Neglected Health Systems Research: Governance and Accountability

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Key Messages

- Governance, that is how political, economic and administrative authority is exercised within the health system, is an important dimension of the planning, organization and performance of health systems, yet only limited knowledge and understanding is available to inform policy and practice.
- Research on governance and accountability has been neglected. It largely focuses on specific health interventions or services, with little work on the effectiveness of different regulatory, incentive, oversight, participation or decision making options for wider health systems, including at the global level.
- Work in this area faces conceptual, analytic and design challenges and the contested, political nature of the issues may discourage research and researchers.
- These barriers are not insurmountable: conceptual, analytic and design challenges can be addressed through reviews of analytic methodologies and multi-country studies, including historical analyses, using shared analytic frameworks on common themes and widening use of innovative tools. Demand can be strengthened through integrating research on governance within national policy development and strategic review processes, and through civil society- researcher links in community based and participatory action research.
- While national authorities should support research on governance issues relevant to national policy and plans; multi-country and community based research calls for wider institutional funding from international agencies and research funders.
- Research on governance and accountability not only fills knowledge gaps, but can and should build the networks of actors and processes for dialogue, shared reflection and analysis that are important for policy and practice.

Alliance for Health Policy and Systems Research

World Health Organization

Governance and accountability count in health systems

Historically, public health planning has been a top-down process, driven by expert identification of priorities and strategies. But health systems not only produce health care and impact on health, they also can shape wider norms and values. While they may reflect existing patterns of social inequality, they also provide a site from which to contest them, contribute to social cohesion and build and sustain social and political support for governments (Gilson *et al.* 2007). The design and functioning of health systems is not simply a result of technical knowledge and capacities. Health systems are shaped by the choices made by political actors and by how leaders and managers exercise authority. They are a product of decisions about how resources should be raised, allocated and rationed, how public inputs are organized and listened to, and the signals sent to health workers about their roles, orientation and performance. These features of governance and accountability are recognized to be central to the performance of health systems, even while there are debates as to how they should be organized and measured (WHO 2000; Navarro 2001). They have become of even greater importance in recent years with mounting political and leadership challenges.

People have become more informed and aware of their rights to health: Informed populations and civil society organisations from local to global levels are making increasingly vocal claims for governments to meet rights to health and health care, to be accountable for their health actions and to give people meaningful opportunities to participate in the decisions that affect their health. Institutions and people responsible for health systems have had to answer to an increasingly informed public and media for their policy choices and performance in the allocation and use of resources. This draws attention to the effectiveness of the measures implemented to respond to such public demand, from decentralization of health services planning and management to more ad hoc, popular processes involving social groups in policy formulation (Gilson *et al.* 2007; Brinkerhoff 2004; Cornwall and Shankland 2008).

There is greater demand for leadership of public and intersectoral action in health: Non communicable diseaseslike heart disease, diabetes and stroke are now the major sources of death in all regions, except Africa. Significant advances have been made in treating these conditions, but this is neither sufficient, cost effective, nor sustainable when people are returned to the conditions that make them ill. If health systems are to avoid escalating and costly demands for chronic care, their leadership needs to engage communities, industries and services involved with areas such as food, tobacco, media, markets, transport, housing about how their policies and practices affect health. They need to inform and motivate people to make choices and take actions that promote their health, to regulate or create incentives for enterprises to make commercial choices that promote health, and to organise collaborative action across other sectors to ensure health promoting practice (Nishtar 2004; WHO EURO 2006). There is increased demand for the long term vision, policy and regulatory capacities needed to manage the diversity of public and private actors within and beyond the health sector that influence health, capacities that are not always found within ministries of health at national or sub-national level (Siddiqi *et al.* 2006).

Health planners need to demonstrate fairness in a context of scarcity and inequality: With increasing demands and possibilities for care, escalating costs and limited resources, health planners need to set priorities and ration care. Fairly managing the competition for policy attention and resources is critical, given the wide disparities in health and in access to health care resources and services within many countries, and globally. New information technologies have widened the scrutiny by professionals, the public and the media on decisions made by those in authority. Questions are being asked: How fair is the allocation of resources? How are decisions perceived and processes managed for those working within the sector as well as those using the services provided? How effective are the processes for adjudicating and managing different interests in health? How legitimate the decisions? How far are decisions eroded by informal payments and corruption? (Brinkerhoff 2004; Lewis 2006; Sabik and Lie 2008; Siddiqi *et al.* 2006).

National health systems are increasingly influenced by international policies and agreements, and cross-border market forces: This brings the opportunity of new resources through global initiatives and partnerships, new technology and information access. It also brings a range of

challenges, including global pandemics, health impacts of ecological disasters and climate change, global out-migration of health workers, managing influence from global levels of health governance and from external interest groups at national level, dealing with unregulated financial outflows and reduced levels of national authority to regulate goods and services, and managing powerful transnational interests in health, such as from the pharmaceutical sector (Bloom *et al.* 2007; Siddiqi *et al.* 2006; Travis *et al.* 2004).

In the face of such trends, "governance and accountability" has emerged with new vigour in the pronouncements of finance and bilateral aid institutions. The issue is raised in the 2006 World Bank World Development Report as a key determinant of poverty, in the UK government "Report on the Commission for Africa" as key to development prospects and in the US government's Millennium Challenge Corporation as a criterion for funding (Lewis 2006). This has been responded to with some scepticism and caution from low and middle income countries, invoking the democratic deficits of colonialism, of structural adjustment reforms and in the current institutional mechanisms for negotiation of global trade policies. At the same time, there is growing awareness in the same countries of the need to strengthen the mechanisms and capacities to tackle these demands particularly within the public sector and within civil society.

New responsibilities and powers in managing cross border risks to health: Antimicrobial resistance (AMR) poses the problem of leading infections becoming resistant to treatment. It arises not only due to weak services and treatment practices, but also the use of antimicrobial drugs to promote growth of food animals. The scale suggests far reaching responses that call on national governments to report public health risks of urgent international importance in such a way that outbreaks of drug resistant diseases can be caught early. However with most the World Health Organization (WHO) rules and guidelines not obligatory or binding, and this issue not yet included in international health regulations, countries are not obliged to comply and may also have weak capacities to do so. The interdependence of national and international governance needed, and the failure to have binding rules that bind states undermine the response to AMR. In another area, tobacco control, WHO has moved away from its information and guidelines role to adopt a convention that contains rules that binds states under international law to reduce tobacco consumption.

Source: Fidler 2003

This is not only a matter for national, or sub-national level. The absence of global procedural guidelines for managing global and international influence and authority in national health systems exposes countries with weaker public sector capacities (Mills *et al.* 2001; Nishtar 2004b). In recognition of this, there has been global advocacy, including from the United Nations for attention to issues of *global governance*. Calls have been made for stronger mechanisms for ensuring global accountability (Labonte and Shrecker 2007).

What do we mean by governance and accountability?

There are a range of meanings given to the terms governance and accountability, within and beyond the health sector. Concepts and analysis of governance draw largely from political and social sciences. Generally in this paper '*governance*' is understood to refer to the traditions and institutions by which authority is exercised and encompasses capacities to formulate sound policies, generate intelligence, manage resources, exert influence through regulation, provide services efficiently and ensure accountability; including through processes that allow citizens to select and hold accountable, monitor and replace government (Lewis 2006; Plochg *et al.* 2006). '*Accountability*' is a component of governance that refers to the responsibility and ability of one group to explain their actions to another (Hyder *et al.* 2007). The World Health Report 2000 (WHO 2000) uses the concept "stewardship" to capture these functions, although it has thus been suggested that "governance" is a more comprehensive, widely recognised, and thus preferable term (Siddiqi *et al.* 2006). Equally the understanding and learning on governance from other sectors and disciplines represents a resource that could be usefully tapped for the health sector.

In the United Nations system alone, there are different definitions and conceptualisations of governance, with

- the United Nations Development Programme (UNDP) calling it the exercise of political, economic and administrative authority in the management of a country's affairs at all levels, encompassing **"the complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations and mediate their differences"** (WHO EURO 2006);
- the World Bank dividing it into six dimensions: Voice and accountability, political stability / absence of violence; government effectiveness; regulatory quality; rule of law and control of corruption (citing World Bank in Menon Johanssen 2005);
- the World Health Organization using the concept of stewardship, as **"the careful and responsible management of the well-being of the population"** and involving formulating health policy, defining the vision and strategic direction, exerting influence, including approaches to regulation and generating and using intelligence (WHO EURO 2006).

Health systems have begun to integrate a wider vision of governance. While health systems have had a longstanding focus on professional accountability in medical care services, this has usually been exercised by physicians establishing standards and holding each other accountable through professional organisations (Emanuel and Emanuel 1997). This singular conceptualisation, now outdated, has been replaced by concepts that include accountability for *financial control and management*, for *heath service performance* (professional competence; access, public health promotion, legal and ethical conduct), and *political/ democratic accountability* (directly involving the public and including community benefit) (Brinkerhoff 2004; George 2003; Murthy *et al.* 2005). *Financial accountability* typically encompasses compliance with laws, rules and regulations regarding financial control and management; whereas *performance accountability*, encompasses public sector management reform, performance measurement and evaluation, and service delivery improvement. Discussions of political or democratic accountability range from theoretical and philosophical analyses of state-citizen relationships, to discussions of governance, increased citizen participation, equity issues, transparency and openness, responsiveness and trust-building. Various sources describe a spectrum of public involvement covered by the term 'participation', from information sharing, to consultation, to involvement and collaboration in joint action, with higher levels of participation finally associated with decision making being placed in people's control (Loewenson 2007). People exercise this involvement through mechanisms for individual or collective *voice*; mechanisms for *representation* in decision-making (eg. health management bodies, boards), and mechanisms for exercising individual or collective *choice* (WHO EURO 2006).

Yet research on governance and accountability in health is neglected

At a meeting in May 2008 of the Alliance for Health Policy and Health Systems Research, delegates from north and south, government, research institutions and civil society concurred that there was still weak understanding of governance and accountability issues within health systems, and that the issue was poorly researched. Funding for research to generate new knowledge in this area was reported to be difficult to obtain: researchers may have to embed work on governance within funding for more traditional epidemiological, health systems and biomedical research (Alliance HPSR 2008).

Publication is one indicator of the volume of research. Looking specifically at the health sector, journals publishing research on health policy and systems have limited coverage of governance and accountability, particularly in low- and middle-income countries. What is being done, particularly in low income countries, is often difficult to access, for reasons of language, or because it is only documented in the grey literature (Gilson *et al.* 2007; Hyder *et al.* 2007).

While no systematic reviews could be found specifically on governance or accountability in health systems, there are a range of reviews that touch upon the subject. Within health systems, much of the prior work is focused on decision making tools, incentives and management systems to support patient safety, health interventions, or quality of specific health care

services. Reports from 42 different research studies show, for example, evidence of the positive effects of patient involvement on both patients and service provision, although this may also reflect a bias towards publication of successful interventions (Crawford *et al.* 2002).

The analysis of governance issues and decision making processes in larger scale health interventions, such as tobacco control, is far less common, and probably also more complex (Ranson *et al.* 2002). Equally it appears that we have weaker research knowledge on wider dimensions of governance and accountability in health systems, particularly in relation to democratic (political) accountability. More detailed and specific knowledge appears to exist on performance and financial accountability. For example research has been done to assess regulatory and incentive regimes, and to explore the impact of mechanisms for participation and empowerment on specific areas of quality of care or public health outcomes (George 2003). There is also a body of knowledge from research on financial and management issues, highlighting, for example, effects of absenteeism, corruption and informal payments on health care services (Lewis 2006).

Less is known however on the wider effects on health systems of efforts to strengthen empowerment or accountability (Brinkerhoff 2004; Wallerstein 2006) or on the experiences and effectiveness of regulatory or oversight efforts on health systems (George 2003). Yet it is precisely in these wider areas that those investing, participating in or planning health systems face greatest challenges. Even less is known about the impact of different incentives, mechanisms and processes for global governance.

Efforts to explore the relationships between governance and wider dimensions of health system performance through cross country analyses have used methods such as correlation between specific measures of governance and specific measures of health and health care outcomes, such as associations between corruption and infant or child mortality, or likelihood of an attended birth (Lewis 2006) or between the six dimensions of governance set by the World Bank and HIV prevalence (Menon Johanssen 2005). This type of work faces problems in the varying definitions and contexts across countries and in health outcome estimates with high error margins, weakening confidence in the findings and their interpretation.

Hence even while there is a body of knowledge in more specific elements of governance relating to financing or management of specific health interventions, there is a large research gap with respect to the broader issues of how different policy choices and mechanisms affect the performance and impact of health systems. Overall,

- The **political dimensions** of governance and accountability, while given some attention at the micro-level or in relation to specific mechanisms for voice, are less well researched or understood at national level, more so at supra national level;
- The **heath service and clinical dimensions** (ranging in scope from formulating policy to issues of professional competence) are better addressed, but also more at micro-level, with weaker knowledge on health system wide issues and processes while;
- There is more evidence of research on **financial dimensions**, at least in the published literature.

These knowledge gaps, particularly in relation to health system wide and political dimensions, are not unique to particular regions, but are greatest for low income countries (Malhotra *et al*. 2005; Manandhar *et al*. 2004). If these knowledge gaps are to be addressed, then we need to understand better the barriers to doing research on these wider, but important, dimensions of governance and accountability in health policy and systems.

Barriers to research on governance and accountability

Work in this area faces conceptual challenges: Enquiry into governance is often cross-disciplinary and wide-ranging. As noted in previous section, the terms are often ill or differently defined, difficult to measure and thus difficult to monitor (Hyder *et al.* 2007; Lewis 2006). Accountability has, for example, been termed a "*complex and chameleon like term*" (Mulgan 2000 in Brinkerhoff 2004 :p372). Empowerment, a concept used in work on governance, is as complex as it is intangible- a latent phenomenon that can only be deduced from individual or collective actions (Narayan 2005).

Added to this diversity of definition, researchers approaching these concepts from different paradigms are interested in and

measure quite different outcomes, further fragmenting knowledge on the issue. For example, when the health system is examined with an economic lens, health care can be conceptualised as a commodity, where *exit* (changing providers, choice) is the dominant procedure for accountability. Using a political lens, health care is a community good, and *voice* (ability to get information, communicate views in public forums, challenge government and ensure services) is the dominant procedure for accountability (Lewis 2006; Emanuel and Emanuel 1997).

Work in this area faces design challenges: Health system reform often has numerous elements and goals, making it difficult to track and explain effects of changes in governance or accountability alone (Gilson *et al.* 2007; Siddiqi *et al.* 2006). Rapidly changing situations, where roles and positions are being renegotiated may complicate research processes (Hyder *et al.* 2007). A proportion of health system activities, significant in some countries, take place outside formal rules and national legal frameworks. This unstructured environment can make it difficult to design work or to reach the actors involved or the agents that influence them (Hyder *et al.* 2007). Added to this, answers from such research can be *"slow to arrive and uncertain"* given the complexity of associations and long term nature of change, while the problems have been reported to be seen as primarily political, *"therefore best solved using common sense rather than evidence"* (Travis *et al.* 2004).

The design and impact of most health system changes are thus usually highly context-specific, limiting generalization to other settings (Gilson *et al.* 2007). With some policy and decision making shifting to global institutions and private forums, information relevant to governance issues may be outside the reach of national or public sector actors (WHO EURO 2006). Studies on governance do not lend themselves to randomised control trials, making interpretation of causality of policy and effects more difficult. More suitable approaches, including participatory methods and participant observation may be time consuming, intense and less well received as sources of evidence (WHO EURO 2006). Lack of timely and comprehensive routine health information in the public sector adds a further barrier, and it is often difficult to access information from formal and informal private providers (Mackintosh and Koivusalo 2005). Outcomes are thus often qualitative and perceptions of outcomes are often used as a proxy measure of outcomes.

These conceptual and design issues lead to an impression of disconnected local studies, insufficient to facilitate learning across settings and to build a comprehensive and systematic body of knowledge.

Weak support, contested agendas or political opposition may discourage researchers: Research that examines accountability and power may not be welcomed, especially when it is perceived that it could expose corruption or misuse of power for example in conflict situations, in rapidly commercializing or liberalizing environments, or where there are weakened state structures. And yet it is precisely in these environments where information may be most useful to promote ethical practice and social justice in health. Marginalised groups and providers that have an interest in fair process and transparency often have less resources, less understanding of research and less power to exercise demand over academic institutions. The values that draw some researchers to this area may be perceived to compromise 'scientific neutrality'.

The research agenda on governance issues can be highly contested, discouraging some researchers. Private and public providers may be equally committed to research that investigates the clinical effectiveness of treatment regimes. However their priorities for research on governance of health systems may be far less uniform. Private, commercialized providers interested in market leadership may invest in research that informs them about what motivates 'customers' to chose or exit particular services, or about how to improve financial accountability to control financial risks. Public sector providers may be more concerned with understanding how to prioritize, ration and allocate scarce resources in ways that meet population needs and are also perceived as fair and legitimate.

It is not only institutional providers that may fragment or limit the research agenda. Higher income groups that make greater use of public health care may discourage research into the decisions that privilege them, unless there is a counterbalancing demand from less powerful, less wealthy or more marginalised groups, such as through strong civil society organisations (Gwatkin *et al.* 2004). Ironically support may be weakest in precisely those situations where the distribution of authority undermines service delivery. Managers at local levels of health services, for example, have limited incentive to investigate problems when they are powerless to institute changes to correct any deficiencies found (McNamara 2006).

Moving forward: Research that would make a difference

These barriers to research are not insurmountable, and a better understanding of effective options for managing governance issues would have wide potential benefits to health systems. Health system managers and policy makers frequently make decisions on key aspects of governance of health systems. Whether about regulating commercial food markets, creating incentives to retain health workers, or setting up mechanisms for public monitoring of health services delivery, they often do this with a weak evidence base to support them. Given the significant impact of these decisions, this seems akin to doing surgery with a blunt kitchen knife.

Contributing to knowledge on policy and action: Much research and evidence on governance is context specific. The gaps in knowledge appear to focus largely on how different policy choices and mechanisms relating to governance and accountability affect the performance and impact of health systems as a whole. Research priorities could thus be closely linked to the questions that policy makers want to see addressed (Travis *et al.* 2004). Specific priority themes arise out of country and regional contexts, or from specific global processes. There are numerous examples of areas that would lend themselves to qualitative and quantitative approaches, such as those applied by Siddiqi *et al.* (2006) to the processes for contracting of non state actors in health (see box below). This includes assessing the effectiveness of regulatory versus incentive approaches to encouraging equitable health worker deployment; the management of rapid change within health systems, as has been experienced in the transition economies; the effectiveness of public health policies in managing harmful food marketing practices; or the health systems outcomes of different mechanisms for aligning international and global funds to national policy goals. Linking systematic reviews and multi-country studies to questions of direct policy relevance on governance would usefully organize existing and new knowledge.

Multi-country research on contracting processes: A study on contracting out of services to non state actors in ten Eastern Mediterranean Region countries examined the processes for contracting and the capacities and factors influencing these processes. Open ended checklists of agreed parameters were used, with some flexibility for country adaptation, but adequate common terminology and information for comparability. The study collected both qualitative and quantitative information, through document analysis, key informant input, electronic networking and on-site monitoring of country investigators and review by national policy makers. The checklist, e-networking and on-site monitoring enabled cross country comparison, as did the focus on process rather than outcomes. The study drew conclusions on the public policy environment, legal and administrative frameworks, and public sector capacities needed to support contracting of non state actors.

Source: Siddiqi *et al.* 2006

Designing research on governance and accountability in health: Research in this area calls for a range of study designs, a mix of qualitative and quantitative methods, across different disciplines, particularly bringing together health researchers and political scientists (Travis *et al.* 2004). A range of techniques can be used, including review and analysis of historical cases or processes, institutional analyses, or comparative historical studies. Internet and communications technology have demonstrated potential in gathering and disseminating information in research on governance, particularly for comparisons across countries and settings (Siddiqi *et al.* 2006). There is evidence of creative adaptation of tools used in other settings to work on governance, to facilitate quantitative and cross country analysis (Daniels *et al.* 2000, see box below). This signals the potential of making collaborative links between health and political science fields and methods, given the longer and deeper experience of research on governance in the latter.

Developing research and analytic tools: A five country team adapted a policy tool originally developed for evaluating health insurance reforms in the United States into 'benchmarks of fairness' for assessing health systems reform in developing countries. A common concept of fairness was used to develop standardized criteria for different dimensions of fairness, organized as benchmarks. Benchmark 8, for example, on "democratic and accountability" was assessed though eight measurable criteria, such as 'measures for enforcing compliance with rules and laws'. The benchmarks were field tested, and reforms scored on both intention and implementation. Reforms were evaluated on a -5 to +5 scale with zero representing the status quo, and the results used to promote discussion on trade offs of different effects of the reforms. The researchers observe wide agreement on the framework across different political and cultural settings.

Source: Daniels *et al.* 2000

Within the health sector, there has been a bias towards experimental or quasi-experimental designs in field research, particularly to address generalisability and quality of evidence (Wallerstein 2006). As observed above, such designs are not necessary to achieve the data quality needed for new knowledge on governance in health systems. At the same time whether for historical analyses, qualitative approaches or quasi-experimental designs, there is a need for a greater level of sharing of analytic frameworks, parameters, concepts and terms.

Are randomised controlled trials relevant and possible in research on governance? The importance of consumer involvement in health care is widely recognized. Consumers can be involved in developing healthcare policy and research, clinical practice guidelines and patient information material, through consultations to elicit their views or through collaborative processes. A review was done of research published in data bases and grey literature on the effects of different methods of involvement in developing health care policy. A range of research methods were reviewed: randomised and quasi-randomised trials, interrupted time series analyses, and controlled before-after studies.

The review found little evidence from comparative studies of the effects of consumer involvement in health care decisions at the population level. The review did, however, demonstrate that randomised controlled trials were useful and feasible for providing evidence about the effects of consulting consumers to inform health care decisions.

Source: Nilsen *et al.* 2006

One contribution towards this sharing of analytic frameworks and terms may be to implement a review of experimental and observational methodologies for assessing health and health systems outcomes from different dimensions of governance (policy formulation; public involvement in decision making; political / performance / financial accountability, political stability; government effectiveness; regulation; rule of law and control of corruption). Such a review could examine the definitions and parameters used, the nature and effectiveness of different methods, the limits, constraints and sources of bias and methods for dealing with them, to inform and encourage future research, using experimental designs.

Stimulating learning across different contexts: While review and exchange on methods would strengthen the design of research, previous discussion highlights that the generalisability of research findings are limited by diversity in the socio-economic and political context of health systems. One option for addressing this, and for providing useful exchange on contexts, concepts, methods, would be to implement research on governance and accountability within multi-country research programmes. Multi-country programmes of field research can share analytic frameworks, parameters and design, to address shared research questions that arise from policy processes or from single country examples or case studies. They can also discuss and develop shared approaches for how to address the practical problems facing such research, such as the impediments to accessing information from the private and informal sector, or the measurement of outcomes that are subjective in nature. Studies of impacts of decentralization on health systems (Bossert 2000) are one example of such an approach.

Supporting demand for research on governance and accountability: The political and institutional dimensions and implications of work in this area means that research on governance and accountability is more likely to be stimulated and supported when there is demand from policy and practice. To some extent this means going upstream, to strengthen the strategic management around health systems, and the demand for evidence to exercise this function. This itself is a governance issue, as national and international authorities, civil society and financing agencies are becoming more demanding of evidence based planning not only on *what* is to be done in health systems, but also on *how* it is to be done. For researchers, national or regional policy development or strategic review processes are important sources of demand for research on governance and accountability. In Sweden's National Public Health Strategy and Chile's Intersectoral Policy Development, for example, background papers were commissioned from expert groups to gather evidence from existing operational research, to inform the design and management of legal and incentive systems, inform mechanisms for action across sectors of government, and to explore the effectiveness of mechanisms for responding to public preferences, especially for groups with highest health needs (Public Health Agency of Canada and Health Systems Knowledge Network 2007). Such strategic review processes can mobilize researchers, civil society, health workers and officials towards shared policy goals and a shared agenda for follow up research, to explore the effectiveness of the approaches implemented.

Demand for research on governance and accountability is also coming from civil society. Strengthened links between researchers and civil society have created enabling environments for community based research in this area. Various types of monitoring, such as social audits and community score cards, have enhanced local accountability in service provision and built public involvement in health.

Other innovative approaches exist for work on governance. The loop between research and practice, and between knowledge and the communities affected is more tightly closed, for example, through participatory action research (PAR) processes. PAR provides an opportunity for knowledge and evidence to be generated within communities and local health services. It links research directly to change processes at the local level and can positively transform through research the communication and relationships between the different actors that influence the health system.

Linking research to change: Participatory research in Mumbai encouraged auxillary nurse midwives (ANMs) to listen to their clients and to reflect on the lives women lead. As a result, they no longer saw the women they were serving as guilty, problem cases who needed to follow orders. They now tried to see the reasons behind these women's problems. This changed perspective had spill over effects on both the ANMs' work and home contexts in Mumbai. The insights and experience gained from the guided exploration of their environment led to improved communication and group facilitation skills which they were able to use with their fellow colleagues and supervisors. Within their homes, ANMs learned to share responsibility rather than shoulder work alone and they learned to listen to others, especially to adolescent girls within their families. ANMs in rural Karnataka, when supported by more flexibly minded supervisors, similarly responded to the move away from contraceptive targets in ways that were more supportive of community needs. Despite increasing workloads, they gained the respect of both communities and supervisors, which served to transform their jobs.

Source: George 2003

Application of this research approach in a network of PAR work in East and Southern Africa demonstrated impacts on voice and accountability within marginalised groups, improved quality of and uptake of local health services and improved communication between health workers and communities (EQUINET SC 2007). While these positive gains are not an inevitable outcome of PAR, participatory research on different dimensions of governance in health systems from countries as widely spread as Bolivia, Brazil, Cambodia and Kyrgyzstan were reported to generate knowledge in ways that enhanced involvement in health planning, improved service quality and outreach, and reduced communication barriers for individual patients (Lewis 2006; McNamara 2006).

Funding and organizing research and knowledge networks: This paper suggests that there is both need and demand for research on governance and accountability in health systems and that there are options to overcome the contextual, conceptual, design and institutional barriers that have led to neglect of this area. These remedies however demand resources.

National authorities can and should invest in areas that have specific immediate relevance to policy processes and strategic plans. Investment in multi-country research, important for methodological and analytic development, and in community based research with civil society, important for stimulating uptake of findings, call however for wider funding sources- from international and academic research coalitions and from international agencies. These investments and processes are important to strengthen the quality and uptake of national work. Sensitivities on how funding sources influence agenda's in an area that is often viewed as political need to be recognised and responded to, so that they do not discourage investment in multi-country and community work. It points to the need for resources for multi-country and community based research to come from a wider range of respected research institutions and funders.

While facing all the difficulties documented in this paper, work on governance and accountability has the potential to gather the actors that contribute to health systems to not only generate new knowledge, but also to generate the dialogue, self reflection and analysis that more directly uses this knowledge for policy change and offsets policy opposition (Kwon and Tchoe 2005). The context specific knowledge, the relevance of subjective experience and perceptions as evidence and the need to manage the political processes in work on governance and accountability suggests a need to shift the paradigm from "research" to "knowledge creation and management" (Delisle *et al.* 2005:p3). In this, evidence can be conceptualised not simply as the rational, objective, set of facts it is sometimes made out to be; but rather as forms of knowledge – partial perspectives – forwarded by particular people and institutions, and sometimes contested by others (Hyder *et al.* 2007). Research on governance is then not simply a pure, rational quest for technical fact but "the establishment of facts within particular networks". The research stimulates and supports these networks, and their stability and influence is an important determinant of policy change. Research on governance and accountability offers unique potentials for catalysing such networks and deriving knowledge and learning from them, turning knowledge to practice and neglect to nurture.

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- Promote the dissemination and use of health policy and systems knowledge to improve the performance of health systems;
- Facilitate the development of capacity for the generation, dissemination and use of health policy and systems research knowledge among researchers, policy-makers and other stakeholders.

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