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Literature Review on Governance and Maternal Health[1] Undertaken for CARE USA, Policy and Advocacy Unit

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Abstract: Health sector interventions tended to focus only on technical matters of medical and technical issues, but the rise of the governance concept has broadened the health intervention areas to include socio-economic and political issues, such as civil participation and human rights. Recent literature shows that health interventions at the community level have been effective in improving health systems as well as governance – strengthening health systems is in sync with improving governance. Now, governance is a major component to strengthening health systems. Thus, maternal health interventions can be designed and implemented strategically by incorporating the governance perspective.

Contents:

[1] This literature review is prepared as background research for the LIFT-UP research in Tanzania.

Executive Summary

Governance became one of the important themes in the development discourse in the mid-1990s. Governance is broadly understood as processes/mechanisms of decision-making and implementation of the decisions. The processes/mechanisms are affected by **institutions** such as laws, policies, political and judiciary systems, norms, practices, and administrative structures. These institutions shape the functioning and **interactions** of the governance actors, i.e., (1) the public sector; (2) the private sector; and (3) the civil society. The nature and quality of the interactions between the actors ultimately determine governance outcomes. Recently, an increasing number of development agencies are reframing their development strategies within the governance framework, emphasizing the **reciprocal interactions** of all the actors. As opposed to the old trend of narrow interventions only on the government side, recent literature shows more interest in mainstreaming citizens' voices, aiming at making governments work better and making citizens hold the government accountable.

Looking at the discourse in the health sector, the Alma Ata Declaration in 1978 set the first international guiding values: primary health care (PHC) with substantial community involvement. The debt crisis in the 1980s shifted the focus towards cost-effective health care and user fees to tackle the severe shortage of resources (e.g., the Bamako Initiative in 1987). In the 1990s, the World Bank promoted the concept of health sector reform (HSR), insisting that the private sector should meet health care needs with limited interventions by the public sector, and the PHC concept was almost forgotten. However, the concepts of "human rights" and "governance", which advanced in the overall development discourse in the 1990s, gradually permeated the health sector. As a

result, health issues are now discussed in a broader socio-economic development framework, emphasizing rights and equity issues; and in the governance framework, stressing improvement of processes and institutions, rather than focusing on mere medical/technical issues. In fact, the Millennium Development Goals adopted in 2000 articulated health issues from the stand point of human rights and touched upon governance issues.

Recent literature indicates that governance is becoming an explicit issue in health interventions. There has been a realization that health problems of the marginalized need to address the governance issues, such as participation of the most marginalized people in shaping health policies, and accountability and responsiveness of the government. Also, PHC has become a major health intervention strategy. The recognition of the need to give greater voice to the most marginalized, permeated through human rights and governance perspectives, may have supported the come-back of PHC in the discourse and practice.

Recent discussion in the maternal health sector recommends strengthening of the PHC system from community-based interventions to the first referral-level facility. Construction of such a well-functioning health system that requires the continuum of household-community-facility is not only a technical issue, but also a governance issue, because it involves creating institutional arrangements (such as policies, values, and infrastructure that are more participatory, equitable, and accountable) that allow all the actors – the state, private sector and communities/citizens – to interact well. In this way, the intervention strategies of maternal health are incorporating governance issues and becoming more holistic. There are many success stories of improving maternal health through addressing governance issues, whether interventions are government-led (e.g., the example from India) or citizens-led (e.g., the example from Peru).

As recent maternal health literature focuses on PHC, interventions inevitably involve communities. An extensive literature review by WHO shows that community empowerment is a viable public health strategy. Case studies of maternal health interventions at the community level in literature as well as CARE's own experiences suggest that interventions are successful if: (a) community members are empowered to make decisions by themselves; and (b)

community members are linked with government workers/systems. From the governance perspective, this is a process of facilitating interaction between the state and citizen through developing capacities of citizens to articulate their needs and of the state to be responsive and accountable to the citizens' needs. This suggests that promoting community-government interactions not only improves health systems, but also strengthens governance. Health systems and governance can evolve together simultaneously, reinforcing each other.

In order for maternal health interventions to be sustainable, ensuring the following three points would be keys: (1) institutionalizing community-level interventions within the government structure; (2) including the most marginalized; and (3) going through social norm and value change.

CARE has been successful in improving maternal health through empowering communities as well as building linkages between communities and government health systems. This not only leads to improving health systems but also ultimately strengthening governance by facilitating interaction between citizens and governments. Influential donor agencies in the health sector are recognizing the importance of incorporation of governance issues in the health sector; however, their stance is still top-down, i.e., putting more emphasis on how to help government, rather than emphasizing efforts on empowerment of citizens and communities or making linkages between communities and governments. An influential global NGO like CARE can advocate, with its own successful experiences, for putting more attention to a bottom-up approach that starts at the community level and links communities with the government so that the interaction can start to improve health systems as well as governance.

USAID's recent stances indicate its interest in addressing governance issues in maternal health/health programming. CARE has niche to show its capability to start interventions at the community-level and link communities with government systems, thereby improving not only health systems but also governance.

1. Definition of Governance – Institutions and Interactions

1.1 General definition

Governance became one of the important themes in the development

discourse in the mid-1990s.[2] Each agency/organization has its own definition of governance. For example, the World Bank defines it as: "the traditions and institutions by which authority in a country is exercised. This includes the process by which governments are selected, monitored and replaced; the capacity of the government to effectively formulate and implement sound policies; and the respect of citizens and the state for the institutions that govern economic and social interactions among them."[3] United Nations Development Programme (UNDP) defines governance as: "mechanisms, processes and institutions through which citizens and groups articulate their interests, mediate their differences and exercise their legal rights and obligations."[4] Broadly, governance is understood as processes/mechanisms of decision-making and implementation of the decisions. The processes/mechanisms are affected by **institutions** such as laws, policies, political systems, judiciary systems, norms, practices, values, public service delivery infrastructure, and administrative structures.

The actors of governance are broadly defined as: (1) the state/government/public sector; (2) the private sector; and (3) the civil society. The state creates a conducive political and legal environment; the private sector generates jobs and income; and the civil society mobilizes citizens to participate in economic, social and political activities.[5] These actors play roles and **interact** at global, national, local, and community levels. The institutions shape the functioning of the actors, and thus, affect the nature and quality of the interactions. These interactions ultimately determine governance outcomes – positive or negative.[6]

Good governance, according to UNDP, is characterized by: participation; rule of law; transparency; responsiveness; consensus orientation; equity; effectiveness and efficiency; accountability; and strategic vision.[7] Enhancement of these characteristics in all aspects of activities and interactions of the actors will lead to good governance.

There has been an international consensus that good governance will lead

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[2] According to online research, publication of the World Bank and UNDP documents on governance started to flourish in the mid-1990s.

[3] *Governance Matters* (http://info.worldbank.org/governance/wgi/index.asp)

[4] *Governance for Sustainable Human Development: A UNDP Policy Document* (http://mirror.undp.org/magnet/policy/summary.htm)

[5] *Governance for Sustainable Human Development: A UNDP Policy Document* (http://mirror.undp.org/magnet/policy/chapter1.htm)

[6] Nyingi, Edson Lassy. 2008? *Knowing Governance and Making It Known: CARE Tanzania's Governance Training Manual.* (P. 10)

[7] *Governance for Sustainable Human Development: A UNDP Policy Document* (http://mirror.undp.org/magnet/policy/chapter1.htm)

to sustainable development.[8] Governance is an overarching concept that covers social, economic, political, and legal dimensions of development. Because of this, many of the characteristics of good governance are overlapping with features of human rights and democracy.[9] Inevitably, governance, human rights and democracy are strongly linked and they are mutually reinforcing. Good governance depends on the upholding of human rights and democracy.

1.2 CARE's definition

CARE's definition of governance is in line with the above literature. CARE defines governance as "the rules and institutions that manage public affairs in matters of the state, but also private business, civil-society,[10] and the relations among them".[11] For CARE, "good governance is the effective, participatory, transparent, equitable and accountable management of public affairs guided by agreed upon procedures and principles, to achieve the goals of poverty reduction and increasing social justice."[12]

CARE's **governance framework** shows that the quality of governance improves through **interactions** between the state and citizen,[13] which ultimately leads to better development outcomes. In this framework, CARE has a role in setting up systems of improved accountability between the state (policy makers and service providers) and citizens (service users). This role is in line with the **rights-based approach (RBA)** that CARE takes in its programming, i.e., developing capacities of the state (duty bearer) in providing better services and facilitating citizens (right holders) to claim their rights and get their voice heard by the state. A meta-review of RBA by CARE International UK describes that CARE's RBA projects have often focused solely on assisting the civil society/community to develop the ability to articulate its needs, but experiences have shown that building up government's (and/or the private sector's) capacity as well to effectively meet the strengthened demands of the civil society can be a

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[8] *Governance for Sustainable Human Development: A UNDP Policy Document* (http://mirror.undp.org/magnet/policy/chapter1.htm)
[9] Nyingi, Edson Lassy. 2008? *Knowing Governance and Making It Known: CARE Tanzania's Governance Training Manual.* (P. 15)
[10] The word "civil society" is defined as the multitude of associations, movements and groups - formal and informal - in which citizens organize to pursue shared objectives or common interests. (Burden, Allison. 2009. *Global Governance Research Framework.* (P.8))
[11] Burden, Allison. 2009. *Global Governance Research Framework.* (P.2)
[12] Burden, Allison. 2009. *Global Governance Research Framework.* (P.2)
[13] The world "citizen" is defined as civilians or ordinary people who are living in the territory. (Burden, Allison. 2009. *Global Governance Research Framework.* (P.2))

far more effective way of achieving positive changes. The report emphasizes "the importance of working '*both* sides of the negotiation table,' rights holders and duty bearers."(emphasis added.)[14] In the same line, CARE International's Governance Work Group writes:

> Governance work is about promoting negotiated development. CARE has played roles from strengthening community voice, to strengthening government capacity to deliver services. In the middle of this supply-demand continuum, CARE often facilitates the process of bringing key stakeholders together around specific issues. This work involves a "double impact", with changes both at the household level, and at a higher institutional or policy level. Projects may sometimes be able to produce broader impact by working on the "supply side" of the equation, rather than only working to strengthen the capacity of individual communities.[15]

The above CARE literature suggests that the governance framework, which emphasizes the reciprocity of the interaction of actors, can promote the RBA further by making CARE work with *all* the actors simultaneously– the state, the private sector, and the civil society – thereby creating synergies to achieve larger outcomes, i.e., achieving human rights, poverty reduction, and social justice.

The work in the governance framework often involves change in **power relations**, and thus, political and power analysis is vital for CARE to understand how to intervene to improve governance and what consequences the intervention will bring about.

2. Change of Development Framework – Emergence of Governance

2.1 Emphasis on citizen engagement

In a state, good governance is promoted through interactions between the government and citizens. On the one hand, there is the government that must become more accountable, transparent, responsive, and equitable to the citizen. On the other hand, the citizen/civil society must engage more effectively with the government because greater participation in decision-making process by the citizen/civil society would make policies better fit their needs and interests. Smith aptly describes this reciprocity as: "'governance' represents a shift away from understanding public policymaking and management as solely the domain of governments to arrangements in which private organizations and individuals

[14] CARE International UK. 2005-08? *RBA Metareview*. (P.24-25)
[15] Stuckey, Joe (CARE International). 2004. *Governance Working Group Paper #2: Towards Understanding of Governance*. (P.2)

may be instrumental".[16]

Decentralization theoretically helps promote the interaction between governments and citizens, as it brings the government closer to people, and thus, allows people to participate more effectively in local affairs, makes the government more responsive and accountable to people's demands, and more transparent with better information flows. Some argue that to date the donor focus has been on helping increase state's capacity to manage public resources and deliver services, rather than supporting state-citizen relationships in a wider sense of mutual respect and democratic accountability.[17] In other words, decentralization has been implemented only through capacity development of the government side.

On the citizen's side, they need to have capabilities to claim their demands, such as awareness of their rights and ability to organize themselves. Even if a state creates opportunities for dialogue with citizens, some people, particularly the poorest, are too alienated to enter the dialogue because they lack capabilities and resources.[18] The question is how to mainstream citizens, especially the most marginalized, into government decision-making processes. In recent years, there has been an increasing understanding of the vital role of citizens' participation in holding governments accountable.[19] Recent literature shows more and more interest in mainstreaming citizens' voices at all levels of governance, rather than investing only in government capacity. For example,

- The United Nations (UN) introduces the "engaged governance" concept which is defined as "an **institutional** arrangement that links citizens more directly into the decision-making processes of a State so as to enable them to influence the public policies… in a manner that impacts more positively on their social and economic lives." (emphasis added.)[20]
- *Human Development Report 2003: Millennium Development Goals* writes "Action must be driven not just by politicians and government agencies but also by communities, local authorities and civil society groups"[21] in order to apply

[16] Smith, Stephanie. 2007. *Governance and India's Maternal Mortality Crisis.* (P.4)
[17] Development Research Centre. 2006. *Building Effective States: Taking a Citizen's Perspective.* (P.4)
[18] Development Research Centre. 2006. *Building Effective States: Taking a Citizen's Perspective.* (P.6)
[19] Frisancho, Ariel, and Jay Goulden. *Rights-based approaches to improve people's health in Peru.* The Lancet Published Online, December 10, 2008.
[20] Khan, M. Adil. 2005. *"Engaged Governance": A Strategy for Mainstreaming Citizens into the Public Policy Processes.* (P.20)
[21] UNDP. 2003. *Human Development Report 2003: Millennium Development Goals.* (P.31)

pressure and hold the authorities **accountable**.

- *World Development Report 2004: Making Services Work for Poor People* points out "the need to strengthen **accountability** in three key relationships in the service delivery chain: between poor people and providers, between poor people and policymakers, and between policymakers and providers." (emphasis added.)[22]
- A World Bank document on Community-Driven Development writes that decentralization is successful "only if it is tailored to reach the poor and voiceless, receives adequate support as well as sufficient autonomy from the center, and if institutionalized mechanisms of wide and regular participation are put in place."[23] "The starting point must be to empower communities by giving them more resources and authority to use these flexibly. And enhanced participation will at some point need a local government structure for sustainability. The two can evolve together dynamically, strengthening one another."[24]
- World Health Organization (WHO) states "After years of relative inattention, there is now a resurgent interest in the role of the state. However, the **emphasis is on 'good governance'** and effective stewardship, **rather than a return to earlier 'command and control' models**. The public in most countries no longer accepts a passive role and rightly **demands a greater say in how health services are run, including how health authorities are held accountable**..." (emphasis added.)[25]

In sum, an increasing number of development agencies are reframing their development strategies within the governance framework, emphasizing **interaction** of states and citizens. As opposed to the old trend of narrow interventions only on the government side, current development programs are aiming at broader and more dynamic issues of **creating institutional arrangements** (such as laws, policies, values, service delivery infrastructure, and administrative structures that are more participatory, transparent, responsive, equitable, effective, efficient and accountable) that allow both governments and

[22] World Bank. 2003. *World Development Report 2004: Making Services Work for Poor People.* (P.1)
[23] World Bank. 2000. *Community Driven Development: A Vision of Poverty Reduction through Empowerment.* (P.4)
[24] World Bank. 2000. *Community Driven Development: A Vision of Poverty Reduction through Empowerment.* (P.6)
[25] World Health Organization. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* (P.10)

citizens to interact. The aim of the interaction is for governments to work better and for citizens to hold the government accountable. This shift of focus by development agencies – more focus on citizens rather than governments alone – shows quite a contrast with CARE's recent trend discussed above (Section 1.2) – more focus on engaging with governments rather than working solely with citizens/civil societies/ communities. The governance framework urges donors – bilateral and multilateral agencies as well as Non-Governmental Organizations (NGOs) – to incorporate all the governance actors, connect them, and prepare a negotiation table for them to work synergistically.

2.2 Different ways of engaging citizens

There are broadly two ways in which citizens/civil society can engage in mainstreaming their voices towards the state: (1) participating in decision-making and policy formulation, including budgeting; and (2) monitoring policy implementation. Advocacy, networking, and use of media often accompany in these processes. These processes occur at global, national, local, and community levels. Also, these actions can start through forums created by the state, through external catalysts like NGOs/CBOs (Community-Based Organizations), and through self-organized social/community movements.[26]

One of the most widely known participatory decision-making initiatives at the **local government level** is "people's budgeting system" initiated in Porto Alegre, Brazil, in 1989, where citizens involved in social policy discussions, allocation of resources, and monitoring of public spending. The initiative had significant impacts on poverty reduction.[27] This example demonstrates the capacities of citizens for holding the state accountable to them, and the capacities of the government to engage with citizens' demands. Even with the impressive results, these initiatives cannot be sustainable unless they are institutionalized as a permanent feature of decision-making.[28]

People's participation in decision-making can occur at the **community level** too. For example, in Afghanistan, the National Solidarity Program, run by the Ministry of Rural Rehabilitation and Development funded by various bilateral

[26] Development Research Centre. 2006. *Building Effective States: Taking a Citizen's Perspective.* (P.12)
[27] According to *Human Development Report 2003: Millennium Development Goals* (P.142), the initiative in Porto Alegre succeeded in doubling the rate of access to water and the enrollment rates of primary and secondary schools from 1989 to 1996, largely due to redistribution of resources to the poorer areas.
[28] Khan, M. Adil. 2005. *"Engaged Governance": A Strategy for Mainstreaming Citizens into the Public Policy Processes.*

and multilateral donors, is aiming at laying "the foundations for a strengthening of community level governance".[29] Under the program, each community sets up a Community Development Council (CDC) and community members elect council members. Facilitation Partners (FPs) drawn from NGOs or a UN agency assist CDCs to hold community meetings and establish community development plans, in which community members directly make decisions. In this capacity, CDCs made considerable contributions to the improvement of welfare and the inclusion of marginalized groups, particularly women. However, participation of the most marginalized depended on the capacity of FPs.[30] This tells us that inclusion of the most marginalized needs a conscious effort. Otherwise, unequal power relations persist.

The **Citizen Report Card (CRC)** is a tool of citizen-based monitoring of public service delivery, based on user surveys.[31] It aims at putting feedback from citizens to achieve greater accountability in public policies "through the extensive media coverage and civil society advocacy that accompanies the process".[32] A case of the Philippines demonstrates that the participatory process that involved government, civil society, academic institutions and the private sector in the design of the questionnaire and in the analysis and presentation of the results had an impact of getting political attention at the national level.[33] However, again, one of the criticisms is that "CRC initiatives … will serve little long-term purpose unless implementation is followed by efforts at institutionalization on a sustained basis. Institutionalization efforts depend heavily on political commitment".[34]

At the community level, the **Community Score Card (CSC)** is an instrument to get accountability and responsiveness from government service providers. The CSC tracks expenditures, monitors quality of services, and generates criteria for basic needs. It also includes an interface meeting between service providers and communities, which allows for immediate feedback on service quality, which in turn becomes a strong instrument for citizen

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[29] Nixon ,Hamish. 2008. *The Changing Faces of Local Governance? Community Development Councils in Afghanistan.* (P.18)
[30] Nixon ,Hamish. 2008. *The Changing Faces of Local Governance? Community Development Councils in Afghanistan.*
[31] Nyingi, Edson Lassy. 2008? *Knowing Governance and Making It Known: CARE Tanzania's Governance Training Manual.* (P.23)
[32] World Bank. 2004. *Citizen Report Card Surveys: A Note on the Concept and Methodology.* (P.1)
[33] President Macapagal-Arroyo claimed to hold her cabinet accountable and responsive to grassroots feedback. (Barns, Jeremy R. 2003. *Engaged Governance: An Overview of the Philippine Experience.*)
[34] World Bank. 2004. *Citizen Report Card Surveys: A Note on the Concept and Methodology.*

empowerment.[35]

Two points can be drawn from the above citizen engagement experiences: (1) Citizen engagement needs to be embedded in a institutional framework; otherwise, it will not be sustainable.[36] (2) The inclusion of the most marginalized must be consciously focused on; otherwise, the old power structure persists and an intervention cannot make any positive change.

3. Governance and Health

3.1 How governance came into the health sector? – A historical view

The Alma Ata Declaration in 1978 signified the first global commitment in the health sector. The declaration articulated primary health care (PHC) as a set of guiding values. With a slogan of "Health for All," it aimed at universal, preventive and curative services, with substantial **community involvement**. Collaboration with other sectors, such as education, food, and housing was stressed too.[37] The district health system concept was subsequently developed as a model for the implementation of PHC.

In the early 1980's the debt crisis hit many developing countries, and subsequent structural adjustment programs deteriorated the health care systems. To deliver health services as efficiently and effectively as possible in the time of resource shortages, interventions that focused on the most basic and cost-effective care such as "selective primary health care" and GOBI-FFF (Growth monitoring, Oral Rehydration, Breastfeeding, Immunization - Food supplementation, Family spacing, Female education) were practiced. The Bamako Initiative in 1987 led by WHO and United Nations Children's Fund (UNICEF) proposed a new way to tackle the severe shortage of resources and deteriorating health care systems. The initiative's objective was to provide a basic package of integrated services through health centers that employ user fees and community co-management of funds. However, the introduction of user fees drew strong criticisms as it prevented the poor from using essential health services.[38]

In the 1990s, the concept of health sector reform (HSR) marked a major change in the health development approaches. Drawing on the neoliberal

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[35] Nyingi, Edson Lassy. 2008? *Knowing Governance and Making It Known: CARE Tanzania's Governance Training Manual.* (P.23)
[36] World Bank. 2000. *Community Driven Development: A Vision of Poverty Reduction through Empowerment.*
[37] *Declaration of Alma-Ata* (http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf); Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries.*
[38] UNICEF. 2007. *The State of the World's Children 2008: Child Survival.* (P. 30-36)

ideology, *World Development Report 1993: Investing in Health* by the World Bank framed a new view that the private sector could most efficiently meet health care needs, and that the public sector should fill the gap to correct market failures.[39] User fees, cost recovery, private health insurance, and public-private partnerships became the focus for health care services.[40] Some critics insist that the HSR did not work because the overall weakening of the state functions could not manage market-based systems well, and that it failed to reach the most marginalized.[41] The HSR emphasized too much on technical prescriptions, rather than policy processes.[42] The HSR showed little provision for ensuring equity in access to services.[43] Since the report was issued, the World Bank and other similar agencies have made little reference to PHC as endorsed at Alma-Ata.[44]

The 1990s also saw the rise of human rights in the overall development discourse. After the end of the Cold War, the entire international community recognized the realization of human rights – both "civil and political rights" and "economic, social and cultural rights" – as an essential agenda in development. Health was seen as an intrinsic good that must be attained by everyone as "right-to-health". The human rights concept focused on equity which led to the emphasis on the creation of equitable health systems.[45] Also, the human rights concept shifted the framework of health development from a technical, medical issue towards a broader socio-economic issue. For example, in the International Conference on Population and Development in 1994, reproductive health was understood broadly, linking biomedical to social, economic, and political dimensions, and conceptualized as an essential part of development and a fundamental human right. In addition to the emphasis on human rights, the 1990s saw the emergence of the concept of "human development" initiated by UNDP. Further, UNDP asserted that human development and governance were indivisible concepts. This led health interventions to include improvement of processes and institutions – which were governance issues – rather than keeping

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[39] UN Millennium Project Task Force on Child Health and Maternal Health. 2005. *Who's Got the Power?*
[40] Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries.*(P.19)
[41] UN Millennium Project Task Force on Child Health and Maternal Health. 2005. *Who's Got the Power?*
[42] Robinson, Dorcas. *Market-mediated, Community-financed Health Care Services: Some Assumptions and Contradictions.*
[43] Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries.*(P.20)
[44] Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries.*(P.19)
[45] Backman, Gunilla et al. 2008. *Health Systems and the Right to Health: An Assessment of 194 Countries.* (P.1)

them as mere medical/technical issues.

The culmination of the above notions was the Millennium Development Goals (MDGs) adopted in 2000. The MDGs articulated health issues from the stand points of human rights and human development, and touched upon governance issues.[46] Now, health is an issue that is discussed in broader socio-economic development and governance frameworks.

3.2 Recent debate on governance and health

A review on recent health literature indicates that governance is becoming more and more relevant in the health sector. Firstly, WHO is becoming explicit in taking actions on governance issues in its work. Secondly, there has been increasing emphasis on socio-economic aspects, especially equity issues, in the health literature. Alma Ata already talked about equity,[47] but with the greater attention on human rights, human development, governance, and the MDGs, the issues of equity and social justice are emphasized ever more. There has been a realization that health problems of the marginalized cannot be tackled only through technical interventions exclusively related to health, but need to take broader actions that would involve participation of these marginalized people in shaping health policies, programs, and practices. This, in turn, becomes a governance issue, as governance talks about the institutions to enable those people's involvement. Below are some citations from recent health literature. Key words and phrases include: equity, accountability, responsiveness, participation, policy, "technical solutions alone cannot solve problems", "focus on the whole health system", "collaboration with other sectors".

- A report published by WHO in 2007 ("*Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*") describes "governance" as one of the six building blocks to strengthen health systems.[48]
- Governance, "… involves overseeing and guiding the **whole health system**, private as well as public, in order to protect the public interest…with rising

[46] For example, one of the targets of MDG 8 includes governance issues.
[47] GEGA. 2003. *The Equity Gauge: Concepts, Principles, and Guidelines*.; Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries*.
[48] Six building blocks are: health service delivery; health workforce; health information; medical products, vaccines and technologies; health financing; and leadership and governance. (World Health Organization. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action*. (P.3))

expectations…There is increased attention to corruption, and calls for a more human rights based approach to health. It requires **both political and technical** action, because it involves reconciling competing demands for limited resources" (emphasis added.)[49]

- "WHO's tendency at present is to focus on the development of specific technical health policies. This is important, but the **added challenge** for governments is to provide vision and direction for the **whole health system**, and oversee implementation of agreed health policies through systems... These include: reconciling competing demands for resources; working **across government** to promote health outcomes; managing growing private sector provision; tackling corruption, responding to decentralization; **engaging with an increasingly vocal civil society**…" (emphasis added.)[50]
- "Build coalition **across government** ministries, with the private sector and with communities…to ensure the health **needs of the most vulnerable** are properly addressed…" (emphasis added)[51]
- The four components of Primary Health Care (PHC) reforms described in *World Health Report 2008: Primary Health Care: Now More than Ever* are: (1) Universal coverage reforms to improve health **equity**; (2) Service delivery reforms to make health systems more socially relevant and **responsive**; (3) Public **policy** reforms to promote the health of communities; and (4) Leadership reforms to make health authorities reliable by the **inclusive**, **participatory**, **negotiation**-based leadership.
- In *World Health Report 2008: Primary Health Care: Now More Than Ever*, the word "governance" was used 22 times, which is a dramatic increase compared to seven times appeared in *World Health Report 2000: Health Systems: Improving Performance*.
- WHO is developing indicators for governance in health systems? The indicators are categorized into rules-based indicators (*existence* of institutions, policies, etc.) and outcome-based indicators (*enforcement* of institutions, policies, etc.). One of the indicators reads "Existence of effective civil society

[49] World Health Organization. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* (P.23)
[50] World Health Organization. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* (P.24)
[51] World Health Organization. 2007. *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action.* (P.24)

organizations in countries with mechanisms in place for citizens to express views to government bodies", which shows WHO's recognition of the importance of citizen's engagement in governance.[52]

- WHO states its stance on governance as: "The increased interest in governance has been driven by the need for greater **accountability**... This concerns the management of **relationships** between various stakeholders in health including individuals, households, communities, firms, governments, non-governmental organizations, private firms, and other entities which have the responsibility to finance, monitor, deliver, and use health services. … Governance in health is a **cross-cutting theme**, which is intimately connected with issues surrounding **accountability**." (emphasis added.)[53]

4. Governance in Maternal Health

4.1 Governance perspectives in maternal health strategies

The UN Millennium Project Task Force on Child Health and Maternal Health issued a report titled "*Who's got the Power?: Transforming Health Systems for Women and Children*" in 2005 whose stance is similar to those of the above (Section 3.2). The first similarity is that the report puts emphasis on **equity** underlined in the MDGs and human rights perspectives. It contends that dysfunctional, irresponsive, and abusive health systems intensify exclusion, voicelessness, and inequity, and thus, calls for making health systems functional to the most socially excluded people.

The second similarity is that the report insists that the solutions to the MDGs cannot be simply a technical one which derives solely from epidemiological studies, but the solutions should take account of the **socio-political dimensions** of health care. Thus, solutions would be "deeply and fundamentally **political**. It is about access to and the distribution of power and resources" (emphasis added).[54] The overriding recommendation of the task force is "pro-poor" strategies that are based on research from multiple disciplines, including epidemiology, economics and political economy, anthropology and the behavioral sciences, institutional analysis on law, policy, social networks, information and education, because these **institutional arrangements** influence

[52] World Health Organization. 2008. *Health Systems Governance.*
[53] World Health Organization. 2008. *Health Systems Governance.* (P.2)
[54] UN Millennium Project Task Force on Child Health and Maternal Health. 2005. *Who's Got the Power?* (P.2)

the way events happen. The report advocates for health system strengthening in the framework of good governance: it does not frame system strengthening as a mere technical, managerial matter.

The third similarity is that the report takes explicit actions on governance issues. The report recommends three principles to close the inequity gap: (1) strengthening the legitimacy of the state through good governance; (2) enhancing collaboration between public and private sectors; and (3) strengthening the voice of the poor and marginalized to assert claims. The report states that building constructive accountability mechanisms into the system requires building the capacity of communities, civil society organizations, and government staff at every level. This capacity building of each actor and enhancement of interaction between each other are the very essence of the governance framework.

4.2 Strengthening maternal health systems is a governance issue

With the above principles as the foundation, the report "*Who's got the Power?*" suggests specific actions to strengthen health systems. The report recommends that maternal health strategies should focus on strengthening the **primary health care system from community-based interventions to the first referral-level facility** at which emergency obstetric care (EmOC) is available, focusing on the district level where critical planning, budgeting, and implementation decisions are made. The report insists that the "selective primary health care" which had been practiced in many countries was problematic, as it neglected the crucial first-referral facilities on which reduction of maternal mortality heavily depends. Similarly, another report (Nanda, Geeta, Kimberly Switlick, and Elizabeth Lule. 2005. *Accelerating Progress towards Achieving the MDG to Improve Maternal Health: A Collection of Promising Approaches*) also calls for more emphasis on skilled delivery care and the management of complications, rather than merely training traditional birth attendants who provide essential support to women during birth preparedness and strengthen community-based referral practices. Improving the primary health care system and facility-based system at the same time requires good interaction between individuals, communities, health workers at the community and facility levels. **Construction of a well-functioning health system from household-community-facility is not only a technical issue, "but also questions of governance** – how to develop

effective, efficient and equitable maternal health policy and practice."[55]

A strong, well functioning health system performs all of the functions including household prevention and care-seeking behaviors; the delivery of services within the community by health workers; a competently staffed and adequately supplied clinic; and a first-level referral hospital at the district level where health professionals manage life-threatening conditions. This **continual** system requires enhancement of both **supply & demand** sides, which needs all the actors' interaction. Here again, the governance framework is relevant. First, governments need to have good health policies in place, promote decentralization to districts, prioritize resources to the most marginalized, tackle corruption to get trust from citizens as well as donors, make high-quality services and functional referral systems available – all of which will improve the supply side of health care service, which in turn will promote demand as the service will gain trust from users if service improves. Secondly, citizens should claim their needs, monitor governments' policies and practices, and change behavior for appropriate service utilization – these will promote demand for good services. Third, the private sector needs to participate in a healthy competition for more options for citizens, which will enhance the supply side of health care. As all of these actors interact, supply and demand will be enhanced and an incentive of system improvement will be generated.

In sum, the intervention strategies on maternal health are becoming more holistic and incorporating governance issues, because performance of health systems depends on overall governance of a country.

5. Effectiveness of Maternal Health Interventions

5.1 Better governance brings about better outcomes

There are many success stories of improving maternal health through addressing governance issues. A study from India demonstrates improved governance can result in better maternal health outcomes such as increased rates of institutional delivery and decreased maternal mortality.[56] The state of Tamil Nadu introduced the "maternal death audit system" in 1994 which allowed interactions of various actors including bureaucrats, public health officials and

[55] Smith, Stephanie. 2007. *Governance and India's Maternal Mortality Crisis*. (P.11)
[56] Smith, Stephanie. 2007. *Governance and India's Maternal Mortality Crisis*.

other individuals and organizations to change policy formulation and implementation in favor of better maternal health. The audit system provided the government with qualitative and quantitative data which informed policy making, and became a learning mechanism. "The audits began to capture dynamics of the problem from social, medical and health system management perspectives and were used to 'sensitize' policy".[57] The system informed the government of the problems on the ground and the government developed and implemented solutions.[58]

Two important lessons can be drawn from the study. First, the interaction of various actors can change institutional political economy and bureaucracy, thereby improving governance, and ultimately brings about good health outcomes. Secondly, cultural considerations are important to identify problems. Maternal health is a sensitive issue that is influenced by social values and customs, such as patriarchy, education, class, caste, and religion, which need to be taken into consideration when analyzing problems and developing solutions.[59] The holistic approach of governance is well situated to examine the interactions between actors and to include sensitive lenses for analyzing cultural aspects of maternal health.

The above example was an initiative from the state. There was political will, commitment, and strong leadership. CARE Peru's work on ForoSalud with Physicians for Human Rights tells us that an initiative from civil society too can generate good results in reducing maternal mortality.[60] ForoSalud established a civil society network, consisting of community leaders and health professionals at local, regional and national levels, together with civil society and grassroots organizations, to participate in health policy decision making at national and regional levels. ForoSalud supported the development of accountability

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[57] Smith, Stephanie. 2007. *Governance and India's Maternal Mortality Crisis*. (P.20)

[58] For example, the audit system helped identify the lack of human resources and lack of trust between health workers and patients. Then, the government developed incentives and strong monitoring mechanisms to address human resource vacancy and its commitment problems.

[59] As for cultural sensitivity, a study from Peru is indicative. A study found an acute rejection within the indigenous communities to use government health facilities. This was because the facilities did not take account of local cultural conceptions of health. After consultation with the indigenous communities, culturally sensitive facilities were introduced such as ropes in delivery rooms for women to give birth squatting and gripping the rope as they were accustomed to. These changes led to an increase in deliveries in facilities. The success helped generate a corresponding change in national health policy. (Cited from Backman, Gunilla et al. 2008. *Health Systems and the Right to Health: An Assessment of 194 Countries*.)

[60] Frisancho, Ariel, and Jay Goulden. 2008. *Rights-based approaches to improve people's health in Peru*; Alarcón, Luz Estrada. *Global Health Council, 35th Annual International Conference on Global Health (Individual Abstract Submission)*; Arroyo, Ariel Frisancho. *Global Health Council, 35th Annual International Conference on Global Health (Individual Abstract Submission)*.

mechanisms for citizens, including citizens' surveillance of health services linked with ombudspersons to monitor women's health rights. ForoSalud presented the citizen's proposals through eighty regional and two national-level meetings to discuss changes needed in the health system. ForoSalud representatives have been elected as the community organization representatives within the National Health Council and Regional Health Councils, where they succeeded in getting a number of their policy proposals included in Regional Health Policies. These processes have promoted positive developments, such as improved attitudes on the part of health service providers towards women service users, and better responsiveness of services to the needs of poor people. This is a good example that civil society networks can enable the poor and mostly excluded people to participate in pressing government policies and services to be improved.

5.2 Rationale for community-level interventions in maternal health

As discussed in Section 4.2, the UN Millennium Project Task Force on Child Health and Maternal Health (in the report "*Who's Got the Power?*") insists Primary Health Care (PHC) as the best intervention, supported by facility-level interventions. Also, recent WHO's approaches put priorities on PHC.[61] A trend back to PHC implies the direction towards more **community-level** interventions. Hall and Taylor suggest that the come-back of PHC was largely drawn from NGOs, academics and community groups.[62] Their accumulated success in interventions at the community level may have led the trend back to PHC. In addition, the recognition of the need to give greater voice to the poor,[63] permeated through the rise of human rights and governance perspectives, may have been another driving force to put PHC back as the major health intervention strategy.

Maternal health interventions at the community level have many benefits. First, community participation and mobilization are effective means to

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[61] As seen in 3.2, the theme of *World Health Report 2008* is PHC. Also, the statement of the Director General of WHO in 2008 reiterates the importance of PHC. *Return to Alma Ata.* (http://www.who.int/dg/20080915/en/index.html). This is a significant change from *World Health Report 2000: Health Systems: Improving Performance* which, according to Hall and Taylor, marked "the end of WHO's use of PHC as the means for the delivery of healthcare services in resource-poor countries."(Cited from Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries.*(P.19))

[62] Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration and Primary Health Care in Developing Countries.*(P.19)

[63] Hall, John J. and Richard Taylor. 2003. *Health for All Beyond 2000: The Demise of the Alma-Ata Declaration: and Primary Health Care in Developing Countries.*

behavioral change around care seeking.[64] If an intervention involves community health workers and traditional birth attendants in the community, both supply side issues (quality of service) and demand side issues (behavior change) can be tackled simultaneously. Second, a substantial community involvement creates **supportive environments** for tackling **sensitive** issues. "It is at the community level that social issues are discussed, and norms are formed and enforced. Through community dialogue and collective action, social issues that are beyond the mandate of public institutions can be addressed."[65] So, there are good reasons to intervene at the community level to promote maternal health.

Before going in detail, some key terminology regarding community-level interventions must be defined. There are commonly-used words such as: community involvement, engagement, participation, empowerment, and mobilization. These words are defined and used differently in different organizations and contexts. For the sake of simplicity and clarity in this paper, I will define the words as the following:

- Involvement, engagement and participation as a broad concept of *including community members in the process of an intervention*. This can be from little meaningful participation to engagement in full decision-making and collective action.[66]
- Empowerment has a clear distinction from involvement/engagement/participation in the sense that it *increases the capacity of a community* to do things for/by itself. Empowerment enables people "to act through collective participation by strengthening their organizational capacities, challenging power inequities and achieving outcomes on many reciprocal levels in different domains: psychological empowerment, household relations, enhanced social capital and cohesion, transformed institutions, greater access to resources, open governance and increasingly equitable community conditions."[67] The World Bank has identified four

[64] USAID and ACCESS. 2006. *Home and Community-Based Health Care for Mothers and Newborns.*
[65] IAWG. 2007. *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators.* (P.3)
[66] *An Annotated Guide to Technical Resources for Community Involvement in Youth Reproductive Health and HIV Prevention Programs.* (P.7) (http://www.fhi.org/NR/rdonlyres/edgso43rqu57soi72aatcwk57clvxy7pzpaggaqy3kju7bhvkt4hdcf5cwpid54qf242euggycnaqf/TechnicalResources1.pdf)
[67] Wallerstein, N. 2006. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report. (P.19)

characteristics to ensure that participation is empowering: people's access to information on public health issues, their inclusion in decision-making, local organizational capacity to make demands on institutions and governing structures, and accountability of institutions to the public.[68]

- Mobilization is a set of interventions aimed at *stimulating a community to engage in self-activities*.[69] It is a process to reach empowerment. Also, according to Susan Igras, Community Mobilization is "a capacity-building process through which individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis."[70]

5.3 Effectiveness of community-level interventions – Improving both health systems and governance

An extensive literature review of community empowerment and health outcomes by Health Evidence Network (HEN) of WHO shows that community empowering initiatives can lead to better health outcomes and that empowerment is a viable public health strategy. The report states that empowerment strategies are promising in working with socially excluded populations, and that socially excluded populations can challenge non-responsive or oppressive institutions and redress power imbalances.[71] In other words, community empowerment can make the most marginalized involved in governance improvement as well as health improvement.

The report states that socially excluded populations need effective empowerment strategies such as: increasing community members' knowledge and skills in controlling health; building supportive environment and a deeper sense of community to enhance consciousness on public health issues; promoting community actions in health planning, implementation, and evaluation; training on advocacy and leadership; promoting governmental/institutional accountability and transparency; making health care sensitive to the users. The most effective empowerment strategies the report found were "ensuring autonomy in decision-making, sense of community and local bonding, and psychological empowerment of the community members

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[68] Cited in Wallerstein, N. 2006. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report. (P.9) (Originally from: D. Narayan. 2002. *Empowerment and Poverty Reduction: A Sourcebook*. Washington, World Bank.)
[69] Adopted from http://www.scn.org/cmp/key/key-m.htm
[70] Igras, Susan. *Community Mobilization.* (http://www.globalhealthlearning.org)
[71] Wallerstein, N. 2006. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report.

themselves."[72] It is noteworthy that report notes "participation alone is insufficient if strategies do not also build capacity of community organizations and individuals in decision-making and advocacy."[73] The findings of the report include the following:

- Patient empowerment and family caregiver interventions have shown improved self-regulated disease management and use of health services.
- Youth empowerment interventions strengthened self and collective efficacy, stronger group bonding, formation of sustainable groups, increased participation in social action and actual policy changes.
- Some literature showed linkages between increases in women's empowerment and greater demands for health care, improved nutrition and contraceptive use.
- A four-year NGO-government integrated effort to reduce maternal mortality showed community development of plans for emergency transport systems in 80% of the participating villages, a five-fold increase in women's plans to delay pregnancy and awareness of danger signs, greater community participation and formation of new lay health worker associations.
- Interventions that have been most integrated with the economic, education, and/or political sectors have resulted in greater psychological empowerment, autonomy and authority, and have substantially affected a range of health outcomes.
- Empowerment strategies are more likely to be successful if integrated within macro-economic and policy strategies aimed at creating greater equity. Case studies have shown that synergy between all elements (anti-poverty strategies, NGO-government collaboration, empowerment) is probably most effective at improving health and development outcomes.

A report by USAID and ACCESS shows critical elements of linkages between community mobilization and maternal health outcomes: community mobilization to assess their own health needs and develop and monitor their solutions has been highly effective in improving utilization of emergency care services.[74] For example, the MIRA Makwanpur Project in Nepal, utilizing

[72] Wallerstein, N. 2006. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report. (P.5)
[73] Wallerstein, N. 2006. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report. (P.4)
[74] USAID and ACCESS. 2006. *Home and Community-Based Health Care for Mothers and Newborns.*

women's group for educating safe motherhood and for discussing problems and solutions, showed a significant decrease in neonatal and maternal mortality. The Warmi Project in Bolivia formed women's groups and developed their skills in planning and implementing safe motherhood education. It also trained health workers and husbands to get wider community mobilization. The project resulted in a significant perinatal mortality decrease and increased women's access to prenatal care. These projects seem to have gone through effective community empowerment strategies that were enumerated in the above WHO's HEN report, such as decision-making and deeper sense of community. This corroborates the effectiveness of these strategies.

CARE has been implementing maternal health projects involving communities. The FEMME Project in Peru worked not only with women, their families and the community at large, but also included all levels of health workers and policy makers to improve the availability, utilization, and quality of care in emergency obstetric care (EmOC). The project learned from women why they would not use health care, and worked with the community to overcome these challenges. It engaged political leaders on the issues of health care access for women. Thanks to the project, the rate of women who used EmOC services increased from 30% to 75%, and maternal deaths reduced by half in the project area. The Ministry of Health launched new national clinical guides for obstetric and neonatal emergencies, based on the Guidelines developed in the project area. CARE states, "health systems and access to health care are not just technical supply-and-demand problems; rather, they are at the core of people's relationship with government and society."[75] This statement indicates that CARE has been engaged in governance issues in a maternal health project through connecting the communities and the government to improve the health care system.

Another CARE program, the Child Survival Program in Sierra Leone, aiming at improving the health status of children and women, also has succeeded in mobilizing communities and linking them with the government health system. The program demonstrated significant increase in the rate of skilled birth attendance (from 15% to 34%) and the use of antenatal care (from 57% to 84%). The program formed 54 Community Health Clubs (CHCs) whose members

[75] Davenport, Ann. 2007. *Voices from the Village: Improving Lives through CARE's Sexual and Reproductive Health Programs, The FEMME Project in Peru: Partnerships for Improved Health.* (P.6)

included women and men with different age, education and ethnic backgrounds. The CHC members were trained with the "Communicating Health Communicating Rights" package which addressed various health issues ranging from maternal child survival needs to gender inclusion, democratic practices, and transparency. The CHCs promoted community-led actions in the delivery of health services through the Village Development Committees, a traditional community leadership mechanism. The CHC members supported outreach activities of the governments' Peripheral Health Unit (PHU) staff. The project simultaneously built the capacity of PHU staff in training CHC volunteers and traditional birth attendants, which enhanced the interaction between communities and government health workers. The project increased utilization of services, empowered communities, facilitated community cohesion, and provided a direct link between the community and the government health system.[76]

The above two interventions show that CARE has been successful in improving maternal health through empowering communities as well as building linkages between communities and government health systems, which not only leads to improving health systems but also ultimately strengthening governance by facilitating interaction between citizens and governments. Michell's evaluation synthesis of CARE's health and HIV programs indicates the same point: CARE's programming "makes sure that improvements to health services answer the health needs of those that are going to be using them" through creating links between the community and health structures.[77]

6. Sustainability of Maternal Health Interventions

6.1 Institutionalizing community-level interventions within government structure

Overall, the above reviews of maternal health interventions at the community level suggest that interventions are successful if: (a) community members, i.e., citizens, are empowered to assess the situation and make decisions by themselves; and (b) community members are linked with government workers/systems. From the governance perspective, this is a process of

[76] Gopinath, Ranjani. 2008. *Child Survival Project: For Di Pikin Dem Wel Bodi. CARE Sierra Leone Child Survival Project Final Evaluation Report.*

[77] Mitchell, Vanessa. 2007. *Synthesis Report of CARE Approaches: to Community Engagement in Health Programs.* (P.5)

facilitating interaction between the state and citizen for achieving better governance through developing capacities of citizens to articulate their needs and of the state to be responsive and accountable to the citizens' needs. Promoting community-government interactions not only improves health systems, but also strengthens governance. Health systems and governance can evolve together simultaneously, strengthening and reinforcing each other. It could be described as a process of building "trust" among all the actors.[78]

As discussed in Section 2.2, institutionalizing the process of state-citizen interaction is a key to making the process sustainable, and hence, to strengthening governance in the long run. In the maternal health sector, the same would hold true: institutionalizing community-government interactions, i.e., making them a formal, normative model, will make the intervention more sustainable. Thus, when intervening at the community level, working together with government workers/system at any level – community, district, regional or national – and getting governments' involvement and endorsement is a key to achieving sustainability. Creating an enabling environment for collaborative work between communities and governments simultaneously serves to achieve the continuum of care of "household-community-facility" which the maternal health literature recommends.

Literature review for this paper found that influential agencies in the health sector, namely WHO and the World Bank, are recognizing the importance of incorporation of governance issues in the health sector; however, their stance is still top-down, i.e., putting more emphasis on how to help government, rather than emphasizing efforts on empowerment of citizens and communities or making linkages between communities and governments. An influential global NGO like CARE can advocate, with its own successful experiences, for putting more attention to a bottom-up approach that starts at the community level and links communities with the government so that the interaction can start to improve health systems as well as governance.

6.2 Including the most marginalized

Another key for community-level interventions to be sustainable is

[78] The phrase "building trust" was used, inspired by the "Vigilantes de la Vida" episode describing CARE's maternal health improvement interventions in Peru (available from: http://www.womenempoweredproject.com/).

inclusion of the most marginalized. An oft-fallen pitfall of community-level interventions is that they end up working with only influential/powerful people within the community, excluding the most marginalized, often unintentionally. The most marginalized are the last ones to come forward, as they have less information, knowledge, and resources to participate. The question here is: how deep and broad the intervention reaches out in a community. The more number of people are engaged, the more chance of social change for a better outcome. Significant, sustainable change can only happen if the most marginalized have much greater involvement in shaping health policies and practices.[79] WHO's HEN report states that "Questions to pose within any community include: …whose voices remain hidden, and what are the power inequalities which may prevent participation of certain sectors."[80] Similarly, the World Bank states "When community-driven development does not pay attention to issues of social inclusion, groups of poor people may be excluded, investment choices may not reflect the true needs of the poor, and impacts may be significantly compromised. "[81] Thus, in order to make community-level interventions sustainable, a conscious effort to reach out the most marginalized needs to be taken.

A project in Indonesia funded by the World Bank gives us a good example of inclusion of the most marginalized group in a community. The Kecamatan Development Project (KDP), in which communities proposed infrastructure projects, took affirmative actions to widen community participation specifically targeting women who, as a group, have traditionally been discriminated against. For example, social mapping of all community households was used to identify the most marginalized households – poor, female-headed households, and to ensure that infrastructure would be located where it benefited these households. Also, separate community meetings for women and men were held to let women formulate their own proposals. This was a strategy to avoid men's tendency to dominate in mixed-sex meetings. Evaluations of the KDP project found that all categories of community members, including women and the poor, were more satisfied, compared to communities in which the affirmative

[79] Alarcón, Luz Estrada. *Global Health Council, 35th Annual International Conference on Global Health (Individual Abstract Submission)*
[80] Wallerstein, N. 2006. *What is the evidence on effectiveness of empowerment to improve health?* Health Evidence Network report.
[81] http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTCDD/0,,contentMDK:20433192~menuPK:608237~pagePK:148956~piPK:216618~theSitePK:430161,00.html

actions were not used. "This increased satisfaction enhances project sustainability by lowering the potential for social conflict and giving all community members a stake in ensuring continued project success."[82] Another example of a water and sanitation project from Sri Lanka funded by the Asian Development Bank adopted similar affirmative actions to include the most marginalized population in a village – female-headed households – into the project process.[83] The project set a rule of obtaining consent from 75% of total families in a village for the final decisions on water supply options, which protected the bargaining power of the most marginalized. The project also ensured that women's voices were represented by making it compulsory for women to occupy at least 40% of the membership in decision-making committees. As a result of these rules, the families of low-income groups obtained more benefits than families in high-income groups, and 80% of female-headed families were provided with water supply facilities. The above examples suggest that affirmative actions are effective in ensuring positive outcomes of the project reach the most marginalized populations in a community.

6.3 Going through social norm and value change

Findings of the Inter-Agency Working Group on the Role of Community Involvement suggest community-level interventions can bring about sustainable results. The Group's findings demonstrated that the interventions with significant community participation (dialogue and collective action) yielded changes not only in individual, but also at the structural level, i.e., community norms and values, such as the importance of providing youth with opportunities to develop skills and the need to strengthen community institutions that serve youth. The authors suggest that behavior change is more likely to be sustained in the communities that underwent this kind of normative change at the community and structural level.[84] Thus, improving maternal health through community interventions have a good chance to bring about change in social norms and values, which in turn will make the behavior change more sustainable. This is another benefit of intervening at the community-level.

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[82] World Bank. 2004. *Promising Approaches to Engendering Development: Participatory Approaches to Increasing Women's Voice in CDD [Community-Driven Development] Projects: Examples from Indonesia.*

[83] Dissanayake, Ananda. 2003. *Inclusion of Marginalized Groups in Rural WATSAN in Sri Lanka*

[84] IAWG. 2007. *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators.*

7. USAID's Stance on Governance and Maternal Health

USAID's recent approaches indicate its interest in addressing governance issues in maternal health/health programming. First, in the USAID report to Congress, "*Working toward the Goal of Reducing Maternal and Child Mortality: USAID Programming and Response to FY08 Appropriations*," there are quite a few maternal and child health (MCH) programs/projects that are incorporating governance issues:

- In Mali, health projects collaborate with democracy and governance projects to strengthen locally elected health committees to manage health centers.
- In Madagascar, USAID supports a decentralized health system through active engagement of the private sector and mobilization of community and civil society.
- In Benin, USAID helps communities become more active participants in the health system through peer education and local radio. At the same time, USAID supports the capacity building of the government to meet the needs of communities.
- In Malawi, the MCH program supports the Small Project Assistance Program through which communities develop capacities for decision-making and management of community grants to improve maternal health at the community level.
- In Mozambique, community-based mobilization is coupled with increased capacity at the district and provincial levels for planning and implementation of community-defined solutions.
- In Indonesia, NGOs, community leaders, District Health Department employees, members of health care professional associations, and members of parliament work together to learn advocacy skills, which has resulted in dramatic increases in MCH budgets at the district level and has strengthened community interest and engagement in MCH issues.
- In Azerbaijan, USAID assistance is increasing interaction of health care professionals and policymakers with community civilian and local governments.
- In Guatemala, civil society strengthening aims at improving public health expenditures.

Not much details of each country programs/projects are discussed in the report, but the above descriptions indicate that USAID is aware of the importance and effectiveness of framing MCH issues with governance issues to improve maternal health.

The second indication of USAID's interest in governance in the health sector is that the Global Health Bureau is implementing a health systems strengthening program (administered by the Health System Division of the Office of Health, Infectious Diseases and Nutrition within the Bureau). The Health System is one of the seven areas that the Global Health Bureau focuses on.[85] The health systems strengthening program focuses on six components to improve health systems, one of which is "governance". The six components are: service delivery, governance, financing, pharmaceutical management, human resource, and information.[86] Here, USAID is explicit on tackling governance issues to improve health systems.

Regarding the budget, in Fiscal Year (FY) 2007, the USAID's **total health budget** was nearly $4.15 billion (See Table 1) and the **Child Survival and Health (CSH) Programs Fund Budget** was $1.9 billion (See Table 2), according to the *Report to Congress: Child Survival and Health Programs Fund Progress Report Fiscal Year 2007*. The report divides these budgets into five program categories: Child Survival & Maternal Health; Vulnerable Children; HIV/AIDS; Infectious Diseases; and Family Planning & Reproductive Health. Thus, it is unclear how much was spent on the health systems strengthening program. The FY 2008 Appropriations Act created a new account, the Global Health and Child Survival (GH/CS) Account, which combined the Child Survival and Health (CSH) Programs Fund and the Global HIV/AIDS Initiative (GHAI) Account.[87] In fact, *Guidance on the Definition and Use of the Global Health and Child Survival Account* published in 2009 writes "At this point, there is no directive or special budget category for health systems development or capacity strengthening. Therefore, to the extent that the activity is part of any health program for the purpose of that program, it should be funded with monies from the FP/RH, Child and Maternal Health, Vulnerable Children, HIV/AIDS, and Infectious

[85] Other areas are: Environmental Health; Family Planning; HIV/AIDS; Infectious Diseases; Maternal and Child Health; and Nutrition. (http://www.usaid.gov/our_work/global_health/#)
[86] http://www.usaid.gov/our_work/global_health/hs/news/hs_fastfacts.pdf . These six areas are exactly the same categories as WHO defined as six blocks for improving health systems (Refer to Section 3.2).
[87] USAID. 2009. *Guidance on the Definition and Use of the Global Health and Child Survival Account.* (P.19)

Diseases budget categories".[88] It is worthwhile to note that the guidance writes: "The types of activities which are generally funded under the GH/CS Account include, but are not limited to: *Direct service delivery; System strengthening in both public and private sectors; Community participation and mobilization*".[89]

As the third indication of USAID's interest in the governance issue, there is a five-year (2006-2011) cooperative agreement called "Health Systems 20/20". The project is one of the principal projects administered by the Health Systems Division described above. The Health Systems 20/20 builds capacity in health financing, operations, and governance for health system leaders and health workers on the ground. By strengthening health systems, the project aims to enable people to gain access to PHN (population, health and nutrition) services. The countries where the project is implemented include: Cote d'Ivoire, Ghana, Kenya, Liberia, Madagascar, Malawi, Mozambique, Namibia, Nigeria, Rwanda, Senegal, Southern Sudan, Tanzania, Uganda, Zambia, India, Indonesia, Vietnam, Egypt, West Bank, Yemen, Bolivia and Peru.[90] The project implementing team is led by Abt Associaes and includes the Aga Khan Foundation USA, BearingPoint, Bitrán y Asociados (Chile), BRAC University (Bangladesh), Broad Branch Associates, Forum One Communications, RTI International, Training Resources Group, and Tulane University's School of Public Health. The project also works with 16 developing country organizations.[91]

The project's total funding ceiling is $125,000,000. As of the end of Year 2, the project had core and field obligations totaling $19,707,976.[92] The project is a "Leader with Associates Cooperative Agreement," and Abt Associates is the "Leader" and the recipient that is primarily responsible for the project implementation. Leader with Associates Cooperative Agreements allows USAID missions or bureaus to negotiate separate, additional "Associate Awards" (associate cooperative agreements) under the Health Systems 20/20 umbrella to support the same objectives as the Leader agreement.[93] Associate Awards have

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[88] USAID. 2009. *Guidance on the Definition and Use of the Global Health and Child Survival Account.* (P.77)
[89] USAID. 2009. *Guidance on the Definition and Use of the Global Health and Child Survival Account.* (P.21)
[90] http://www.healthsystems2020.org/section/where_we_work/
[91] USAID. 2008. *Health Systems 20/20 Year 2 Annual Report.* (P.1)
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[93] For further details on the Leader with Associates Cooperative Agreement, refer to *Health Systems 20/20 Project, 2006-2011 Cooperative Agreement No. GHS-A-00-06-00010-00 Associate Awards* (USAID, 2006). Also, http://www.healthsystems2020.org/content/resource/detail/1923/; and http://www.healthsystems2020.org/section/about/missions/awards .

no ceiling and are outside the Leader Award ceiling of $125 million. Two associate awards have been awarded by Year 2.[94]

Although the project is for improving the utilization of population, health and nutrition (PHN) services and not specifically for MCH, it takes governance perspectives and explicitly aims at creating synergies between government, citizens, civil society, and the private sector. The approach of the Health Systems 20/20 is to tackle "both the demand and supply sides of governance. On the demand side, work with citizens and oversight entities inside and outside of government enhances capacity to exercise voice and accountability. These practices go hand-in-hand with strengthening the MOH and other health sector actors: the supply-side of governance improvement."[95] On the website, the Health Systems 20/20 is emphasizing the reciprocity of both demand and supply sides on the governance issue, but the available documents suggest its interventions so far are mostly at the government-side, such as policy formulation, financial system and human resource management, information and data collection. Here, CARE has niche to show its capability to start interventions at the community-level and link communities with governments to improve governance and health systems.

The above facts show that there are good chances that USAID would be interested in framing maternal health programming with the governance issues, i.e., building a functional health system for improving maternal health is good not only for its own sake, but it simultaneously leads to strengthening governance by enhancing government capacity and civil society involvement.

Table 1: FY 2007 USAID Total Health Budget by Program Category and Bureau

Program Category	Amount	%
Child Survival & Maternal	442,863,000	11%
Vulnerable Children	19,482,000	<1%
HIV/AIDS	2,650,963,000	64%
Infectious Diseases	586,153,000	14%

[94] USAID. 2008. *Health Systems 20/20 Year 2 Annual Report.* (P. 19)
[95] http://www.healthsystems2020.org/section/topics/governance

Family Planning &	450,375,000	11%
Total	4,149,836,000	100%

(Source: USAID. 2007. *Report to Congress: Child Survival And Health Programs Fund Progress Report Fiscal Year 2007*)

Table 2: FY 2007 Child Survival and Health Programs Fund Budget by Program Category and Bureau

Program Category	Amount	%
Child Survival & Maternal	396,617,000	21%
Vulnerable Children	6,482,000	<1%
HIV/AIDS	572,500,000	30%
Infectious Diseases	529,143,000	28%
Family Planning &	396,683,000	21%
Total	1,901,425,000	100%

(Source: USAID. 2007. *Report to Congress: Child Survival And Health Programs Fund Progress Report Fiscal Year 2007*)

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