Addressing Governance Challenges and Capacities in Ministries of Health

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## Contents

Acknowledgements ........................................................................................................................................ iv

Introduction: Governance and the Ministry of Health ........................................................................... 1
  A Timeline of Change ............................................................................................................................... 2
  Governance ............................................................................................................................................. 3
  Capacities .............................................................................................................................................. 4

1 MoH Governance: Definitions and Issues ......................................................................................... 7
  1.1 What do we mean by “governance”? ............................................................................................. 8
  1.2 In what ways does “governance” apply to an MoH? .................................................................... 8
  1.3 What are four major roles of MoH governance? ......................................................................... 9

2 MoH Capacity: Definitions and Issues .............................................................................................. 13
  2.1 What do we mean by “capacity”? ..................................................................................................... 14
  2.2 What governance capacities does an MoH require? ................................................................... 15

3 The Governance and Capacity of a Ministry of Health: Country Examples ................................ 19
  3.1 Around the world, what are the major challenges for MoH governance capacities? ................ 20
  3.2 What are some specific governance roles for an MoH? .............................................................. 25
  3.3 How can an MoH uphold governance principles while ensuring wide stakeholder participation? ........................................................................................................................................ 30
  3.4 How can an MoH effectively manage governance relationships? ............................................ 31

4 Strengthening MoH Governance Capacities: Examples .............................................................. 37
  4.1 Strategic planning and policy development. ................................................................................ 38
  4.2 Procurement. .................................................................................................................................. 38
  4.3 Human and financial resource management. .............................................................................. 39
  4.4 Evidence usage. ............................................................................................................................... 39
  4.5 Regulation. ..................................................................................................................................... 39
  4.6 Reform. ......................................................................................................................................... 40
  4.7 Values. ......................................................................................................................................... 40
  4.8 Managing relationships. ................................................................................................................ 40

5 Strengthening Governance Capacities: Observations and Recommendations .......................... 43
  Summary ............................................................................................................................................... 44
  Lessons learned ................................................................................................................................... 44
  Recommendations ............................................................................................................................ 45

References ............................................................................................................................................... 47
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Introduction: Governance and the Ministry of Health

In addressing the big societal challenges of today – from containing communicable diseases to offering health services at all levels – how equipped is a Ministry of Health (MoH) to govern? This question occupies many health authorities around the world. National health authorities occupy a central role in health system governance. As Ministries or Departments of Health, these authorities have a unique mandate over population health, charged with ensuring the health and wellness of millions. What kinds of capacities does an MoH require to govern responsibly and effectively? How can we better understand the terms “governance” and “capacity” as applied to an MoH? What are some strong country examples from which we can collectively learn? And how can we better assess the ways in which an MoH changes and adapts to very dynamic context?

What kinds of capacities does an MoH require to govern responsibly and effectively?

In recent decades, the role of an MoH has shifted from that of funder and provider to more of a steward of the entire health system. While states have always been tasked with various degrees of “oversight,” current oversight measures for an ever-more complex health sector require a distinctly outward-looking and inclusive multisectoral approach to governance, and being better equipped to address increasingly pluralistic systems [1, 2]. Notably, an MoH today often does not hold exclusive authority over health, sharing that responsibility with sub-national actors – such as provinces, states and districts – with supra-national actors – including global foundations and multilaterals – with legally empowered agencies, councils and institutions charged with particular governance functions, and with citizens [3, 4]. Surrounding all these actors are broader networks and structures that can include other parts of government, civil society, researchers, professional groups, the private sector, including health sector stakeholders and other industries, donors, and regional and international bodies.

Clearly, the governance context for any MoH has become highly complex and dynamic. Many different actors – in some cases already part of the governance structure – now advance their own interests. Particularly in low- and middle-income countries (LMICs),

1 Note that throughout this Working Paper, we will use the generic term “Ministry of Health” or “MoH” as a proxy for the major national health authority in any country, no matter its correct designation.
A lack of resources may compound the complexity, as do the weight of other line ministries exerting their own influence, or bureaucratic structures that may prove slow in adapting to the fast-changing, modern environment [5].

The governance context for a modern MoH has become highly complex - and continually shifting.

In this WHO Working Paper, we seek to understand and illustrate this interplay between governance and capacity in Ministries of Health across the world.

**A TIMELINE OF CHANGE**

As illustrated in Table One to the right, various pressures have combined to push and pull on MoH governance abilities and capacities for decades. In most LMICs, MoHs emerged from colonial systems and were often reconfigured in these newly independent states. MoHs have also been shaped by global trends and milestones; for example, the Alma Ata Declaration helped expand efforts around primary care and social determinants of health. However, these trends were met with emerging fiscal constraints in the 1970s and 1980s, which often squeezed MoH budgets [1, 6]. Other political, administrative and/or fiscal reforms from the 1980s and 1990s onwards (e.g. diversifying purchasing and provision of health services, decentralization measures) created new management and organizational structures in Ministries, in many cases implemented without related capacity-building efforts [1]. Furthermore, the rapid rise of market-based approaches to health services in the last few decades has presented new oversight and regulation challenges [7].

From the 2000s onwards, following increased global attention to health inequities (for instance in the context of the Millennium Development Goals), Ministries engaged with new stakeholders. This included new philanthropic foundations, private sector corporations, new bilateral and multi-lateral agencies, plus a more diverse set of international NGOs [5]. A cross-sectoral, “Health in All Policies” approach was adopted [5]. And an increased focus on Universal Health Coverage – as reflected in the Sustainable Development Goals [8] – supported calls for deeper systems thinking as part of health systems strengthening [9] and demands for MoHs to actively engage citizen voice across the health system [4].
### Table 1. Historical context of evolving role of Ministries of Health

<table>
<thead>
<tr>
<th>Timeframe</th>
<th>Contextual factors in LMICs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900s – 1980s</td>
<td>Postcolonial reconfiguration of Ministries of Health in low- and middle-income countries</td>
</tr>
<tr>
<td>1970s – 1980s</td>
<td>Fiscal restraint imposed in response to economic crises, structural adjustment programs etc.</td>
</tr>
<tr>
<td>1978</td>
<td>Alma Ata Declaration expands focus on primary health care, health as a human right, and social determinants of health</td>
</tr>
<tr>
<td>1980s – 1990s</td>
<td>Transition to multi-party democratic structures in some LMICs trigger core MoH changes (e.g. expanded stakeholders, enhanced role of sub-national actors, etc.)</td>
</tr>
<tr>
<td>1990s –</td>
<td>Focus on health sector and/or civil service reform leads to staff reduction, introduction of new forms of recruitment and pay, and to decentralization</td>
</tr>
<tr>
<td>1990s –</td>
<td>World Development Report highlights new reforms, including purchaser-provider split; development of the sector wide approach (SWAp)</td>
</tr>
<tr>
<td>2000 – 2015</td>
<td>Millennium Development Goals increase momentum for countries to achieve targets in maternal and child health and certain communicable diseases; World Health Report (2000) on health system performance highlights the “stewardship” function of MoHs</td>
</tr>
<tr>
<td>2012 –</td>
<td>Increased focus on <em>Health in All Policies</em> approach requires Ministries of Health to take an active approach in inter-sectoral coordination</td>
</tr>
<tr>
<td>2016 –</td>
<td>Sustainable Development Goals promote a Universal Health Coverage (UHC) and multisectoral action</td>
</tr>
</tbody>
</table>

*Sources: [1, 2, 5, 6, 8]*

As we see in this timeline, for an MoH the backdrop, the actors, the issues are all continually changing. But what does this imply for an MoH’s capacities to govern? Where does its governance remit begin and end? And – what exactly do we mean by “governance” and “capacity”?

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**Where does governance begin and end for a Ministry of Health?**

**GOVERNANCE**

Definitions of “governance” vary widely [10, 11]. The WHO has advanced its own definition of “governance” as linked with leadership and stewardship, and focuses on policy frameworks, harmonization, alignment, oversight and regulation [12]. Similarly, other approaches outline the responsibilities and tasks an MoH is expected to fulfill, including strategic planning, policy development, coordination, convening of stakeholders, regulation, performance, quality and equity assessment, monitoring and evaluation, audit and inspection [5]. Beyond this, public policy and public administration understandings of “governance” emphasize participation, transparency, fairness and trust-building [11]. Emerging from this are governance needs that include
addressing corruption, failures of implementation, economic or ecological catastrophes, the priorities of development partners – and managing those external priorities, especially in an emergency setting.

**CAPACITIES**

Given these considerations, how do existing MoH capacities translate into specific governance roles? Which capacities exist, which need strengthening, and which are missing? In this *WHO Working Paper*, we explore different types of capacity and show how each critically influences an MoH’s ability to govern. Importantly, this paper focuses on organizational and individual capacities – and uses this lens to understand four key governance roles, including how an MoH is equipped to perform its de jure governance role; how an MoH can respond to changing contexts; how an MoH can manage stakeholder relationships; and how an MoH can best uphold governance principles, such as accountability and transparency.

Informed by a comprehensive scoping review [13], Section I of this paper asks: what do we mean by “governance”? And in what ways does an MoH actually exercise its governance responsibilities? In Section II we ask, what do we mean by “capacity”? What capacities are required for an MoH to exercise its governance roles? How can we “load” MoH capacity with governance roles to understand the strengths and challenges for any MoH?

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**How do existing Ministry of Health capacities translate into specific governance roles? Which capacities exist, which need strengthening, and which are missing?**

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In Section III, we apply these questions to countries around the world. How have MoHs demonstrated – or failed to demonstrate – capacity for governance, in varied contexts and along different roles? What initiatives have strengthened MoH governance capacities? Where does future work lie? We provide some examples of strengthening governance capacities in Section IV and we conclude in Section V with some observations, recommendations and thoughts on what comes next.

Our exercise has initially focused on low-and middle-income countries but carries insights for all health authorities globally.
Section 1

MoH Governance: Definitions and Issues
This section introduces some key concepts around “governance”. The term is multifaceted, so what exactly do we mean by “governance”? And given the rapidly shifting environment – globally, nationally and locally – in what ways does an MoH actually interpret and exercise its governance responsibilities?

1.1 WHAT DO WE MEAN BY “GOVERNANCE”? 

Generally, “governance” refers to accountability, representation, stewardship, ownership, power, authority and the rule of law. It encompasses a “set of processes (customs, policies or laws) that are formally or informally applied to distribute responsibility or accountability among actors of a given [health] system” [10]. The WHO definition pairs governance with leadership and stewardship, and stating that it involves “ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability” [12]. These processes or rules “can be both formal, embodied in institutions (e.g., democratic elections, parliaments, courts, sectoral ministries), and informal, reflected in behavioral patterns (e.g. trust, reciprocity, civic-mindedness)” [14]. Importantly, governance implies the transfer of “some decision-making responsibility from individuals to a governing entity, with implementation by one or more institutions, and with accountability mechanisms to monitor and assure progress on the decisions made” [15].

1.2 IN WHAT WAYS DOES “GOVERNANCE” APPLY TO AN MOH?

An MoH is typically mandated to “steer” health policy by regulating and monitoring health functions in both public and private sectors, and in some cases, directly managing health service delivery [16]. Ministries typically undertake an array of de jure roles, including the formulation of a strategic vision for health, the balancing of centralized and decentralized authority for decision-making, the management and implementation of policies, programs and interventions, regulation and oversight, and monitoring and evaluation, notably of performance, quality and equity [1]. As part of a broader government system, Ministries engage with political leadership, other line ministries, legislative bodies, sub-national state actors and political parties.

In recent decades, “governance” has evolved from being a state-centered concept to one that is collaborative [2], with shared responsibilities across a range of actors at multiple levels and various sectors. The increasingly complex challenges that society faces demand that the state reach across boundaries, and become more inclusive, strategic and agile in its approach [4].

"Leadership and governance involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition building, regulation, attention to system-design and accountability [12]."
1.3 WHAT ARE FOUR MAJOR ROLES OF MOH GOVERNANCE?

In this section, we explore four major roles of MoH governance:

- De jure governance processes;
- Preparation for and response to change in context;
- Relationship management; and
- Values management.

Role 1: “De jure” governance processes.

MoHs have certain de jure (by right, or based on laws and actions of the state) governance roles pertaining to health [10, 16]. Over the last few decades, driven by various factors, the focus of MoHs has shifted from service delivery to an emphasis on stewardship, including policy development, strategic direction and oversight [1, 17, 18, 19]. Additional roles include citizen empowerment and responsiveness to needs; evidence and knowledge management; resource management, including fundraising and financial management; contracting and compliance; procurement and supplies management; and quality, equity and performance monitoring. How effectively a Ministry can implement its de jure governance responsibilities is a key performance area for any MoH.

Role 2: Preparation for and response to changes in context.

An MoH is increasingly required to prepare for and respond to fast-moving contexts - within government and across society [2, 10]. Examples of changing contexts include epidemiological shifts, crises, income inequality, urbanization, globalization, the marketization of health, climate change, and the rise of citizens and consumers as active participants in health sector governance [4, 16]. The speed and predictability of these factors might also vary considerably, necessitating short-, medium- and long-term perspectives to the response. This demands absorptive, adaptive and transformative capacities when responding to rapidly changing contexts, as seen, for instance, during the 2014 Ebola outbreak in West Africa [20] and illustrated in Figure 1 below.

An MoH is also a political actor, and as such is subject to sudden political shifts - not only locally and nationally, but also globally, demanding Ministries engage with an ever-wider range of actors [4]. The nature of reform in the health sector is also highly context-specific, and dependent on the intersection of global, national and local actors and trends. How swiftly and effectively an MoH can respond to the shifting context underlines its resilience, relevance - and of course its capacity.
**Role 3: Relationship management.**

Ministries of Health must engage an array of stakeholders in governance, both within and outside government. From a systems-thinking perspective, Ministries are embedded in various overlapping systems, often playing a moderating or arbitrating role to manage all the competing stakeholder interests [14]. For instance, citizen groups might not wield similar power to that of organized labor. Or private sector actors might have direct access to executive leadership allowing them to bypass the MoH. In this way, Ministries must exert their leadership and diplomatic capacities to generate consensus and manage stakeholder interactions [1].

**Role 4: Values management.**

In the end, as a governance body, an MoH must adopt and actively manage certain values or principles [10]. Underlying these norms is the view that a shared approach to governance, involving “whole of government” and “whole of society,” is preferable to that of a narrow, overly centralized view of health and health governance [4]. This potentially includes processes that propagate values or principles such as accountability and transparency, participation and efficiency.
Section II

MoH Capacity: Definitions and Issues
This section explores various definitions and issues surrounding governance “capacity” of Ministries of Health. This WHO Working Paper focuses on six capacities deemed crucial in supporting MoH governance roles. Besides these capacities, a range of “soft capacities” are equally important, as illustrated in Box 1 below.

**Box 1: Soft Capacities**

While the literature on “soft capacities” is growing [21], these capacities are not specifically included in this paper. Such capacities include abilities to navigate complexity, to learn collaboratively, to engage politically, and to be self-reflective and focused on building trust [22, 23]. These capacities “enable different perspectives to be taken and ... seek to better connect individuals to themselves, to others and to their social environment” [23]. Future research in soft capacities will undoubtedly help make these abstract concepts more tangible and directly actionable by stakeholders seeking to improve the governance roles of Ministries of Health.

### 2.1 WHAT DO WE MEAN BY “CAPACITY”?

Capacity is a dynamic concept referring to both processes and outcomes [22, 24]. At an organizational level, capacity is the ability “to function as a resilient, strategic and autonomous entity” [25], a combination of “individual competencies, collective capabilities, assets and relationships that enables a human system to create value” [22].

Capacity is clearly central to health system performance. When applied across a system, Rodriguez et al (2017) map capacity as individual competencies (e.g. individual mindsets, skills and motivations), organizational competencies (e.g. “structures, practices and resources” and systemic interactions (e.g. an enabling environment that promotes stakeholder engagement) [26]. The effective combination of these capacities can greatly improve health systems performance, and as a result, ensure improved health and social outcomes. Importantly, this paper focuses primarily on individual and organizational competencies, leaving systems-level issues for future research for future research.

Capacity includes individual competencies, organizational competencies, and systemic interactions [26].
2.2 WHAT GOVERNANCE CAPACITIES DOES AN MOH REQUIRE?

In our current dynamic health settings, what specific capacities does an MoH need to execute its governance roles effectively. Drawing on a typology developed by Potter and Brough (2004), we present six categories of capacities, further illustrated in Figure 2.[27]

Figure 2. Governance Roles and Capacities

<table>
<thead>
<tr>
<th>Governance Roles</th>
<th>Governance capacities</th>
<th>Performance area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. “De jure” governance processes</td>
<td>Structural capacity: Role capacity, Personal capacity, Workload capacity, Performance capacity, Supervisory capacity</td>
<td>Implementation of de jure responsibilities</td>
</tr>
<tr>
<td>2. Preparation for and response to changes in context</td>
<td>Supervisory capacity</td>
<td>Resilience and relevance</td>
</tr>
<tr>
<td>3. Relationship Management</td>
<td>Leadership and diplomacy</td>
<td></td>
</tr>
<tr>
<td>4. Values management</td>
<td>Values propagation and alignment</td>
<td></td>
</tr>
</tbody>
</table>

2.2.1 Structural Capacity.

Within an MoH, the “governance architecture” should be assessed. Are there, for instance, appropriate ‘decision-making fora’, organizational flows, structures and efficiencies? [27] Are there relevant committees, task forces and commissions that can greatly assist Ministries in responding to evolving contexts (e.g. response to disease outbreak or implementing reform measures)? Task forces, networks, and fora are also critical for an MoH to successfully manage relationships with other stakeholders, both within and outside government. To ensure the application of broad governance principles, participatory, transparent and efficient mechanisms must take root, including public consultations and performance frameworks with a focus on citizens and incorporating citizen voice.

2.2.2 Role Capacity.

Does the MoH have the appropriate authority or responsibility to make decisions and undertake governance roles? “Role capacity” may refer to both formal and informal ownership of particular decision-making roles and requires that an organization has sufficient legitimacy and power to undertake those roles. Governments may consider establishing stand-alone institutions (Ministry-led or multi-sectoral) to oversee and steer efforts. Ministries might also strengthen their role capacity through legislative efforts that synchronize or harmonize health sector governance roles, built upon comprehensive

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1 Potter and Brough (2004) include three other capacities that were not included in this framework - facility capacity (Are facilities adequately sized, equipped, staffed and diversified to support the workload?), support service capacity (Are there sufficient support services to ensure that tasks may be implemented as required?) and systems capacity (Are there external linkages, such as those with the community and NGOs? Do financial and information systems function efficiently?) [27]. We acknowledge that these types of capacity overlap with those selected for our framework. Readers should also note that the original framework presented a “hierarchy of capacity needs” where capacities were sequenced in order to achieve systemic capacity building.
and clear legal frameworks. These frameworks can also support relationship building across stakeholders, reinforcing good governance principles at the very center of the health system, including citizen participation, transparency, integrity and accountability.

2.2.3 Personal Capacity.

Are staff sufficiently knowledgeable, skilled, and confident to perform their assigned duties? [27] These competencies may be technical, managerial, inter-personal, or involve other role-related skills. Ministry staff must have the appropriate skills and knowledge for their positions and must be sufficiently motivated and confident to perform their tasks. Individual competencies must be understood and targeted through needs assessments, consensus building, learning by doing, and trial and error – and supported by an enabling environment. Additional skills essential to managing relationships include negotiation, conflict resolution, knowledge exchange and consensus building.

2.2.4 Workload Capacity.

Is there sufficient staff to perform the work? Is there an appropriate mix of educational backgrounds and skills across the MoH workforce? Are there clear, practical job descriptions with commensurate compensation? To perform its many roles, Ministry staff must have a diverse and appropriate skillset – and the needed time and space. These capacities allow staff to appropriately engage with other stakeholders (for example, Ministries of Finance, professional associations or the public-at-large), and to engage in negotiations or public relations.

2.2.5 Performance Capacity.

Are the necessary resources – the tools, infrastructure, finances, equipment and consumables – in place to support MoH staff? MoH staff require the appropriate physical infrastructure (buildings, rooms, etc.), office infrastructure (desk space, internet connection, etc.), financial resources to fund salaries and routine activities, and accessibility to knowledge resources (scientific literature, grey literature, etc.). Performance capacity may also refer to resources required to manage crises or reforms.

2.2.6 Supervisory capacity.

Are there internal reporting and monitoring systems? [27] Accountability mechanisms? Supervisory capacity also describes the availability of incentives and sanctions to facilitate the delivery of functions. Accountability measures – including incentives, sanctions, and reporting mechanisms – keep an MoH transparent and operating with integrity. This demands mechanisms for feedback and input, frequent monitoring of programs, and commissioned independent evaluations – all of which can promote a learning by doing or a trial and error approach. Mechanisms that allow for external stakeholders to obtain recourse for decisions, or to hold Ministry staff to account are also important.

Another aspect of supervisory capacity includes the MoH’s management capacities. How well do upper-level MoH staff ensure professional outcomes of staff under their supervision? In which areas does an MoH require stronger supervisory capacity?
Now that we’ve reviewed the key terms of “governance” and “capacity,” including their different dimensions and applications, we turn in **Section Three** to an appreciation for how this interplay has influenced Ministries of Health around the world.
Section III

The Governance and Capacity of a Ministry of Health: Country Examples
In this section, we provide specific country-based examples of major governance and capacity successes and challenges. In Section 3.1, we explore some of the challenges created by change, and describe how different countries have responded to those changes. In Section 3.2, we investigate how the roles for an MoH have shifted over time. In Section 3.3, we examine how an MoH can uphold governance principles while ensuring wide and inclusive stakeholder participation? And in Section 3.4, we explore the specific dynamic of how MoHs have managed governance relationships.

A Note about Methods: The findings in Sections 3 and 4 draw upon a scoping review [13] that we conducted to understand the governance capacities of Ministries of Health. We included scientific articles, research or analytic reports, and official presentations available from 1993 onwards. Our focus was primarily on LMICs, but we drew upon certain high-income country examples for additional insights. In total, 115 resources were selected for analysis (78 scientific articles and 37 grey literature resources) [13].

3.1 AROUND THE WORLD, WHAT ARE THE MAJOR CHALLENGES FOR MOH GOVERNANCE CAPACITIES?

MoHs work under rapidly changing contexts. These changes can arise internally (through reform, crises, political trends and transitions), externally (through global policy shifts, crises, and macroeconomic trends) – or through a combination of both [28]. Change poses unique and distinct challenges for a Ministry’s governance responsibilities, for its governance capacities, and for the long-term development of its capacities. Here, we review some real-world examples of how change has posed distinct challenges for the six MoH governance capacities outlined above.

As illustrated below, we address change in various countries in terms of political transitions, crises, reform, macroeconomic trends, global policy trends, and social movements and social change.

3.1.1 Political transitions.

Political transitions arise through the creation of entirely new political systems (e.g. following conflict, or from military rule to democratic government), new economic systems (e.g. shifts away from socialist towards market-based economies), or through elections (e.g. pendulum shifts between ruling political parties). These transitions can be extremely challenging for an MoH, with the transition sometimes exacerbated by the relatively low power that institutions (like a line ministry) wield in the government [5].
In many parts of the world (e.g. sub-Saharan Africa, central and eastern Europe and central Asia), the transition towards multi-party democracy in the 1980s and 1990s brought with it an expanded set of stakeholders, including new political parties, international donors, and the private sector. In many cases, this created new capacity challenges for an MoH [18, 29, 30, 31]. In Mozambique, South Africa and Cambodia, for instance, Walt et al (1999) report on the lack of consensus among civil servants and new staff brought on by political liberalization directly influenced donor relationships, which became cautious and even hostile [18].

This expansion of stakeholders following political transition had an immediate impact on the role capacity of an MoH. For example, in post-socialist Slovenia, Albreht and Klazinga (2002) report that new legislation made the MoH the primary system administrator – but with considerable responsibilities devolved to new agencies (including an independent national health insurance agency and a professional chamber). This both fragmented and duplicated the MoH’s role and created conflict between the MoH and the new professional chamber [30]. A variation on this theme also appeared in Poland, where Sabbat (1997) details how political transition resulted in the MoH becoming increasingly fragmented, lacking a binding vision of health for the country [32].

Post-conflict transitions offer a different set of challenges, often affecting an MoH’s personal and structural capacities, and its ability to manage stakeholders – especially external ones [33, 34]. Over 1991 to 1993, for instance, as described in Lanjouw, Macrae and Zwi (1999), Cambodia had numerous struggles with its donor relationships. Against the backdrop of a complex and crowded stakeholder environment, the structural capacity of the MoH was too weak to coordinate the vast sums of aid flowing into the country [35]. The coordination committees established to help coordinate aid ultimately led to a focus on donor-prioritized projects, rather than on building MoH capacity to manage the entire system. Another challenge here was the arguably deliberate donor under-investment in coordination mechanisms, and the bypassing of UN-led coordination mechanisms in favour of directly sub-contracting with (the now proliferating) NGOs [35]. This situation has played out in many other countries as well. In Sierra Leone, Witter et al (2016) show how donor involvement stretched the MoH’s already limited personal capacity to manage new stakeholder relationships [33].

Interestingly, periods of political transition can also offer unique opportunities to build MoH capacity. In post-Taliban Afghanistan, as described in Cross et al (2017) and Dalil et al (2014), the MoH took an early stance on prioritizing its stewardship role – largely through leading the development of the Basic Package of Health Services, and its regulation of the private for-profit health sector [36, 37]. In Timor-Leste, Alonso and Brugha (2006) illustrate how Timorese staff were involved in all decision-making with
the United Nation Transitional Administration for Timor-Leste. Progressive withdrawal of international staff and timorization were seen as critical for building legitimacy of the new MoH - despite resistance from international NGOs [38].

3.1.2 Crises.

Crises faced by an MoH are manifold, and can be political, ecological, financial or epidemiological and/or health security crises. They often create major capacity challenges. Political instability, as shown in the experience of Pakistan - described in Ejaz, Shaikh and Rizvi (2011) and Khan (2007) - can contribute to wavering ownership of policies and programs by successive governments [39, 40]. The low priority given to health by various military regimes in Pakistan has also led, as in Siddiqi et al (2011), to resource constraints, further weakening the MoH’s performance capacity, which in turn deepened dependence on international donors [41]. Successive regimes and the uneven democratic climate also resulted in non-participatory health policy development and a vastly weakened structural capacity [41].

Capacity issues also emerge when the MoH is tasked with formulating or implementing policy that emerges as a result of a political crisis. For example, in Lebanon, El-Jardali et al (2014) show how a political crisis unrelated to health policy kickstarted health insurance reforms [42]; and in Ghana, Agyepong and Adjei (2008) illustrate how a political window caused by crisis also created strong momentum for health insurance reform [43]. However, in both cases, despite the opportunity crisis created, the MoH lacked structural and personal capacity to “steer policy in the desired technical direction” [43].

Examples from sub-Saharan Africa highlight how political unrest can create critical MoH challenges for its structural, role and workload capacity [44, 45]. As a consequence of political unrest in Mali from 2012 onward, ties between donors and the MoH became bifurcated. Two health coordination structures – one for development and one for humanitarian needs – sowed confusion and directly affected structural capacity; the competing coordination structures led to divergent planning processes and timeframes [44]. As donors began to bypass the public system, the MoH lost personal and workload capacity to coordinate and plan system-wide interventions, with the public perception of the MoH consequently eroding.

Health crises, such as the 2014-15 Ebola epidemic in West Africa, also highlight key capacity issues, as reported by Blanchet et al (2017) [20]. Liberia, Guinea and Sierra Leone all exhibited weak MoH capacities that directly influenced disease surveillance, partnership management, community engagement, financial management, and international coordination [46]. MoH staff had to assume emergency roles and tasks outside their regular mandate, complicating existing workload capacities to balance emergency and routine functions [47].

In some Latin American countries, the debt crises of the 1970s and 1980s reduced government spending in health and thus triggered health system reform, forcing Ministries to rethink and reorganize their mandate and structure [1]. In Costa Rica, Chile and Colombia, as observed in PAHO (2007), the governments displayed high-level commitment to strengthening the MoH’s stewardship role and broader role capacity [16]. These legislative efforts highlighted the separation of functions within the MoH, focusing on overall stewardship (including policy direction, financing and regulation) rather than the provision of health services, while also clearly defining roles and responsibilities for various government institutions. In Chile, an inter-ministerial committee, comprised of Health, Treasury, Labor and the President’s Office, played a critical role in guiding the reform [16].
3.1.3 Reform.

From a structural and role capacity standpoint, reform processes tend to create both strong opportunities and tremendous challenges for an MoH. Some Ministries have determined their capacities insufficient to manage reform and thus created new structures or bodies to do so. These have included new health insurance agencies in Nigeria, Ghana and Slovenia; a National Council of Social Security in Health in Colombia; an insurance planning secretariat in Uganda; and the Health Promotion Foundation Act in Thailand. While these structures have given legitimacy and capacity to reform efforts, they have also complicated lines of authority and responsibility for the MoH.

In Thailand, this issue was successfully addressed, as in Adulyanon (2012), with the Minister Minister of Health serving as the vice-chair for ThaiHealth [48]. Uganda developed a new secretariat for insurance reform – but in the process, report Colenbrander, Birungi and Mbonye (2015), did not consult with stakeholders in developing a reform plan, which created opposition to proposed reforms [49].

In Colombia, however, as reported by Bossert et al (1998), the MoH dominated the National Council of Social Security in Health and maintained considerable veto power, creating an environment where consensus was “more imposed than forged” [1].

In some countries, the process of health sector reform has highlighted key role capacity opportunities and challenges within Ministries and affiliated institutions. Sector-wide approaches (SWAp)² also placed more attention on improving planning functions within the MoH. For example, in Bangladesh (as seen further in Box 2 below, and reported by Ahsan et al (2016)), the capacity of the MoH to prepare and manage budgets – which combines role capacity (more responsibility), structural capacity (relevant committees and taskforces) and personal capacity (increased technical skills) – strengthened considerably through the timely preparation of financial reports, the utilization of treasury systems, and through audit committees and financial management taskforces [50].

² The Sector Wide Approach (SWAp) is, according to Foster (1999), a “method of working between Government and donors,” the key characteristics of which are “that all significant funding for the sector supports a single sector policy and expenditure programme, [is] under Government leadership, [adopts] common approaches across the sector, and [progresses] towards relying on Government procedures to disburse and account for all funds” [125].
Box 2: Capacity evolution in Bangladesh’s MoHFW through sector-wide approaches

The 1998 introduction of the sector-wide approach (SWAp) for the health, nutrition and population sector in Bangladesh created new capacities within the Ministry of Health and Family Welfare (MoHFW), as reported in Ahsan et al (2016) [50]. The SWAp stimulated the MoHFW’s approach to donor coordination and management, efforts further supported by development partners [51]. Capacity has since increased in:

- MoHFW control over the SWAp process, with better management of the annual program reviews and mid term reviews from 2012-2014.
- MoHFW management, especially in the Directorates that perform administrative duties, using techniques such as management capacity appraisal.
- MoHFW financial management, through the formation of an audit committee and a financial management taskforce.

The MoHFW has shown significant progress in its structural capacity, supervisory capacity and personal capacity. Additional capacity challenges remain, particularly regarding the overall MoHFW strategy for health, its ability to coordinate various vertical programs, and a lack of clear sectoral boundaries (where, for instance, urban health is the responsibility of the Ministry of Local Government).

The MoH has, in some cases, itself been the target of reform efforts. In Uganda, despite high-level political and donor commitment, reform efforts were reportedly unable to adequately address internal MoH power dynamics and territorial disputes [17]. In Costa Rica however, the process of MoH reform was more successful, with PAHO (2007) showing how legislation and broad consensus-building efforts strengthened structural, role, performance and personal capacities [16].

3.1.4 Macroeconomic trends.

Countries transitioning to new economic models have created MoH capacity challenges, especially in reconciling existing norms and structures to new market realities. For example, in several countries, the MoH had challenges in overseeing and regulating the rapidly increasing numbers of private health facilities. From a structural capacity standpoint, in Kazakhstan, Chanturidze et al (2015), report that evidence and intelligence systems were insufficient to capture the needed health system data [52]. In Viet Nam, Fritzen (2007) illustrate how a similar insufficiency arose to track the emerging private sector [19]. In Chile, as in Buchan (2004), the introduction of free-market policies complicated the government’s ability to register health professionals [53]. Although mechanisms existed for the Chilean MoH to observe voluntary professional associations, there were no regulatory frameworks to clarify roles and responsibilities in the regulation of health professionals, such as accreditation or registration.

Performance capacity may also be exacerbated by broader macroeconomic trends. For example, in Tajikistan, increased donor funding reportedly buttressed a decline in national funding [54]. However, in several European countries, as in Veillard et al (2011), the 2008 financial crisis sharply reduced capacities to develop health systems policies [28]. Similarly, in Pakistan, Siddiqi et al (2004) show how the unpredictability of its macroeconomic situation gave the Ministry of Finance greater influence to determine which policies and interventions of the National Health Policy would ultimately be financed [41].
3.1.5 Global policy trends.

Many MoHs have experienced tremendous – and in many cases positive – shifts due to global policy trends. From the 1990s on, global health initiatives focused on HIV/AIDS, malaria, TB, tobacco control, and polio eradication, all of which radically changed MoHs [18, 55]. The HIV/AIDS initiatives, for instance, have reportedly had a mixed impact on Ministry capacity. They have directly increased performance capacity for priority diseases and issues, but weakened capacity for intra-Ministerial coordination, planning, and monitoring and evaluation [56]. Similarly, the increase in funding for tobacco control in the 2000s resulted in increased structural capacity within Ministries [57]. Following the ratification of the Framework Convention on Tobacco Control in 2004, in 2006 the Turkish government – as found by Hoe et al (2016) – formed a National Tobacco Control Committee, with the MoH successfully leading 130 individuals from various sectors to develop the National Tobacco Control Programme and Action Plan [58].

3.1.6 Social movements and social change.

While perhaps not as prevalent, MoH capacity to engage with social movements and social change has nonetheless become an increasingly important issue. In the United States, the Department of Health and Human Services initiated an internal Lesbian, Gay, Bisexual, and Transgender (LGBT) coordinating committee involving senior representatives from multiple divisions. In 2016, the Department underlined this capacity by creating a position titled Senior Advisor for LGBT Health [59]. In France, Faye (2017) shows how the Modernization Act allowed for increased role capacity to strengthen the participation of service users in health sector governance, while also mandating the establishment of a national union of patient associations [60].

3.2 WHAT ARE SOME SPECIFIC GOVERNANCE ROLES FOR AN MOH?

How do governance capacity issues play out within specific MoH governance roles?

As indicated above, from the 1990s on, the MoH’s mandated governance roles have evolved – from one focused to a large extent on health service delivery to one charged with overarching strategy, quality and performance assessment, policy and planning for the sector. From a role capacity standpoint, an MoH appears often insufficiently capacitated to regulate key actors, especially private health providers [61]. Adding further to this challenge is the organizational culture, especially in many LMIC MoHs which still operate from a long history of centralized command-and-control [28, 62]. Favoritism, sectarianism and corruption have also long plagued MoHs and often negatively influenced their mandated governance roles [34, 42].

As to personal, workload and supervisory capacity, Ministries often face considerable challenges in implementing mandated goals. For example, Ministry staff tend to have greater personal capacity leaning towards managing health services provision and operations, rather than towards overall stewardship responsibilities [28, 63]. The organizational culture of Ministries in many LMICs is hierarchal [19, 52, 54, 64], often coloured by an aversion to risk and a fear of retribution from superiors for perceived decision-making inadequacies [54, 64]. Other human resource issues have exacerbated the situation, including a lack of incentives for success, a lack of staffing profiles or position descriptions, inconsistent or unpredictable performance evaluation or promotion structures, limited motivation and enthusiasm, and low pay [65].

Several countries also struggle with externally driven pressures on their organizational structure. Key issues include the frequent turnover of senior staff and limited training of
bureaucrats specific to health [17, 41, 53, 61, 66, 67, 68, 69]. In some countries, such as Tajikistan, Ministry personnel issues are exacerbated by competition for staff with international donors, as reported by Rechel and Khodjamurodov (2012) [70].

Here, we outline a number of key roles of Ministries of Health and how capacity issues demonstrate themselves.

3.2.1 Strategic planning and prioritization.

A crucial role of most MoHs is their overall responsibility for strategic direction and planning and prioritization [5, 10], often collectively referred to as “stewardship” [5, 28, 39, 55, 71]. One key challenge for this stewardship function lies with Ministers of Health themselves. Ministers are often in office for a short and unpredictable period of time, which does not serve either medium- or long-term planning [72].

Key facilitators supporting structural capacity for strategic planning tend to be coordination committees with international donors. For example, as reported by Rodriguez, Banda and Namakhoma (2015), in Malawi, the final Integrated Community Case Management policy was produced by the Child Health Technical Working Group, a group consisting of both MoH and donor stakeholders, with Ministry officials taking the lead in policy formulation [73]. However - as reported by Seitio-Kgokgwé et al (2016) - experience from Botswana suggests that structural capacity, without adequate personal capacity, can result in “being led from the outside” (i.e. overly influenced by donor-driven priorities) [61].

3.2.2 Evidence use, evidence generation and intelligence management.

Central to every MoH across the world is an ability to demand, generate, access, adapt and apply research evidence in their policy-making and evaluation. This capacity may exist internally in the form of professionals with requisite scientific expertise (epidemiologists, social scientists, statisticians, etc.) or externally (for example, academic or research institutions). A detailed conceptual framework for understanding evidence use in MoHs was developed and tested across eight LMICs [26]. Organizational capacities – “structures, practices and resources” – examined by Rodriguez et al (2017) included creating organizational incentives for the demand and use of research, to investments to access and assess research, to fora for sharing, discussing and communicating research. In many LMICs, despite a high self-reported use of evidence of inform policy-making, few institutional mechanisms are typically available at the Ministry level – including sabbaticals to research institutions, or Memoranda of Understanding with research institutions for commissioned research [74].

Personal capacity for evidence generation and use within Ministries is also a major challenge. A 2013 assessment of MoH research units in 14 sub-Saharan African countries found that only one country had a leader of an MoH research structure with health research management training [75]. However, evidence generation and management were also found to be key areas of personal capacity development in several countries [74, 76]. Examples of activities include training workshops and programs, policy retreats between researchers and policymakers, incorporation of evidence-to-policy modules in postgraduate training programs, and regular seminars [76]. In Lao People’s Democratic Republic, as illustrated by Jonsson et al (2015), developing the personal capacity of policy-makers by instituting their involvement in operations research projects was seen as a successful aspect of implementing the National Drug Policy [77].
3.2.3 Policy development.

Strengthening personal capacity within an MoH to develop strategy and policy is critical [16, 36, 52]. In Kazakhstan, a project by the MoH and UNDP to develop the MoH’s policy-making capacity – as reported by Chanturidze et al (2015) – drew upon a formal needs assessment of the strengths and weaknesses of self-reported organizational capacities and individual competencies among MoH staff [52]. A clear success from this capacity-building effort was the development of the Health Sector Strategy 2013-2017. In Rwanda, as found by Fox et al (2010), technical capacity for policy-making was seen as strong among a small group of committed MoH staff; however, these processes could be strengthened with greater involvement from other stakeholders, particularly front-line actors [78].

Some Ministries face capacity issues in terms of how they reconcile contested viewpoints in the policy-making process [73, 79, 80]. For instance, in developing a National Health Research Policy in Gambia, Palmer, Anya, and Bloch (2009) describe how a technical successfully advocated for the policy, and for an inclusive approach to policy-making; however, the policy stalled in the final process of Cabinet approval, primarily due to the perception among senior MoH officials that the policy would weaken government ownership [80]. In Malawi, the early stages of developing Integrated Community Case Management policy saw challenges in securing internal agreement among various vertical programs within the Ministry [73].

3.2.4 Citizen empowerment and responsiveness to needs.

Some MoHs have prioritized citizen voice in their policy-making efforts – and have been proactive in engaging with citizens to ascertain their needs. In Brazil, as described by Gragnolati, Lindelow and Couttolenc (2013), an ombudsman is appointed by the MoH to the National Health Surveillance Agency to ensure public participation, accountability and transparency – all supported by mandatory public consultations and open dissemination of information through web platforms [81]. In Chile, PAHO (2007) show how the MoH used various mechanisms to gather citizen feedback on an ongoing health sector reform process; at nearly 300 community meetings, citizens discussed sectoral problems, with an additional 200 meetings organized to discuss citizen feedback on draft legislation on patients’ rights and duties, as well as on a reform intervention plan [16].

3.2.5 Performance monitoring.

Information, evaluation and a broader understanding of performance is key to any bureaucracy, especially an MoH. In Sri Lanka, as in Hornby and Perera (2002), ensuring a flow of reliable information between federal and provincial structures was seen as a key function of the MoH, and as a contributing factor to growing the MoH as a “learning organization” [82]. In Senegal, Gueye Ba et al (2010), describe how the MoH adopted performance monitoring mechanisms for a school health program through qualitative stakeholder feedback, and through a quantitative analysis of school health facilities [83].

3.2.6 Procurement.

Issues around procurement appear to combine capacity weaknesses from both an organizational and personal standpoint. For example, Palesh et al (2010) show how in Iran, managing the flow and distribution of health technologies was a major challenge – due to a lack of rules and regulations, and against the context of a highly active private
sector [68]. Furthermore, there was a major lack of internal and external coordination, exacerbated by management instability within the Ministry, featuring frequent staff turnover. In the example of Benin, procurement processes have reportedly been highly politicized, and subject to corruption – further complicating the MoH’s role capacity [84].

To deal with this issue, structural capacity interventions have included multi-stakeholder boards and committees [16, 38, 84, 85]. For example, in Timor Leste and Sri Lanka, Alonso and Brugha (2006) describe how boards and committees involving both health and business stakeholders, in addition to other stakeholders, were developed to address issues with access to medicines [38]. In Brazil, the national health authorities reportedly played a key role in managing relationships with private drug manufacturers, civil society, donors, and the public sector in order to strengthen national production of anti-retroviral therapy pharmaceuticals [16].

3.2.7 Program planning and management.

Ministries across the world have persistent issues with role and structural capacity for program planning and management. In many LMICs, MoH initiatives pertaining to non-communicable diseases are often divided by disease- or risk-factors, which often results in uncoordinated programs in response – with examples including programs for HIV/AIDS, diabetes, cardiac disease, cancer, etc. [57, 86]. Global policy trends also influence these structures. For instance, the increase in funding for tobacco control programs in the 2000s reportedly led to increasingly separate tobacco control units within Ministries [86]. Further, the mandate and functions of these units in terms of technical advice, program management, and implementation are sometimes uncoordinated with other structures within Ministries [57].

3.2.8 Personnel management.

Many countries face key role and structural capacity issues when implementing functions related to human resources for health (HRH). These include the lack of clear mandates for HRH units, multiple national and sub-national units responsible for the HRH function without adequate coordination, little decision-making power within Ministries, and weak coordinating powers with external actors [19, 66, 72, 87]. Coordination challenges are exacerbated in the case of HRH policy as many stakeholders have “veto power,” turning this policy space into one with a collective-action problem [19, 72]. Further, HRH management may not align with other health policy and systems considerations. For example, in Ghana, as argued by Koduah, van Dijk and Agyepong (2016b), the MoH finds itself well situated to influence human resource policy given that 90-93% of the government’s allocation to the health sector goes towards public-sector salaries; but, as a result of this financing arrangement, the government has few resources to allocate to other health priorities, allowing donors to promote and finance policies that satisfy their own agendas [88].

3.2.9 Regulation and standards.

Reviews of health sector regulation in LMICs have found key capacity challenges with the institutions tasked with these functions [89, 90], particularly in the context of expanding private sectors [19, 89]. In terms of structural capacity, regulatory institutions often lack the mechanisms to monitor the private sector [19, 89], including provider abuses. Regulators also sometimes lack the structural capacity for information gathering and sharing, which is necessary to ensure transparency in the system [91]. For example,
MoHs are often not in a position to gather information on the quantity and quality of NGOs operating in the health sector due to inadequate rules and structures around registration, information sharing, and so on [90].

From a performance capacity standpoint, regulatory institutions in many LMICs appear to lack financial, human resource and logistical capacities. For example, in the United Republic of Tanzania, Uganda, Papua New Guinea, and Liberia, as found by Janovsky and Travis (2010), statutory bodies had “small, poorly funded secretariats with limited IT capacity,” operating from restricted or insufficient office space [90]. In cases when regulatory authorities are not well resourced by the government, scope for corruption increases, as observed by Ma, Chen, and Tan (2015) in China [92].

3.2.10 Contracting and compliance.

Little has been documented about the capacities for an MoH to initiate, monitor, and evaluate contracts with third parties, and to monitor compliance with rules and regulations. In Viet Nam, compliance is reportedly weak in following the official mandate that only those health professionals who have worked for five years in the public sector may work in the private sector [19]. Research from Benin, as reported in Houngbo et al (2017), found that the system for awarding contracts for health technologies was highly politicized, and lacked accountability [84].

In Afghanistan, the MoH reportedly appeared to show strong supervisory capacity for monitoring performance-based contracts through the Grants and Contracting Management Unit [37, 93]. For example, contracts would be reviewed regularly, partners were called in for meetings when necessary, and contracts were terminated when necessary [37]. A contributing factor to the success of the Unit was the presence of former NGO staff with important knowledge regarding NGO processes.

3.2.11 Resource management, including fundraising and financial management.

MoHs face several capacity shortages with regards to resource management [64, 94, 95]. From a personal capacity standpoint, there are challenges in planning, allocating and executing budgets, and difficulties in managing and supervising funds [65, 94]. There are also major structural and workload capacity challenges, particularly in the limited number of Finance personnel within MoHs, and issues in coordinating with Ministry of Finance staff [65, 95].

Some countries showed progress in building capacity at multiple levels around resource management. In Thailand, ThaiHealth reportedly used sub-committees, such as audit and fiscal policy, to monitor operational compliance and certify financial audits [101]. External, independent evaluations are also done on projects exceeding 20 million baht (around US $700,000). These committees were found to be resource intensive, but useful in the area of financial policy. In Bangladesh, as shown in both Ahsan et al (2016) and Buse (1999), the process of managing the SWAp led to a considerable improvement in the Ministry’s ability for timely financial reporting [50, 64].

Other countries, however, demonstrated a lack of performance and personal capacity in resource management. Ministry officials in Uganda were reportedly more concerned with expanding resources rather than managing inefficiencies within the system. For example, as found by Colenbrander, Birungi and Mbonye (2015), the MoH was focused on increasing wages for health workers, despite previous experience having shown that such increases were ineffective [49]. In Malawi, despite playing a central role in steering Integrated Community Case Management policy, Rodriguez, Band and Namakhoma (2015) illustrate how the MoH was unable to secure internal resources, and depended
on inadequately coordinated donor funding, raising questions about the financial sustainability of the program [73]. Finally, other articles raised the issue of Ministries not always being able to absorb (i.e. appropriately spend) additional resources [37, 38].

3.3 HOW CAN AN MOH UPHOLD GOVERNANCE PRINCIPLES WHILE ENSURING WIDE STAKEHOLDER PARTICIPATION?

Beyond dealing with the technical dimensions of governance, upholding governance principles – accountability and transparency, fairness, participation, integrity, prudence and efficiency, and keeping the public’s welfare in mind – is a critical role for an MoH [5]. However, MoH capacity in this regard is typically ambiguous and/or limited [63]. Several countries have developed interventions to directly strengthen an MoH’s ability to uphold governance principles, including the promotion of accountability and transparency as two core, overarching values. In this section, we provide examples of how countries have incorporated such governance principles into MoH functions.

Ensuring the participation of a broad base of stakeholders – from both within and outside government – is seen as a key governance objective for MoHs around the world. And yet, despite this, MoHs have a decidedly mixed record on stakeholder engagement. For example, capacity issues include broad MoH challenges with stakeholder negotiation and mediation [30], a tendency to keep decision-making groups small [48, 78, 96], the lack of formal stakeholder fora [97] and engagement with individuals rather than networks due to weak systemic capacity [54].

In Ghana, despite the existence of stakeholder fora for a wide array of participants, including civil society, government partners, and implementing actors, Koduah, van Dijk and Agyepong (2016a) found that decisions tended to be made in closed meetings open only to the MoH and donors [98]. In Brazil, participatory health councils were reportedly mandated at each level of the health system – central, regional and local [81] – but there is no legal authority for government to act on their recommendations, and further, insufficient budgets limit the performance capacity of these councils [99]. Moreover, these councils often lack trust among Ministry staff, professional representatives and user representatives, and an inability to transform their proposals into action [100]. However, there were also several promising examples of MoHs broadening stakeholder engagement. Some of the more successful attempts at this have been mandated by law, strengthening role and structural capacity. For example, through the National Health Act (2007), Rasanathan et al (2012) report that Thailand’s National Health Assembly is organized annually by the National Health Commission Office with the purpose of engaging a range of stakeholders from civil society, government and academia [101]. Further, ThaiHealth has developed several important mechanisms to improve capacity for addressing accountability and transparency – examples include the involvement of external experts in a Board of Evaluation, and the execution of a performance evaluation that, in the ideal scenario, will lead to improved transparency and accountability [102].

In India, the advent of the National Rural Health Mission in 2005 evidently provided an opportunity to broaden participation of civil society and citizens in the health sector; stakeholders used the term “communitization” to describe the approach of increasing public/citizen ownership of the health system [103]. To achieve this, Gaitonde et al (2017) report that the Ministry formed an Advisory Group on Community Action, and provided financial resources for this group to implement activities in certain states to mixed effect [103]. A key lesson from this exercise was the need for expanded spaces and strengthened institutional norms to build trust relationships between policymakers and civil society.
In Afghanistan and Benin, Ministry units and technical committees were established to monitor and evaluate contracts; in Benin, as shown in Hounkpo et al (2017), this was done explicitly to reduce corruption in the procurement system [84]. Other countries, such as Kenya, have apparently struggled to improve transparency and reduce corruption. An initiative to strengthen the capacity of the Kenya Medical Supplies Agency (KEMSA), supported by development partners, was stymied by conflict and tension among senior Ministry of Health staff with a key stake in KEMSA’s operations [86]. Consequentially, KEMSA fell into further disarray, which in turn expanded avenues for corrupt behavior.

3.4 HOW CAN AN MOH EFFECTIVELY MANAGE GOVERNANCE RELATIONSHIPS?

Managing relationships with a wide range of stakeholders – within and outside government – is a central governance function for an MoH [5, 10]. Capacities here include the need to convene, build consensus, negotiate, mediate, problem solve, and resolve conflict. In this section, we explore how MoHs have managed relationships with, in no particular order, the private sector; with political leadership; with other line ministries; with civil society; with organized labor groups; with donors – both generally and within emergency contexts; and between the center and periphery.

Managing relationships with a wide range of stakeholders - within and outside government - is a central governance role for an MoH.

3.4.1 Managing relationships with the private sector.

The term “private sector” denotes a diverse set of stakeholders, including health sector providers and facilities, industries (hospitals, pharmaceuticals, medical device manufacturers, etc.) and industries from other key sectors that directly influence health (for example, agriculture, food, beverages or manufacturing). Experience shows a mixed record in the relationship between the MoH and the business community. As shown in Omaswa and Boufford (2014), many Ministers of Health believe that business stakeholders tend to promote their own business interests rather than national health priorities; nonetheless, these Ministers often did see these companies as beneficial to the overall objectives of the MoH [5]. In Botswana, the Ministry was reportedly seen as lacking the role capacity to enforce rules with the private sector due to unclear regulations (except in the case of HIV/AIDS). As found by Seito-Kgokgwre et al (2016), the MoH attempted a consultative committee with the business community; however, the business community was represented by a trade group that had not developed its own capacity to be productive in those meetings [61].

For most countries, building trust between the public and private sectors is essential and constitutes an important dynamic. In Saudi Arabia, for Public-Private Partnerships (PPPs) to be successful, Alonazi (2017) found that the business sector needs to have
trust-based relationships with the MoH, particularly around reimbursement [104]. To that end, building capacity within the MoH around resource management and mobilization is of paramount importance. Similarly, Afghanistan presents a successful example in trust building. There, as shown in Cross et al (2017), the Minister chairs a quarterly forum with private for-profit health sector actors – the Public Private Dialogue Forum – which has resulted in greater levels of trust and collaboration, a regular flow of information, and the resolution of several key issues [36].

3.4.2 Managing relationships with political leadership.

An MoH often has distinct challenges in engaging with political leadership or other ministries - particularly challenging as, historically, an MoH typically has less comparable power and influence. In Tajikistan, for instance, Mirzoev, Green and Van Kalliecharan (2015) found that the MoH requires executive support or support from other Ministries when initiating or approving policies [54]. In some countries, the “Minister of Health” position was more a political than substantive post [1, 32, 54]; for example, in Poland, Sabbat (1997) reported that the Minister of Health is typically the weakest political coalition partner [32]. In some European countries, as argued by Veillard et al (2011), MoHs lack the power and influence inside governments to define a government-wide vision on health [28].

This lack of relative power can result in MoHs addressing policy demands from the executive that may conflict with their professional judgment. In many places, political decisions threaten to override technical decisions - with, further, those political decisions often taken without sufficient time for effective MoH planning or implementation. For example, MoHs in both Niger and Uganda reportedly had to actively manage the political goals of the executive [105, 106], and donor concerns in another instance [49]. In Tajikistan, Rechel and Khodjamurodov (2010) show that the MoH was under pressure from the executive to roll out a basic health services package, even though there was insufficient involvement of local authorities, health professionals and the public [70]. Similarly, in Senegal, Mbaye and Ridde (2013) describe how the executive branch unilaterally created a program for elderly care, giving the MoH limited time and ability to plan and execute effectively - which ultimately limited the program’s success [107]. As a consequence of all this, MoHs across the globe must find effective ways of inserting their own perspective and experience into wider governmental decision-making processes in government.

3.4.3 Managing relationships with other ministries.

Interactions among line ministries illustrate some clear issues in role capacity. Fuzzy roles and responsibilities among ministries often - and predictably - lead to weak coordination structures and habits [41, 61, 64, 65, 95]. In Botswana, as described in Seitio-Kgokgwe et al (2016), a coordinating committee was set up between the MoH and the Ministry of Local Government; however, the terms of reference were not constructed properly, and there were no statutes guiding participation - ultimately resulting in the committee’s complete ineffectiveness [60]. Similarly, in Kenya, Tsofa, Molyneux and Goodman (2016) show how a core team was organized to improve coordination across the MoH and the Ministry of Finance, but a lack of clear leadership structures, terms of reference or reporting responsibilities rendered the team ineffective over time [95].

From a personal capacity standpoint, high-level MoH staff in Uganda, Ghana and Senegal were reportedly found in need to require further skill building in arbitration and negotiation with Ministries of Finance, particularly to advocate for more funding [94].
However, Ministries of Finance in these countries did not exhibit flexibility and open communication during budget discussions. Ministries of Finance were also found to provide insufficient feedback to MoHS during budget preparation, and limited training for MoHS regarding medium-term expenditure frameworks.

However, some positive examples highlight that intra-governmental collaboration can indeed be built. In Afghanistan for example, Cross et al (2017) found that the Ministry of Public Health worked closely with Finance and other legislative actors in developing private sector regulations [36]. As in Galbally et al (2012), ThaiHealth initiated a small unit to engage with Members of Parliament, providing them with updates and data regarding health programs [102]. In another positive example from Chile, inter-ministerial collaboration, in addition to high-level presidential support, evidently facilitated the passage of multiple pieces of legislation that enabled health reform and strengthened the stewardship role of the MoH [16].

3.4.4 Managing relationships with donors.

MoH capacity in coordinating aid relationships is complicated by the significant power donors wield. In Tajikistan, for instance, where certain donors - such as the World Bank - are more dominant than the MoH, Mirzoev, Green and Van Kalliecharan (2015) found that there is limited capacity to build trust with donors, reconcile short-term projects with long-term objectives, and influence knowledge production among donors [54]. Bangladesh apparently experienced similar weaknesses within the system to coordinate aid, as reported by Buse (1999), including broad structural and personal capacity issues [64]; however, the MoH also made significant progress in managing the SWAp process and taking a coordinated approach to engaging with donors [50].

MoH capacity in coordinating aid relationships is complicated by the significant power donors wield.

MoHs have attempted other structural capacity efforts for engaging with donors, such as special units charged with aid coordination [18]. However, these units have a mixed record of success, due to issues of role capacity, or internal disagreements within the MoH. Donors also sometimes bypassed these units to interact with the top decision-makers at the MoH.

However, some Ministries did build capacity to engage more productively with as in Rwangomba (2007), Rwanda took a holistic approach to aid coordination, focusing on role, personal and structural capacities [108]. For example, role capacities were strengthened through a Government of Rwanda aid policy, which provides a framework for all aid negotiations, through the development of donor coordination groups, and through stronger coordination across Ministries. Civil service reform has also helped with improving personal capacity, through increased salaries, performance contracts and intensive training programs [108].
3.4.5 Managing relationships with donors in an emergency context.

This MoH-donor relationship becomes even more stressed during times of crisis or emergency. In particular, crisis can directly challenge the governance capacities of an MoH. How, for instance, will MoHs coordinate inflows of additional external funding – both to government and non-government actors? How will the MoH coordinate the actions of various stakeholders (within government, across donor agencies, etc.) some of whom are new to – and potentially ignorant of – the country context? How will MoHs share data with international agencies? How will the MoH enforce transparency among donors, creating a “comprehensive picture of monetary and in-kind pledges and disbursements” to the crisis, while also demanding transparency among the NGOs receiving donor funds [46]? And, perhaps most of all, given all of these new/urgent inputs, how will emergency services be coordinated and effectively delivered?

Clearly, resource-poor health systems have limited capacities to manage a massive infusion of external resources in responding to an emergency. However, the 2014-15 Ebola virus disease (EVD) epidemic in West Africa provides an important case study, with Liberia’s governance response particularly notable. Despite systemic governance inefficiencies before the outbreak, as shown in Nyenswah, Engineer and Peters (2016), Liberia nonetheless successfully created an Incident Management System (IMS) within the MoH. This allowed the country to establish a distributed leadership approach to guide “strategic engagement with both local community leaders and international stakeholders” [109]. Thematic teams within the IMS took leadership across the health system in responding to the epidemic, with teams led both by Liberians and international partners “so that the IMS did not have to deal separately with organizations planning activities in the same thematic area, thereby avoiding duplication of functions or activities... Decisions were taken and reviewed daily on the basis of available data and communicated intensively within the health system, with the population, and with international stakeholders” [109].

The global response to the 2005 Asian tsunami provides additional illustration on this dynamic. In reviewing national and global responses to the disaster, de Ville de Goyet (2007) calls for external expertise in an emergency so long as the MoH can employ a “selective and closely coordinated use of this expertise, as was done in India and Thailand” [110]. In Indonesia and Sri Lanka, by contrast, well-funded NGOs reportedly had “little incentive” to coordinate with national governments or the UN [110]. Further, de Ville de Goyet (2007) reported that international actors marginalized local actors by restricting access to foreign assets, operating only in English, and frustrating the role capacity of national authorities in Indonesia and Sri Lanka to “filter, coordinate, or manage the overwhelming number of aid responders, or assume the technical lead in adapting indicators and standards to local realities” [110].

3.4.6 Managing relationships between center and periphery in a decentralized system.

Managing national-subnational relationships can also be extremely challenging. From the perspective of role capacity, many countries in Europe lack the appropriate authority to ensure alignment between health system objectives and performance of sub-national actors [28]. This issue takes on a different dimension in LMICs; in Kenya for example, even though the MoH ought to involve sub-national counties in planning, Tsofa, Molyneux and Goodman (2016) report that this tends not to happen in practice [95]. Brazil has experimented with several arrangements for improving coordination across levels of government, including bilateral and trilateral committees; these committees, as described in Gragnolati et al (2013), have been overly bureaucratic – and thus
new mechanisms are under consideration, including the establishment of a regional coordinating level between the center and the municipalities [81].

In Uganda, additional resources reportedly supported the development of the Health Planning Department; however, the strengthening of the Ministry appears to have come at the expense of the districts, suggesting that power has been recentralized at the central level and necessitating the need for structures to better engage the districts [111]. Conversely, in Pakistan, Pervaiz, Shaikh and Mazhar (2015) describe how the abolishment of the federal MoH through the 18th Constitutional Amendment – in favor of devolution of authority to the provinces – only underscored the need for role capacity for a federal structure to coordinate with the provincial departments [112].

3.4.7 Managing relationships with civil society.

Similar to other types of relationships, there is a mixed record in terms of MoH capacity to engage with civil society, particularly NGOs. In Kenya, despite the MoH having the role capacity to engage NGOs through the annual planning process, such involvement has been absent [95].

The South African National AIDS Council (SANAC) illustrates these important linkages between an MoH and civil society. From a structural capacity standpoint, the existence of SANAC is important; however, as raised by Powers (2013), there are valid questions about who is involved, and whether there is an emphasis on those constituents with biomedical expertise and/or engagement with transnational partnerships [113]. From a performance capacity standpoint, this institution was only given limited resources by the government – requiring SANAC to seek funding from private philanthropic sources [113].

Other countries have been more successful in engaging civil society. The autonomous nature of ThaiHealth reportedly allows for more flexibility in the types of partnerships pursued, resulting in increased civil society engagement in the health sector through platforms such as the National Health Assembly [102]. In Timor Leste, Alonso and Brugha (2006) report that NGOs are engaged in the government through a proposal assessment process, and NGO proposals must align with key principles, such as equity, gender and cultural sensitivity [38].

3.4.8 Managing relationships with labor.

Developing capacity to engage with organized labor is challenging, exacerbated in some cases by weaknesses in role capacity, the diversity of professions, sectoral affiliations (public, for-profit private and non-profit) and underlying power asymmetries. Physicians, more than other types of health professionals, seemingly have more engagement and access with Ministries. In Slovenia, as described in Albreht and Klazinga (2002), there was good cooperation between professional groups and the MoH – including the Slovenian Medical Society and the Association of Public Providers of Health Care – but a more challenging relationship between the Ministry and the statutory professional chamber [30]. In India, the Medical Council of India, the professional council for doctors, is technically overseen by the Ministry of Health and Family Welfare; however, major discrepancies in the accountability mechanisms between the two institutions have been noted [91]. Similarly in Chile, Buchan (2004) reports that the MoH did not have a legally clarified role in the regulation of doctors, such as through accreditation or registration of their credentials – although such a system had existed prior to marketization of the health sector [53].
Section IV

Strengthening MoH Governance Capacities: Examples
How can MoHs strengthen governance capacities?

In this section we briefly look at examples of specific measures countries have taken to strengthen MoH governance capacities, including strategic planning and policy development; procurement; resource management; personnel management; evidence use; regulation; reform; values; and managing relationships.

4.1 STRATEGIC PLANNING AND POLICY DEVELOPMENT.

The MoH in Kyrgyzstan made strengthening its stewardship role a key goal during multiple rounds of health sector reform. Some successful aspects of this reform effort include consistency and commitment over several years, and the development of technical capacity within and outside government through collaborative networks, such as the Health Policy Analysis Centre [70, 114]. More specifically, as shown in Ibraimova et al (2011), successful aspects of the initiative include the harmonization of health sector legislation, delegation of tasks to other national health authorities and non-state actors, the strengthening of relationships with other line ministries and the executive leadership, restructuring and reorganization of the Ministry, and coordination of the SWAp [114]. However, key challenges remain in sustaining these initiatives, including the need for performance capacity funding and the broader challenge of senior staff turnover.

The Government of Kazakhstan and UNDP also recognized the need to build the capacity of the MoH in strategy development and policy-making [52]. As illustrated by Chanturidze (2015), the program involved an eight-stage approach that focused on strengthening both individual competencies and organizational capacities, including stakeholder mapping, needs assessment, designing of capacity-building tools, implementation, evaluation and facilitation of an enabling environment. In an effort to strengthen capacity across the MoH, three of five departments were selected for the intervention; activities included short courses, study tours, mentoring and coaching, action learning, work placements and attachments, and training over both the medium- and long-term. One measure of success for this program was that the Department of Strategy Development within the MoH led the development of the Kazakhstan Health Sector Strategy 2013-2017.

4.2 PROCUREMENT.

The MoH in Benin, as illustrated in Houngbo et al (2017), underwent an extensive capacity-building exercise in reforming its health technology management system [84]. Using principles of good governance and applying the Interactive Learning and Action (ILA) approach, the research team undertook a six-phased research and managerial approach, involving preparatory analysis, shared analysis and visioning, priority setting and planning, project formulation and implementation. The initiative appeared to have several positive outcomes, including enhanced transparency for procurement processes, participatory policy-making approaches that bridge the gap between technical and political staff, establishment of technical committees to supervise contracts, and the establishment of a separate directorate for medical devices, given stronger role capacity through legislation. An evaluation of the initiative has yet to be conducted, but early
successes include certain structural changes to the MoH’s functioning, and a reduction in costs for health technologies due to improved contracting procedures.

4.3 HUMAN AND FINANCIAL RESOURCE MANAGEMENT.

As argued by Banteyerga et al (2011), Ethiopia appears to have successfully aligned the Federal Ministry of Health, Ministry of Finance and Economic Development, and Ministry of Capacity Building in applying management techniques to health sector budgeting, accounting and fund utilization [115]. The government more broadly adopted the approach of Business Process Reengineering (led by the Ministry of Capacity Building), which has seen several positive outcomes from a governance standpoint, including increased capacity to plan strategically for HRH, coordinate donors, and manage donor funding [72]. This approach is under current evaluation, among other things assessing whether this increases the centralization of policy decisions, and the related effects [115]. Ethiopia’s MoH has also demonstrated increased personal capacity in its abilities to cost out the activities of the national HRH plan and actively monitor the program [72].

4.4 EVIDENCE USAGE.

In developing a conceptual framework to assess capacity for MoHs to utilize evidence, Rodriguez et al. (2017) highlight the importance of taking broad constructs and converting them into “discrete steps” that enable capacity strengthening [26]. Furthermore, this study underscores the importance of combining programs to strengthen individual competencies with interventions at the organizational and systems level. Similarly, Hawkes et al. (2016) found that in organizing capacity-building efforts for supporting evidence use within four countries, country teams more frequently organized initiatives for building individual competencies around data sources and evidence assessment [76]. Organizational and institutional capacity-building initiatives, however, were found to be more challenging to implement [76]. Structurally, there are a growing number of examples of new platforms to address this issue. They stimulate building the capacities of policy-makers to interpret, assess and evaluate evidence, and to articulate research needs. They also support strengthening linkages between researchers and practitioners [116, 117, 118]. Countries such as Malawi, Zambia and India are experimenting with such knowledge translation platforms, all involving MoHs to different extents. From a performance capacity standpoint, platforms in Malawi and Zambia have been largely funded by external agencies, while the platform in India is funded by the government. From a broader organizational capacity perspective, one study notes that “administrative and political will” allows for flexibility, innovative partnerships, and documentation of practices and guidelines [119].

4.5 REGULATION.

The United Republic of Tanzania, as in Janovsky and Travis (2010), provides a strong example of developing capacity in regulating pharmacies and drug stories. The MoH initiated the Tanzania Food and Drug Authority, and piloted a collaborative approach, including sensitization of key stakeholders, training, pre- and post-inspection visits, and supervision. This pilot approach was then scaled across the country [90]. In China, from 2000 onwards, Ma, Chen and Tan (2015) show that structural capacities began to address challenges in health inspection, clarifying roles for various agencies at the national, regional and local levels. A key form of building structural capacity is by using the results of a nationwide audit of the health inspection system to understand the strengths and weaknesses of the system and adapt accordingly [92].
4.6 REFORM.

The MoH in Saudi Arabia recently attempted to reform service delivery in the health sector, specifically around quality of care [120]. As illustrated by Hassanain (2017), the mechanism for this reform was public-private partnerships with private hospitals, and the MoH established 15 key performance indicators as a way to keep track of reform. The government also established a Performance Improvement Unit within the MoH to apply six sigma principles to help improve the quality and performance of hospital-based services. Despite some initial successes, an inconsistent six-sigma training program (due to difficulties in securing legal approval for secured time-off for training), leadership changes, resistance from civil service employees in the Ministry, and inadequate follow-up, meant that the performance improvement processes were unsuccessful, and indicators returned to baseline after nine months. Based on the lessons learned from this experience, the Ministry plans to continue with the reform efforts, but this time with the involvement of the Central Board of Accreditation of Healthcare Institutions, and with more nuanced analysis for each hospital [120].

4.7 VALUES.

Some MoHs have explicitly focused on strengthening governance principles within the Ministry. For example, since 2012, Ministers of Health from over 49 countries have participated in Harvard’s Ministerial Leadership in Health program. An independent evaluation of these programs has found that the program successfully supported Ministers of Health in articulating a clear and ambitious legacy for their tenure [121]. Another outcome of this program saw a significant proportion of Ministers exhibiting more confidence in building political support for public health strengthening, and in negotiating for increased budgets with Ministers of Finance [121].

In Mongolia, through the Health Sector Development Program funded by the Asian Development Bank, O’Rourke and Hindle (2017) found that workshops for MoH staff focused on several topics, including how learning organizations can create openness and reflection, and community focus [65]. Similarly, in Uganda, a learning-by-doing approach was adopted by the Ministry to several aspects of health sector reform [55].

4.8 MANAGING RELATIONSHIPS.

The Brazilian Observatório on Human Resources in Health is an excellent example of strengthening the capacity of an MoH to manage relationships across stakeholders [122]. From 1999 onwards, Campos and Hauck (2005) found that the MoH served as the secretariat for the Observatório – a network of government, university and development partner stakeholders focused on issues of human resources for health in Brazil. The Ministry, with the support of PAHO, has played a key role in ensuring that the network has adequate role and performance capacity. This support has also facilitated the strengthening of technical capacity, alongside the soft capacities of trust building, collaborative learning, flexibility and adaptability.
Section V

Strengthening Governance Capacities: Observations and Recommendations
SUMMARY

This WHO Working Paper aims to inform current and future efforts to strengthen governance capacities in Ministries of Health (MoHs) across the world. By ensuring and promoting health and wellness for their populations, MoHs hold responsibility for a complex array of governance roles undertaken within a rapidly changing and often volatile political, financial, ecological and health-related context. Despite growing attention to the issue of health sector governance – in LMICs and elsewhere – there has to date been little attention devoted to the capacities of Ministries to actually undertake their governance roles. In focusing on four major dimensions of governance – performing de jure governance roles, preparing for and responding to changing contexts, managing stakeholder relationships and managing values – this WHO Working Paper explores individual and organizational competencies, with the overall systems capacities requiring greater attention in further research.

With attention to six relevant categories of governance capacity – structural, role, personal, workload, performance and supervisory capacity – this WHO Working Paper examines how MoHs deal with current challenges and changes, especially political transition, crises, reforms, macroeconomic trends, global policy trends and social movements/change – along with the resulting capacity gaps that emerge. Examples from around the world reveal how these six governance capacities influence the current execution of specific MoH governance roles, including strategic planning and monitoring, evidence use and development, policy development, citizen empowerment, performance monitoring, procurement, program management, personnel management, regulating standards, contracting and compliance, resource management, fundraising and financial management. This WHO Working Paper also addresses how MoHs work to uphold governance principles while also ensuring inclusive participation, managing various governance relationships with a rapidly expanding array of stakeholders.

LESSONS LEARNED

Given this focus, what lessons can we draw from this WHO Working Paper?

First, there are significant gaps in the knowledge base requiring further research and commentary. These include:

- Relatively little research examines de facto, tacit or relational dimensions of governance. Few interventions focus on MoH capacities to manage relationships, uphold governance principles and/or navigate changing contexts.

- Despite the availability of more evidence regarding mandated governance roles for MoHs, certain aspects, including regulation and the management of contracts, remain relatively underexplored.

- There are few studies on the human aspects of capacity – including personal, workload, and supervisory capacities – and how these interact with role and structural capacity. Moreover, in the body of research on MoH capacity, there remains a significant lack of precision on the types of capacity required.

- Insufficient attention has been paid to the concept of “soft capacities,” including means of political engagement, and how to navigate complexity, build trust and learn reflexively. Given the multiplicity of actors in the health sector and the cross-cutting nature of health across all levels of government, the soft capacities of an MOH are of crucial importance; as such, this is a core challenge moving forward.
• Few studies utilize theory-driven approaches to studying MoHs, with specific attention here to the disciplines of sociology, public administration and political science [123].

Second, this Working Paper suggests that role and structural capacity initiatives are key mechanisms to strengthen an MoH and the other agencies in their task network, particularly given the frequent confusion and ambiguity around roles and responsibilities in the health sector. By clarifying laws, rules and regulations, particularly in terms of the roles and responsibilities that various national health authorities are designed to lead, share or delegate, and by giving other mechanisms (e.g. forums, committees, assemblies and working groups) formal sanction, Ministries might find themselves better positioned to exercise their duties. However, careful attention must be paid to the implementation, monitoring and continuous improvement of these capacity reforms to ensure their effectiveness.

Third, these findings underscore the need for major reforms and investments in personal, workload or supervisory capacity at MoHs. Personal capacity initiatives are required across a range of governance dimensions, and Ministries must actively recruit, develop and maintain diverse, complementary workforces at multiple levels. Building sustained networks and partnerships across state and non-state actors will also contribute to developing capacity within MoHs and the systems in which they are embedded. For such initiatives to be successful, stakeholders must promote organizational cultures within MoHs that support innovation, collaboration and calculated risk-taking. And at the same time, stakeholders must also find strategic ways of engaging with external inhibiting factors such as relatively low power of MoHs across government, and bureaucratic policies that often negatively impact MoH functioning, including frequent leadership transfers.

Fourth, and finally, the sustainability of capacity-building programs demands further attention. In many countries, performance capacity is largely dependent on donors – with positive and negative consequences on MoHs. For example, while donors provide critical funding that facilitates capacity development, the withdrawal of this funding without detailed plans for transition and sustainability can be damaging [124]. Therefore, careful preparation by governments and donors for the sustainability of capacity building programs – such as developing political commitment, domestic funding and monitoring and evaluation strategies – is essential. Medium-to long-term assessments of these programs are also needed to understand their impact on MoH functioning and health systems performance [36, 50].

RECOMMENDATIONS

The mandates of MoHs are continuously evolving, shaped by trends that more recently include a growing focus on universal health coverage, citizen voice and multisectoral collaboration. We strongly encourage further investigations and discussions on this topic, including further research and theory development, as only increased attention to this core issue will strengthen our collective efforts to build Ministry of Health capacities in countries across the world. Specifically, we recommend:

• Continued investment in strengthening MoH capacities alongside the ongoing documentation of these experiences to better capture the breadth of an MoH’s organizational capacity, and its depth in terms of specific governance roles.

• Application of the framework in specific country contexts to map, assess or improve MoH capacities for governance, and then incorporate lessons from those experiences to further refine and improve the framework.
• Continued development and documentation of approaches to strengthen MoH “soft capacities,” including navigating complexity, learning collaboratively, engaging politically and being self-reflective.

• Creation of mechanisms for sharing best practices and cross-learning across MoHs regarding governance and capacity.

• Identification of approaches to monitor, measure and/or assess the progression from processes (governance roles) to outcomes (performance areas) for MoHs.

• Exploration and analysis of governance capacities at the sub-national level, and the flow of capacities between national and sub-national levels.

• Advancement of rigorous, theory-driven research of MoH governance capacities, including the utilization of concepts and methods from political science, sociology and public administration.

This WHO Working Paper has examined the interface between governance and capacity in MoHs, and presents both a multidimensional framework and results from a scoping review of the literature. We encourage further reflection, research, and reform on this critical topic, with the goal of contributing to lasting improvements in population health and health equity for populations around the world.


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In addressing the big societal challenges of today – from containing communicable diseases to offering health services at all levels – how equipped is a Ministry of Health (MoH) to govern? Ministries or Departments of Health have a unique mandate over population health, charged with ensuring the health and wellness of millions. What kinds of capacities does an MoH require to govern responsibly and effectively? How can we better understand the terms “governance” and “capacity” as applied to an MoH? What are some strong country examples from which we can collectively learn? And how can we better assess the ways in which an MoH changes and adapts to very dynamic context?

In this WHO Working Paper, we seek to understand and illustrate this interplay between governance and capacity in Ministries of Health across the world, and offer a range of practical examples and recommendations.