of National Health Protection Mission. In doing so, we point to theoretical and conceptual gaps that need to be addressed for the idea of accountability to have real meaning in policy discourse and evaluation.

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Partnership and Collaboration in Healthcare delivery in Ghana

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Bannasco Francis Ampong-Ansah (UNIVERSITY OF GHANA)

Otchere Lucinda Naomi (University of Ghana)

Ama Boateng (University of Public Service)

The quest of most state governments to adequately cater for the healthcare needs of its people continues to be a difficult task. Most state governments find it difficult in recent times to expand their facilities to cater for health care provision in their countries. Many states have experienced and continue to experience a reduction in allocation of resources to health sector. This has affected the ability of the state to provide for the efficient delivery of health care services to the population. It is argued that since the capacity of the state has proven inept to provide for some of these services, there is the need for other actors to come in to help. In India for instance, the involvement of the private sector in health care delivery is another option being explored by a number of states to augment resources in the health sector. In some African countries like Democratic Republic of Congo partnership between the public and the private healthcare facilities have been seen in the fight against AIDS, Tuberculosis and Malaria. In Ghana, there have been some form of partnership existing between the public health institutions and the private sector to deliver healthcare service. Example is the coalition of non-governmental organizations in health which is seen to be working in some parts of the northern part of Ghana with the state actors like the Ministry of Health, Ghana Health Service in tackling issues on non-communicable diseases. However not much empirical studies have been conducted to identify and better understand these partnerships between the state agencies and the private sector. This study therefore sought to answer the questions of what range of partnership and collaborative activities exist between public and private healthcare institutions in Ghana and also the need for these collaborations. The study adopted the stakeholder theory as various stakeholders come together to ensure the delivery of healthcare in Ghana. The healthcare system usually involves stakeholders which comprise of the public and private facilities, the stakeholder theory is therefore used to analyse the roles of these stakeholders, their interest and their challenges to ensure an effective partnership a health service delivery. It was revealed that there existed no form of direct partnership between the Ghana Health Service and the private health facilities. That notwithstanding, there is some collaboration between them which most of them were just ad-hoc. Some of these were to mark celebrations like World Aids, Tuberculosis and other days. The collaborations that was identified between them seems to have existed for a long time now has been the transfer of patients from the private to the facilities under the Ghana Health Service without any hindrance and the vice versa for specialist services. The perceived need for collaboration that was identified under the study was for the protection of human lives. The study concluded that this collaboration is necessary to ensure an efficient healthcare delivery.