What does success look like for international engagement?

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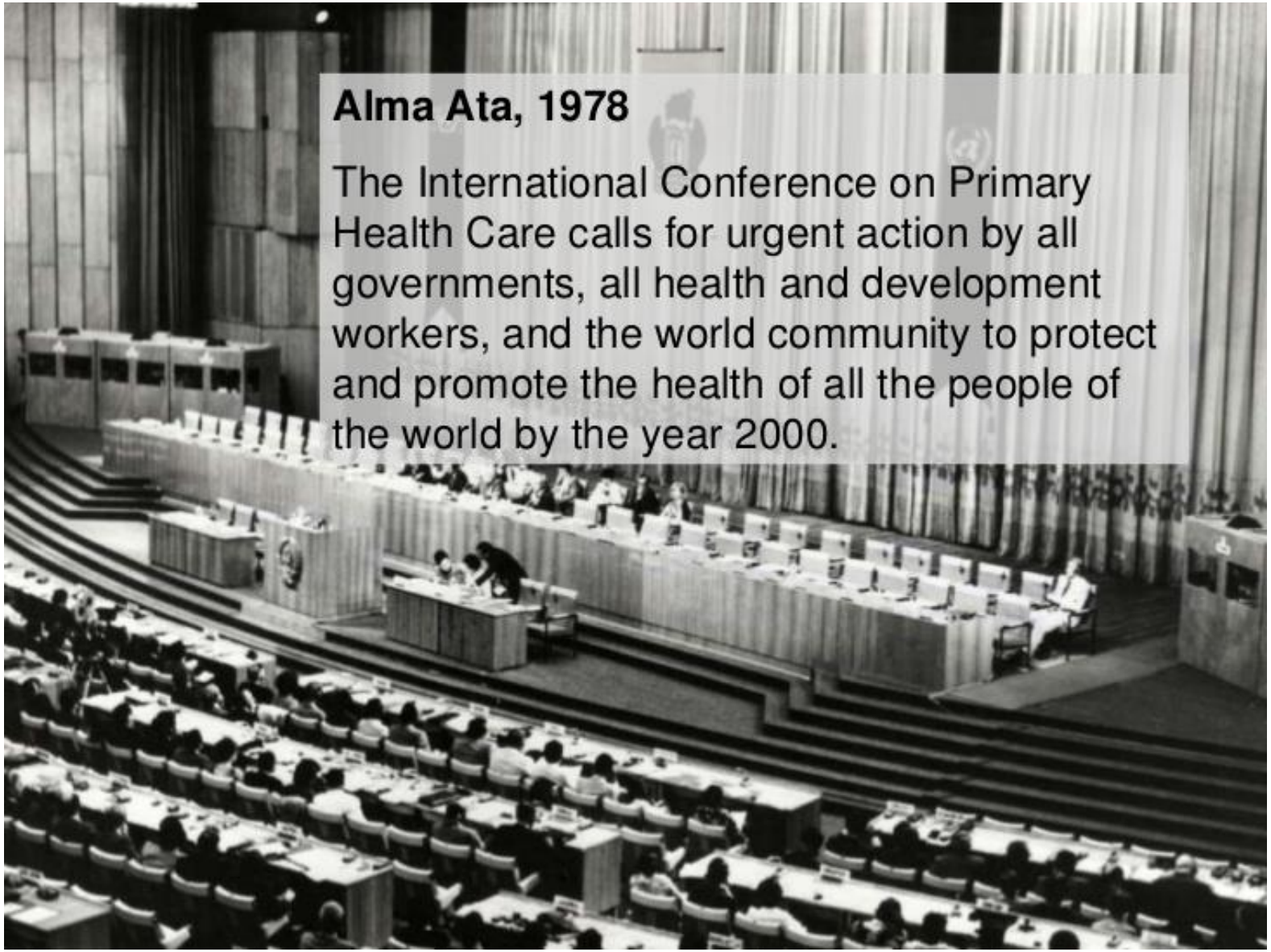
Thinking by analogy:

The Case of Health Systems Performance


Alma Ata, 1978
The International Conference on Primary Health Care calls for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world by the year 2000.

Questions facing the "Health Systems" field in the 1980s-1990s

What are the GOALS of a health system?

What are we trying to accomplish?

What are the COMPONENTS of a health system?

What elements/components are necessary to achieve the goals?

What are their functions?

How does the *system* work?

What adaptations are necessary to respond to variations in context?

Questions facing the "Health Systems" field in the 1980s-1990s

What is the organizing MODEL of health system performance

What outcomes are associated with good performance?

What mechanisms produce, or contribute to, these outcomes?

How does performance vary by context?

How does the perception of performance vary with perspective?

What are the necessary MEASURES of health system performance

Health impact?

Value for money /ROI?

Fairness /ethical value?

Indicators?

Questions facing the "Health Systems" field in the 1980s-1990s

What COMPARATIVE ANALYSES of health systems performance are feasible?

Are there measures/indicators that are stable across different contexts?

Do data exist?

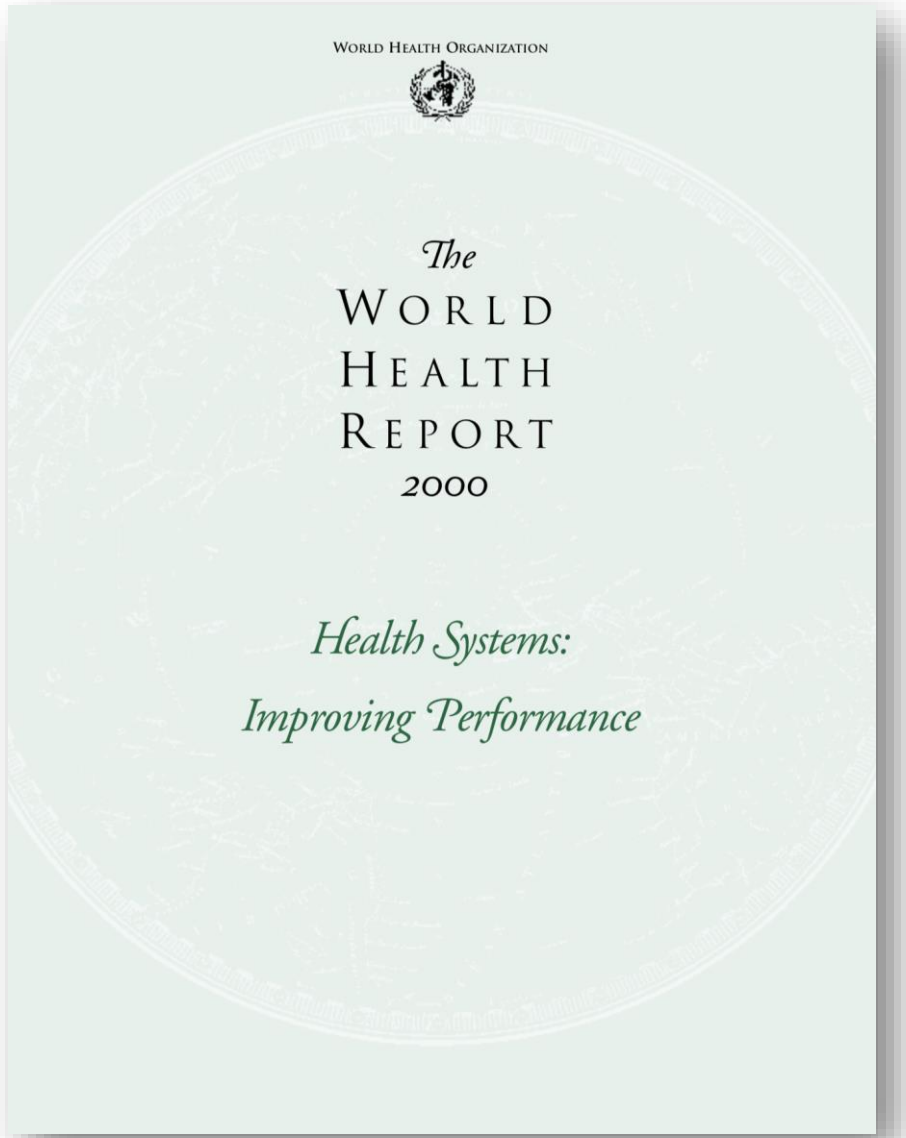
Can they be assembled

What is the PURPOSE and VALUE of the comparisons

Are comparisons meaningful, i.e., can they improve performance

Can they improve investment (e.g., systems-building, research, etc.)

Do they do harm to countries?



What makes for a good health system? What makes a health system fair? And how do we know whether a health system is performing as well as it could? These questions are the subject of public debate in most countries around the world.

Naturally, answers will depend on the perspective of the respondent. A minister of health defending the budget in parliament; a minister of finance attempting to balance multiple claims on the public purse; a harassed hospital superintendent under pressure to find more beds; a health centre doctor or nurse who has just run out of antibiotics; a news editor looking for a story; a mother seeking treatment for her sick two-year old child; a pressure group lobbying for better services – all will have their views. We in the World Health Organization need to help all involved to reach a balanced judgement.

Whatever standard we apply, it is evident that health systems in some countries perform well, while others perform poorly. This is not due just to differences in income or expenditure: we know that performance can vary markedly, even in countries with very similar levels of health spending. The way health systems are designed, managed and financed affects people's lives and livelihoods. The difference between a well-performing health system and one that is failing can be measured in death, disability, impoverishment, humiliation and despair.

Dr Gro Harlem Brundtland

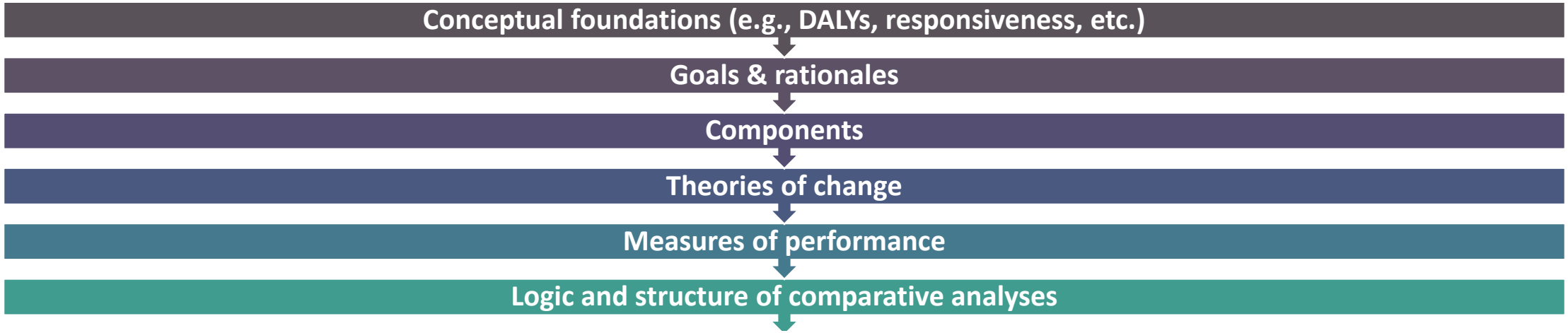
A Framework for Measuring Health Inequality

Emmanuela E. Gakidou, Christopher J.L. Murray, Julio Frenk*

* The authors wish to acknowledge the following individuals for useful input and comments: Gary King, Rafael Lozano, Joshua Salomon, Daniel Wikler, Sarah Marchand and Phillip Musgrove.

What did success look like for health systems

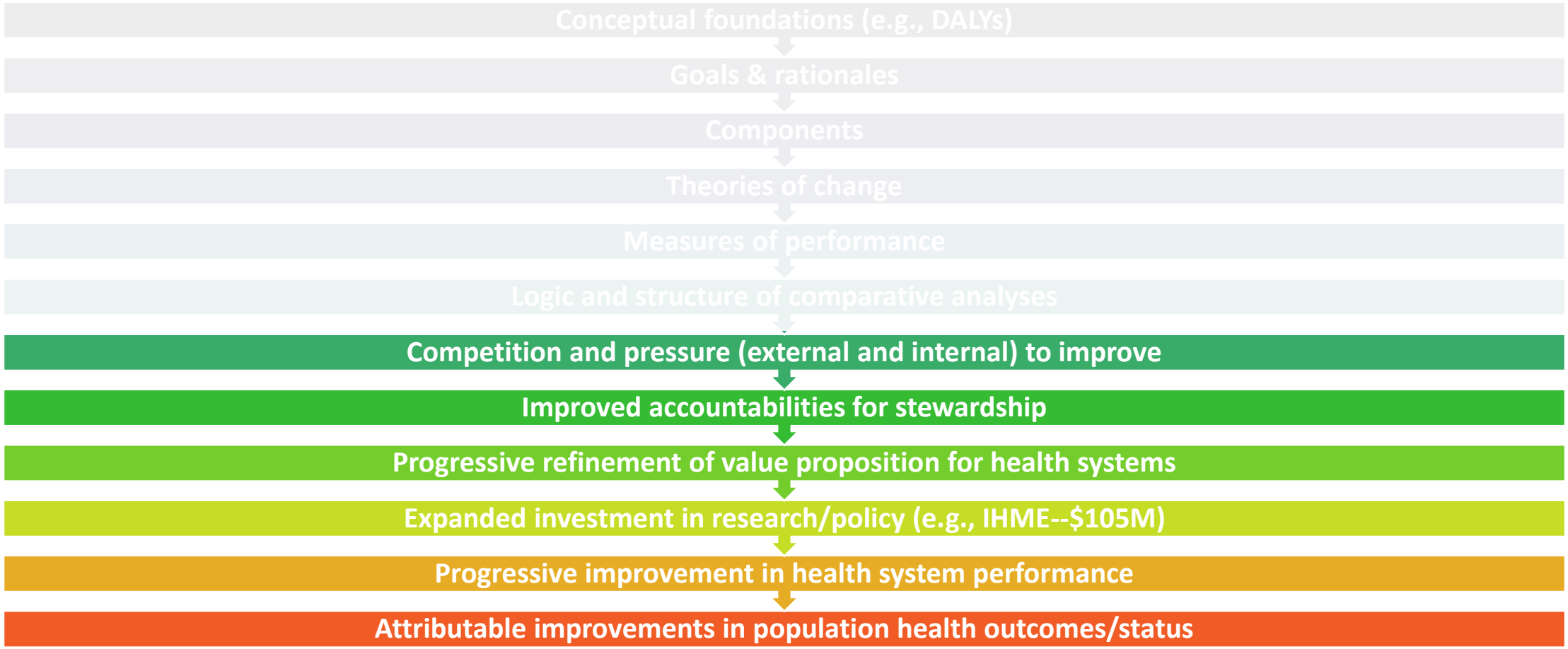
Success for health systems
Phase 1: Achieving clarity on foundations

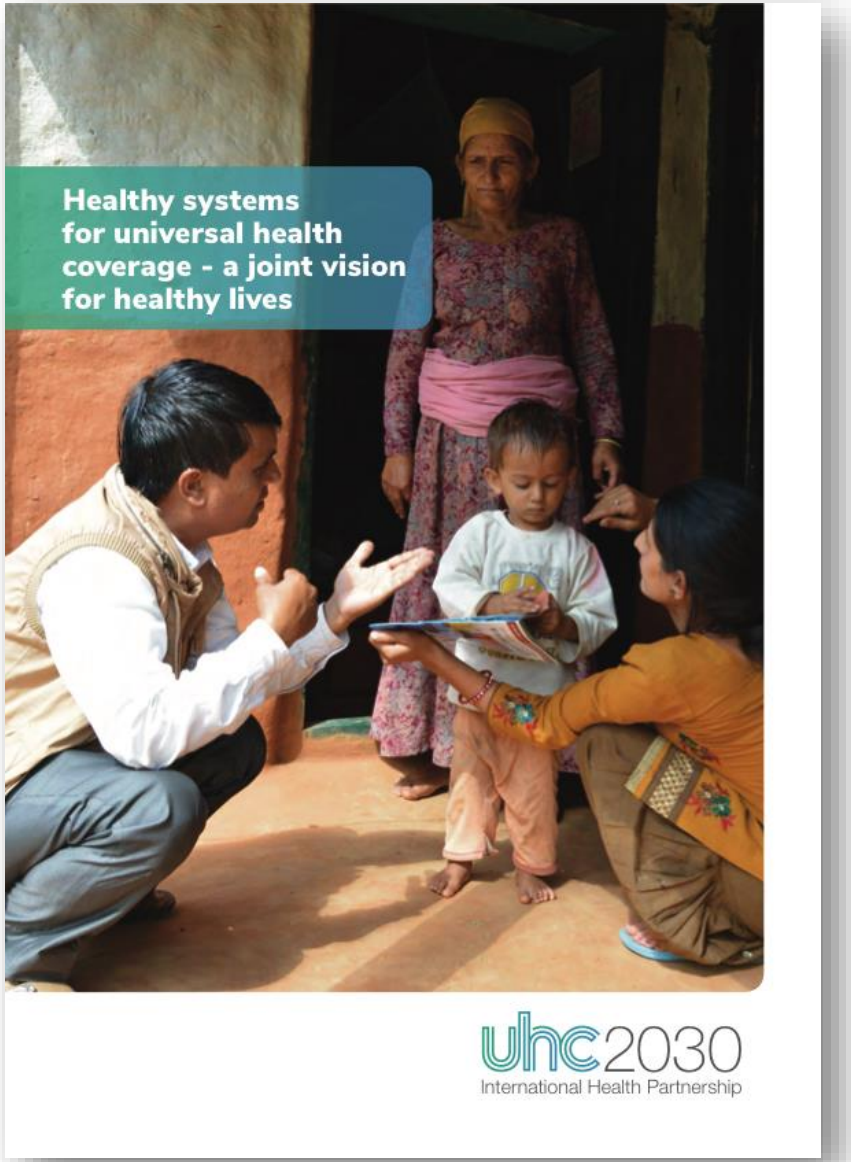


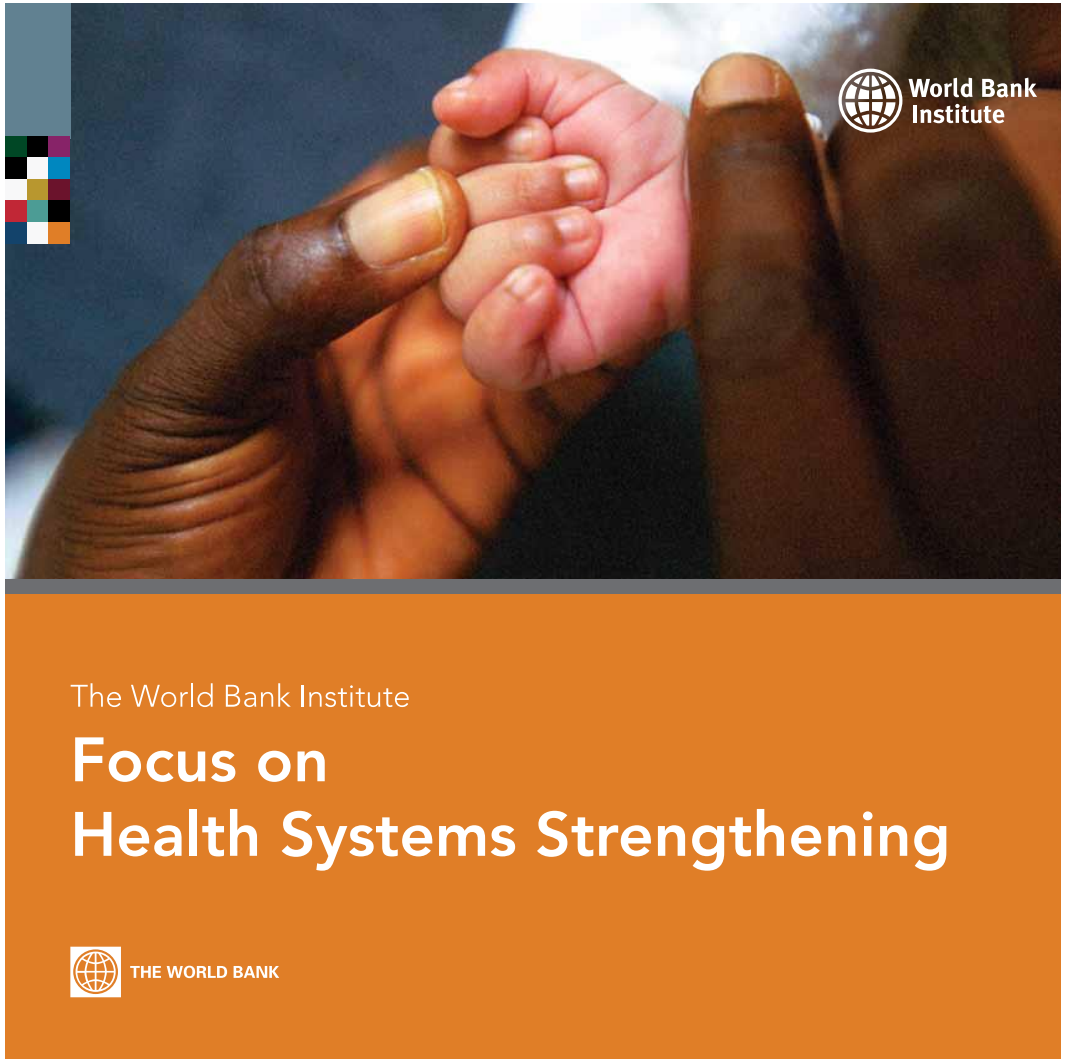
Annex Table 1 Health system attainment and performance in all Member States, ranked by eight measures, estimates for 1997

Member State	ATTAINMENT OF GOALS						Health expenditure per capita in international dollars	PERFORMANCE	
	Health		Responsiveness		Fairness in financial contribution	Overall goal attainment		On level of health	Overall health system performance
	Level (DALE)	Distribution	Level	Distribution					
Afghanistan	168	182	181 – 182	172 – 173	103 – 104	183	184	150	173
Albania	102	129	136	117	173 – 174	86	149	64	55
Algeria	84	110	90 – 91	50 – 52	74 – 75	99	114	45	81
Andorra	10	25	28	39 – 42	33 – 34	17	23	7	4
Angola	165	178	177	188	103 – 104	181	164	165	181
Antigua and Barbuda	48	58	47 – 48	39 – 42	116 – 120	71	43	123	86
Argentina	39	60	40	3 – 38	89 – 95	49	34	71	75
Armenia	41	63	92	111 – 112	181	81	102	56	104
Australia	2	17	12 – 13	3 – 38	26 – 29	12	17	39	32
Austria	17	8	12 – 13	3 – 38	12 – 15	10	6	15	9
Azerbaijan	65	99	130 – 131	125	116 – 120	103	162	60	109
Bahamas	109	67	18	3 – 38	138 – 139	64	22	137	94
Bahrain	61	72	43 – 44	3 – 38	61	58	48	30	42
Bangladesh	140	125	178	181	51 – 52	131	144	103	88
Barbados	53	36	39	3 – 38	107	38	36	87	46
Belarus	83	46	76 – 79	45 – 47	84 – 86	53	74	116	72
Belgium	16	26	16 – 17	3 – 38	3 – 5	13	15	28	21
Belize	94	95	105 – 107	90	146	104	88	34	69
Benin	157	132	175 – 176	160	140 – 141	143	171	136	97
Bhutan	138	158	163	137 – 138	89 – 95	144	135	73	124
Bolivia	133	118	151 – 153	178	68	117	101	142	126
Bosnia and Herzegovina	56	79	108 – 110	124	82 – 83	79	105	70	90
Botswana	187	146	76 – 79	111 – 112	89 – 95	168	85	188	169
Brazil	111	108	130 – 131	84 – 85	189	125	54	78	125
Brunei Darussalam	59	42	24	3 – 38	89 – 95	37	32	76	40
Bulgaria	60	53	161	2	170	74	96	92	102
Burkina Faso	178	137	174	164	173 – 174	159	173	162	132
Burundi	179	154	171	168	114	161	186	171	143
Cambodia	148	150	137 – 138	137 – 138	183	166	140	157	174
Cameroon	156	160	156	183	182	163	131	172	164
Canada	12	18	7 – 8	3 – 38	17 – 19	7	10	35	30
Cape Verde	118	123	154	134 – 135	89 – 95	126	150	55	113
Central African Republic	175	189	183	191	166	190	178	164	189
Chad	161	175	181 – 182	185	58 – 60	177	175	161	178
Chile	32	1	45	103	168	33	44	23	33
China	81	101	88 – 89	105 – 106	188	132	139	61	144
Colombia	74	44	82	93 – 94	1	41	49	51	22
Comoros	146	143	157 – 160	153 – 155	79 – 81	137	165	141	118
Congo	150	142	137 – 138	151	162	155	122	167	166
Cook Islands	67	92	65	89	45 – 47	88	61	95	107
Costa Rica	40	45	68	86 – 87	64 – 65	45	50	25	36
Côte d'Ivoire	155	181	157 – 160	153 – 155	116 – 120	157	153	133	137
Croatia	38	33	76 – 79	83	108 – 111	36	56	57	43
Cuba	33	41	115 – 117	98 – 100	23 – 25	40	118	36	39
Cyprus	25	31	11	44	131 – 133	28	39	22	24
Czech Republic	35	19	47 – 48	45 – 47	71 – 72	30	40	81	48
Democratic People's Republic of Korea	137	145	139	130 – 131	179	149	172	153	167
Democratic Republic of the Congo	174	174	142	169 – 170	169	179	188	185	188
Denmark	28	21	4	3 – 38	3 – 5	20	8	65	34
Djibouti	166	169	170	140	3 – 5	170	163	163	157
Dominica	26	35	84 – 86	77 – 78	99 – 100	42	70	59	35
Dominican Republic	79	97	95	72	154	66	92	42	51
Ecuador	93	133	76 – 79	182	88	107	97	96	111
Egypt	115	141	102	59	125 – 127	110	115	43	63
El Salvador	87	115	128	128 – 129	176	122	83	37	115

Success for health systems
Phase 2: Managing to impact

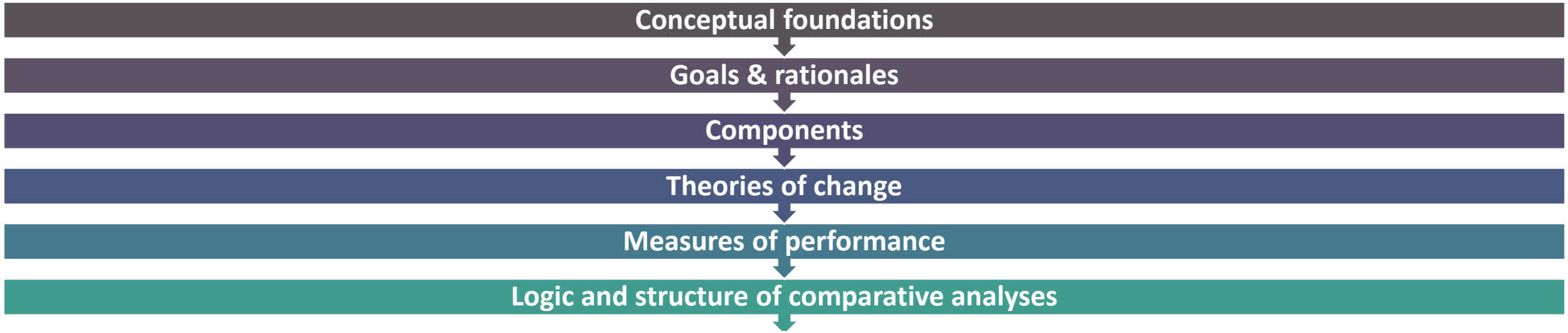



Healthy systems
for universal health
coverage - a joint vision
for healthy lives
uhc2030
International Health Partnership


World Bank
Institute
The World Bank Institute
Focus on
Health Systems Strengthening
THE WORLD BANK

What does success look like for Engagement?

Success for Engagement
How well are we doing?



Steps to success for health systems

Lack of clarity/agreement on…	*Early* Health Systems
Goals & Rationales	✓
Components	✓
Model of performance (theory of change)	✓
Measures of performance	✓
Logic and structure of comparative analyses	✓

Steps to success for international engagement

Lack of clarity/agreement on…	*Early* Health Systems	*Current* "Engagement"
Goals & Rationales	✓	?
Components	✓	?
Model of performance (theory of change)	✓	?
Measures of performance	✓	?
Logic and structure of comparative analyses	✓	?

POLICY FORUM

Members of the Havasupai tribe pray over blood samples at Arizona State University. Disregard for how the research could undermine the tribe's interests led to a lawsuit and out-of-court settlement.

SCIENCE AND SOCIETY

Building an evidence base for stakeholder engagement

The private sector provides lessons and models

By **James V. Lavery**

Science is a social enterprise. Many scientific programs interact with a wide range of communities and stakeholders to secure various types of access and permission, to seek cooperation and collaboration for scientific studies, to fulfill regulatory and ethical requirements, and to try to shape research strategies and to improve the translation of their findings into policy or practice. But these interactions are motivated disproportionately by the interests and goals of the scientific programs and less by the need to elicit and understand their implications for stakeholders. However, there is increasing recognition that substantive community and stakeholder engagement (CSE) can improve the performance, and even make or break the success, of some science programs by providing a means of navigating, and responding to, the complex social, economic, cultural, and political settings in which science programs are conducted. For CSE to become more widely accepted by funders and researchers, and to contribute more conspicuously to the success of science programs and policy, it will have to establish a more coherent and convincing body of evidence about the nature of CSE strategies and their specific contributions to the performance of science programs.

The zeal that drives scientists in their quest for discovery and their deep-rooted faith in the scientific enterprise can sometimes lead them to underestimate, or disregard, the potential for their actions to negatively affect the interests of stakeholders beyond the immediate frame of reference of their scientific protocols. For example, Ashkenazi Jews faced stigmatization and discrimination on the basis of findings of population-genetics research (*1*), and unauthorized research on historical human migration patterns damaged the collective cultural identity of the Havasupai tribe of Arizona (*2*). Despite the importance of such harms, the dominant ethics paradigms in science—scientific integrity and human-subject research protections—provide little guidance about how to anticipate and avoid them.

A common intuition is that these harms can be mitigated by CSE. The idea has attracted interest in a wide range of disciplines, including sustainable development (*3*), regulation of new biotechnologies (*4*), and humanitarian emergencies (*5*), along with long-established practices in community-based participatory research (*6*), patient engagement in clinical research (*7*), and global health (*8*).

Yet, as one recent commentary about CSE noted, "there is limited empirical evidence on the best practices for stakeholder engagement and even less on evaluation of engagement demonstrating the association between the quality and quantity of engagement and research outcomes" (*9*). This lack of evidence about CSE could be the sustaining force for a self-fulfilling prophecy, because those with the authority to make budget decisions for science programs lack clarity about the circumstances under which CSE is necessary, its appropriate scope and form, and a clear and coherent value proposition for how CSE improves the ethics of research and enhances the impact of their investments. The result is often expressed as skepticism or indifference to the potential value of CSE.

KEY CHALLENGES

First, the generation of useful and comparable evidence for CSE is complicated by the absence of an agreed theory of CSE. What are its constituent elements? What mechanisms are involved? What programmatic and ethical outcomes does it produce and under what circumstances? And how do these vary according to the nature of the science and the specific settings of application? Answers to these individual questions would not only provide insights about how CSE works in various contexts but would also facilitate the development of useful theory, which will be essential to move CSE beyond a static and critically unexamined set of practice conventions.

Second, the coherence and comparability of the evidence is undermined by the extraordinary degree of variability in the working language for CSE. Concepts, such as "engagement," "sensitization," "mobilization," "empowerment," and "trust-building," are often conflated and interchanged casually, even though the goals and outcomes they imply differ substantially. Similarly, assumptions about what constitutes the relevant "community," or who should be counted as a legitimate "stakeholder," are often poorly stipulated or specified. This conceptual ambiguity and heterogeneity compounds the problem of insufficient precision and explicitness in the reporting

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PHOTO: JIM WILSON/THE NEW YORK TIMES/REDUX PICTURES

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