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Gita Subrahmanyam, Caroline Jehu-Appiah, Nejmudin Kedir Bilal, Francis Ndem and Nakubyana Mungomba

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CHAPTER 28

Strengthening governance and accountability: Putting Africans at the center of social services

Gita Subrahmanyam, Caroline Jehu-Appiah, Nejmudin Kedir Bilal, Francis Ndem and Nakubyana Mungomba

"Whatever you do for me but without me, you do against me"

—Youth of Kazakhstan[1]

Governance and accountability are central to Africa's development goals. In particular, the continent's focus on sustained and inclusive economic growth and poverty reduction cannot be achieved without addressing governance. Poverty in Africa is partly attributable to waste, corruption, lack of transparency and inefficiency in the delivery of social services. More than 40% of the population of Sub-Saharan Africa is poor—that is, living on less than USD1.25 a day.[2] Only 5 of 54 African countries scored above 50 in Transparency International's Corruption Perceptions Index in 2012.[3]

Building human capital development systems centered on communities—with a focus on empowering the poor, especially poor women—is the key to increasing economic growth, overcoming poverty and achieving the Millennium Development Goals. Well-skilled and healthy people can contribute to more rapid and sustained growth in Africa, and programs focused on developing human capital would allow the poor to escape from poverty. Governance interventions focused on social service delivery are needed to achieve these multiple goals.

This chapter outlines the pivotal role of governance for improved social service delivery, more robust human capital and more inclusive and sustained growth in Africa. It contends that, to enhance governance, better mechanisms are needed to strengthen value for money, voice and accountability, transparency and greater citizen participation in service delivery. The main principle of improving governance and accountability is to put the poor at the center of service delivery, which would ensure that services provided are relevant, equitably distributed and of good quality.

The chapter is organized as follows. The first section defines "governance" and establishes its importance for human capital development. It shows that ideas of who should govern have evolved over time and points to the merits of a more decentralized model for improved human development outcomes. The second section examines the characteristics of governance and accountability in service delivery in Africa today. It demonstrates that overcentralized and weak governance systems have allowed waste, low value for money, poor management practices and regressive policies to continue unabated. Third, it highlights the steps that some African governments have taken to improve their governance systems, while the fourth section suggests actions and policies that can enhance the relevance, quality and equity of social service provision by strengthening governance and accountability. The chapter concludes by summarizing its findings and considering the merits of "new public governance" as a step toward overcoming some of the problems of service delivery in Africa today.

What is "new public governance," and why is it important for human capital development?

"Governance" is a popular but imprecise term that has evolved in relation to changing ideas about the scope of government and who holds—or should hold—political power. It refers to the institutional arrangements and processes by which political decisions are reached or put into practice. Once

a synonym for "government," "governance" has now come to mean the opposite—that is, "governing without government."[4] Since 1980 "governance" has taken on at least six distinct meanings for public service provision: (1) "good governance," where public affairs are managed according to the principles of efficiency, accountability, participation, transparency, equity and rule of law; (2) economic governance, referring to the institutional environment within which the economy functions, including the formal and informal rules and regulations that govern economic transactions and determine access to markets and public services; (3) corporate governance, referring to the structures and processes by which organizations delivering public services are directed, controlled and held to account; (4) new public management, where private sector management methods—in particular, a focus on the "customer" and an emphasis on outputs, value for money, performance standards and measures, and consumer choice—are applied in public service delivery; (5) public–private partnerships, where markets and quasimarkets play a role in delivering public services; and (6) policy networks, where powerful coalitions comprising a variety of state and nonstate actors regulate and coordinate public policy and service delivery.[5] "Governance" thus refers to institutional arrangements and principles on how power should be exercised at both the state and market levels, with responsibility and ethics at the center (1–4 above), as well as political processes involving nonstate actors (5–6).

The movement from "government" to "governance" reflects an ideological shift from viewing state actors as the sole and legitimate source of political authority in a country, toward seeing the benefits of more participatory and diffuse power-sharing arrangements. The core idea here is that modern states should be responsive to the needs and preferences of citizens. The public administration literature thus documents a transition from traditional public administration to "new public management" and then to "new public governance" (table 28.1). What we see as we move down the table is a diffusion of political power based on the notion that neither states nor markets can be trusted to faithfully act in the collective social interest. In most countries the move toward promoting the private sector and privatization in social service delivery occurred in response to systematic problems in state provision linked to rent seeking, inefficient resource allocation, poor quality outputs, low performance, limited responsiveness and weak accountability.[6] Similarly, markets can be viewed either positively as efficient resource-allocating mechanisms or

Table 28.1 **From traditional public administration to new public governance**

Public administration paradigm	Institutional manifestation	Who has power	Basis of political authority	Nature of power	Source of legitimacy	Main contribution to policy process	Policy focus in service delivery	Accountability mechanisms
Traditional public administration	The state as sole policy authority	Government officials	State-centered	Unitary	State as "the epitome of the collective interest" (Pierre and Peters 2000, 15)	Authority (legal framework)	Policy implementation	*Top-down:* "Good governance" *Bottom-up:* Voice/removal from office
New public management	Private–public partnerships	Government officials and market players	Market-based	Devolved	Markets as "the most efficient and just allocative mechanism available" (Pierre and Peters 2000, 19)	Economy and efficiency (value for money)	Service inputs and outputs	*Top-down:* Compact/corporate governance *Bottom-up:* Consumer choice/client power
New public governance	Policy networks	Government, market and civil society actors (any combination of these groups)	People-centered	Plural and pluralistic	Citizens as the only ones who can ensure that their interests are represented and secured	Effectiveness (accountability)	Service processes and outcomes	*Top-down:* Constitutional and legal framework/preference shaping (Dunleavy 1991) *Bottom-up:* Wider citizen consultation mechanisms

Source: Authors' compilation based on Osborne (2006), Skogstad (2003), Pierre and Peters (2000), and Dunleavy (1991).

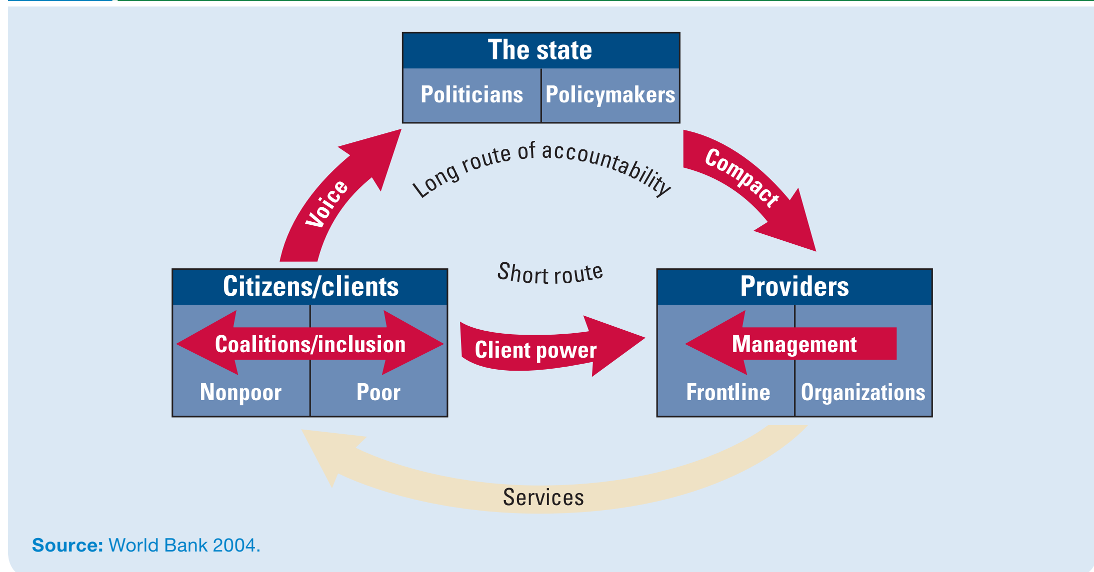
negatively as arenas where self-interested actors pursue their narrow personal goals at the expense of the broader social welfare.[7] New public governance reflects an increasingly popular view that the best way to ensure citizens' welfare is to involve them in the design, implementation and evaluation of public service delivery.

The transition from traditional public administration to new public governance represents an important step toward maximizing human development outcomes. In the new public governance model, multiple interdependent actors—including citizens—participate in policy decisions and contribute to the delivery of public services, leading to more effective policy outcomes. Participation by a plurality of actors both increases the level of expertise available in policy circles and enables the articulation of a wider range of interests. By putting people at the center of policymaking, new public governance ensures that policy decisions are more responsive to local needs and demands and that there is a greater focus on quality and equity in social service provision. In addition, because the model is based on deep decentralization, there is a greater chance of achieving synergy in interventions across social sectors.[8] Finally, it should be noted that the state is not replaced in the new public governance model: rather, civil society becomes a key partner of the state alongside the private sector, and any combination of these three sets of actors may be in force for any given policy area.

In an ideal governance system, power is tempered by accountability and those who hold power are held responsible for both their actions and the outcomes of their actions. Yet in some systems (even democratic ones), this does not happen. This is because people lack information, competence or will to hold those in power accountable,[9] and people in power are not held accountable through institutional mechanisms and processes. These shortcomings can be resolved by increasing transparency, which allows easy access to information; building peoples' skills and capabilities, so that they are better able to process the information they receive; activating peoples' voice, so that they feel empowered to act on the information they have processed; and strengthening institutional mechanisms, so that there are systems of checks and balances, as well as positive or negative incentives inducing power-holders to behave in an accountable and responsive manner. Positive incentives can include performance-related bonuses, commendations for doing a good job or retention of political office because of continued citizen confidence. Negative incentives can include legal redress, public censure, abandonment by citizens or clients or removal from power.

In an ideal service delivery system, there are built-in mechanisms enabling the users of services to hold those providing the services accountable. This can be better understood by examining the relationship between the three key stakeholders in the service delivery process: citizens/clients, service providers and politicians/policymakers (figure 28.1). Service users may pursue a "long route of accountability," whereby in their role as citizens they hold those in power (politicians and policymakers) responsible for putting in place institutional mechanisms (or "compacts") that induce service providers to deliver sufficient, relevant and high-quality outputs.[10] However, problems can occur in this circular relationship: policymakers may lack the competence, information or will to hold service providers fully accountable; or citizens' influence (or "voice") may be weak, as is often the case for poor people or in nondemocratic contexts. A much more straightforward and "short route to accountability" would be to empower service users in their role as clients to directly hold service providers accountable for the quantity, quality and relevance of their outputs. This could be done by increasing the level of competition among service providers, so that they have an incentive to perform better; enabling citizens to monitor and discipline service providers; or strengthening service users' role in policymaking by moving toward a new public governance approach to service delivery. In this way, "client power" is enhanced, and service users are transformed from passive service recipients to active and mobilized participant-members in the process.[11]

Figure 28.1 **Key relationships of accountability in service delivery**



Source: World Bank 2004.

Where accountability channels in service delivery are weak, basic services provided may be insufficient, irrelevant, inequitably distributed or of low quality. Any of these attributes would result in suboptimal human development outcomes. Moreover, other problems could arise, such as the capture of the benefits of government spending or service provision by a small set of actors at the expense of the many. In such situations the biggest losers will most likely be the poor or other vulnerable groups with weaker economic and social influence.

Strengthening governance and accountability in service delivery is thus very important for human capital development. Tying power to responsibility ensures not only that services are delivered but also that the services delivered are relevant, equitably distributed and of good quality. The main principle for improving governance and accountability is to put the poor at the center of service delivery.

What characterizes governance and accountability in service delivery in Africa?

Insufficiently decentralized administrations

Most African countries continue to deliver social services based on a centralized top-down model consistent with the traditional public administration model identified in table 28.1. Service delivery is performed mainly by public providers, and central government ministries retain responsibility for spending and resource-allocation decisions, rather than devolving these functions to regional, local or private providers. Education in most countries is mainly state provided, and across Sub-Saharan countries public facilities provide two-thirds of all health care.[12] In addition, centralized bureaucratic planning often means that policymakers become intensely involved in operational details and concentrate more on inputs than on outcomes and impact.

Where there is decentralization, it is mostly based on a "devolution of power and restriction of budget" approach. Therefore it tends to have the following constraints: weak capacities of local administrators, to whom management and finance functions have been devolved; no formal reporting mechanisms or information requirements; no specific performance requirements; lack of accountability of local-level civil servants either to their vertical line ministries or to local leaders in charge of basic social services; low representation of civil society through capable institutions at the local level; and lack of synergy between interventions across social sectors. Because the voice and authority of line ministries continue to prevail on local institutions, there are often

imbalances in resource allocations—which seems to be the case looking at the differences in spending and outcomes in the health and education sectors in Senegal and Tanzania (table 28.2 below).

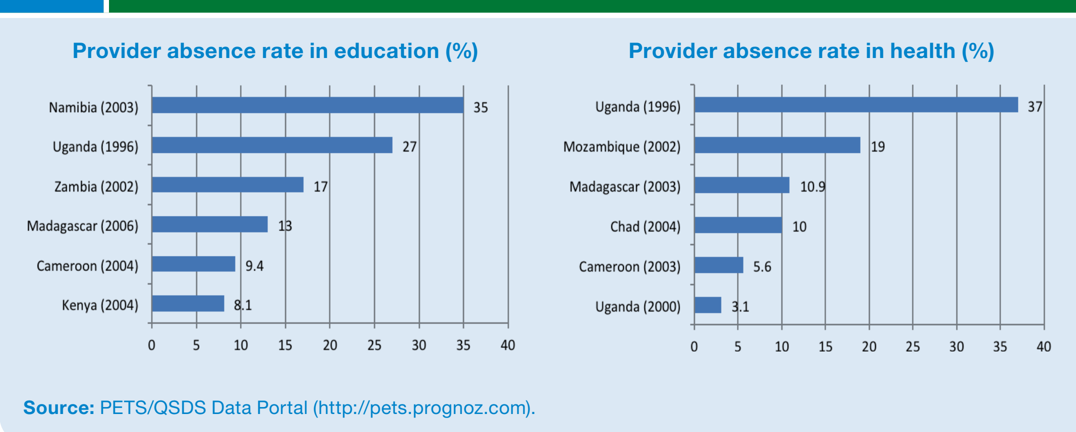
The main inefficiencies in service delivery are closely linked to failures from overcentralized bureaucratic structures. These include inadequate and inefficient resource allocation and financing options; inadequate domestic production of and access to commodities; inappropriate procurement and management of equipment and commodities; inappropriate staff mix; lack of performance incentives; and weak participatory and accountability mechanisms.

Inappropriate, outdated and weak regulation

Regardless of strong centralization, in many African countries government regulations for standards of service delivery are inappropriate or outdated, and enforcement is weak. This creates a lack of motivation and accountability for local civil servants and causes technical deficiencies and leakages of public resources. Due to weak clinical governance, the quality of care in African hospitals is generally low. In addition, the lack of hospital accreditation and weak enforcement of regulations and clinical standards has resulted in the poor quality of care. Due to poor regulation in the pharmaceutical industry, a third of medicines in developing countries, notably Africa, are counterfeit and may be damaging health, rather than contributing to better health outcomes.[13] Resources do not reach the frontline, often because of corruption, and there is inefficient and ineffective investment of the public budget. Across African countries there are indications of "leakages," where funds allocated to particular services do not reach the intended end-user. In Chad 99% of funds allocated never reached local health centers, and in Kenya more than 80% of schools did not receive the full bursaries to which they were entitled.[14] Given the lack of accountability to government and citizens, service providers have a large degree of latitude to follow their own agendas.[15] Moreover, policymakers have difficulty enforcing implementation of their policies and regulations down the chain of command.

Lack of control features and performance incentives lead to inefficiencies in education and health spending, though outcomes vary across African countries. Salaries are the highest-cost items in education and health provision: in some countries, such as Ghana and Malawi, teachers' wages make up more than 90% of primary education costs.[16] Yet in many countries a high percentage of teachers and health workers do not show up to work (figure 28.2). Absenteeism among teachers ranges from 8% in Kenya to 35% Namibia, while absenteeism among health workers ranges from 3% in Uganda to 19% in Mozambique. Improved learning and health outcomes can only be achieved when service delivery providers (teachers, doctors) are actually serving users. The reasons for absenteeism vary across countries,

Figure 28.2 Teacher and health worker absenteeism rates, selected African countries



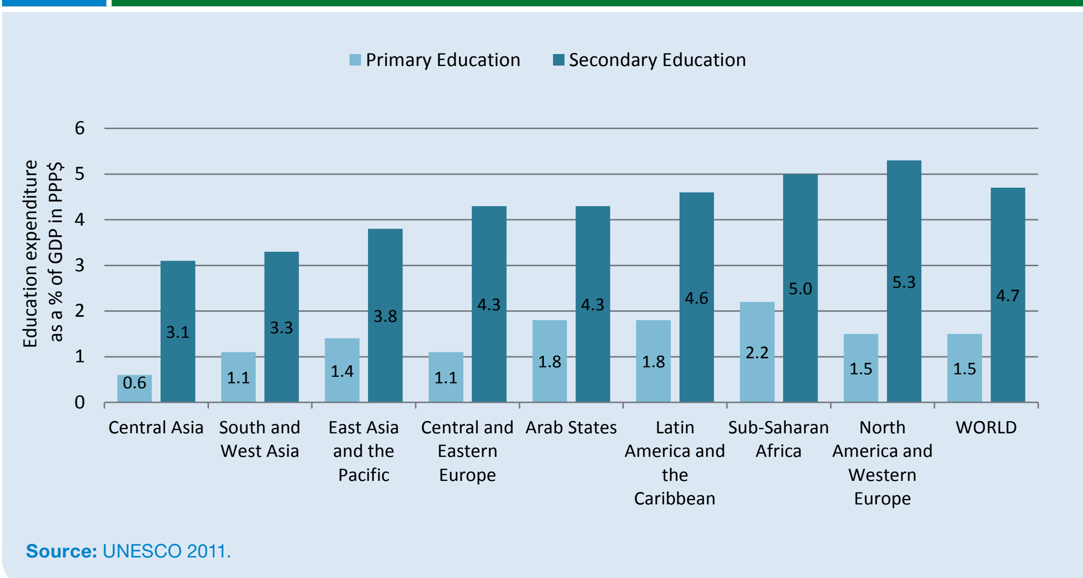
Source: PETS/QSDS Data Portal (http://pets.prognoz.com).

but civil service norms of guaranteed employment and salaries unrelated to merit or performance in many countries enable poor attendance.[17] The absence of incentives often makes it impossible to attract and retain qualified and knowledgeable civil servants in the social sectors, or to provide them with the necessary skills and support.

Low value for money

African governments dedicate a large share of their total spending to social services. Between 37% (Uganda) and 63% (Ethiopia) of total government expenditures in Africa are allocated to social services areas.[18] On average, African countries spend 7.2% of GDP on primary and secondary education and 6.5% on health—higher than any other region in the developing world (figures 28.3 and 28.4). Social protection measures also consume a large proportion of resources, notably in North Africa: in 2008 food and fuel subsidies constituted 31% of current government spending in Egypt, 20% in Morocco and 18% in Tunisia.[19]

Figure 28.3 **Educational expenditures as % of GDP (PPP) by region, 2008**



Source: UNESCO 2011.

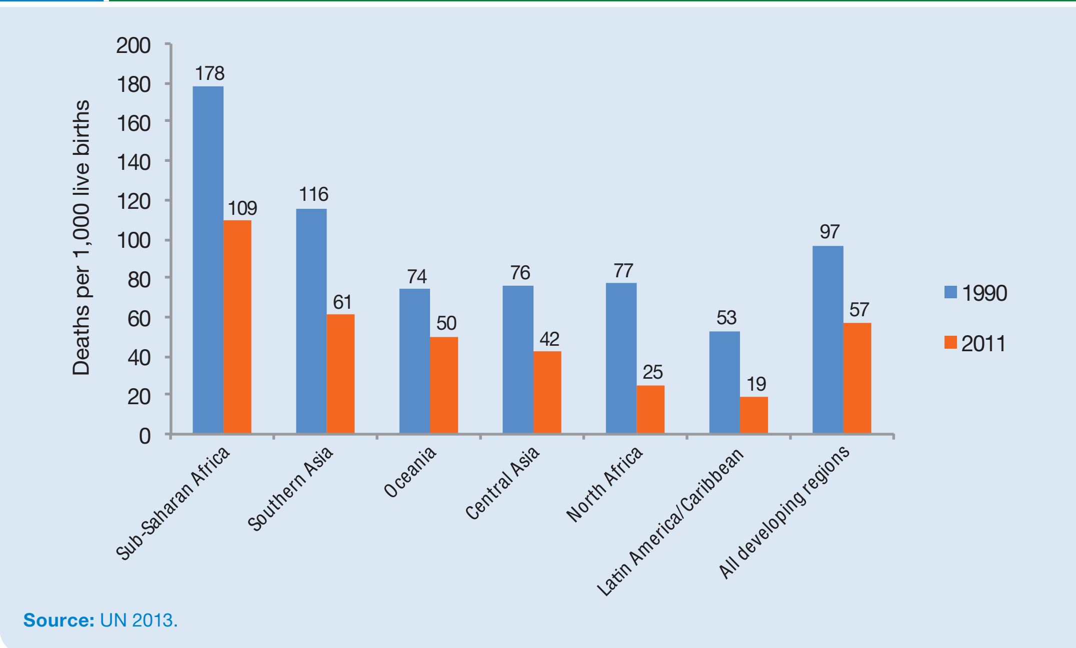
Figure 28.4 **Health expenditures as a % of GDP by region, 2000 and 2009**

Source: WHO 2012.

Yet high spending has not generally translated into productive or effective outcomes. There is a weak link between resources allocated to social services and outcomes of social provision in most African countries—a problem partly attributable to weak governance and poor accountability. For example, the decline in under-five mortality has been slower in Africa than in other developing regions (figure 28.5). In Sierra Leone the government spends 18.8% of GDP on health, yet the country has one of the world's highest rates of child and maternal mortality, and national assessments by health workers indicate that the overall health situation is worsening.[20] In some countries social welfare remains low: nearly 50% of Kenyans live in poverty and more than 40% lack sufficient food.[21]

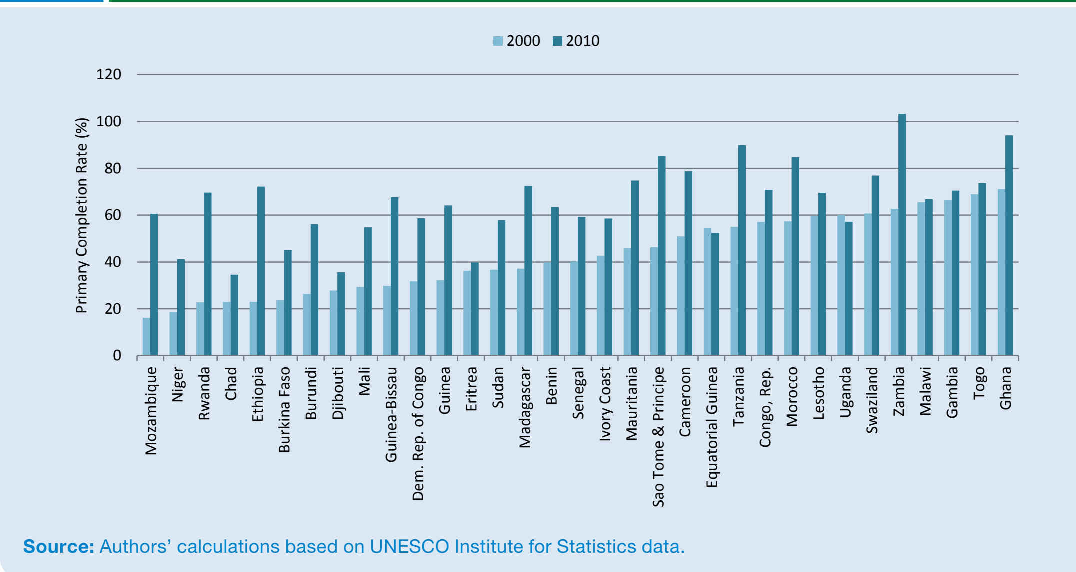
The reasons for poor outcomes differ across countries. While in most African countries the number of students with access to primary education has grown over the past 10 years (figure 28.6), the quality of education

Figure 28.5 **Under-five mortality rate by region, 1990 and 2011**



Source: UN 2013.

Figure 28.6 **Africa's progress toward MDG 2: universal primary education**



Source: Authors' calculations based on UNESCO Institute for Statistics data.

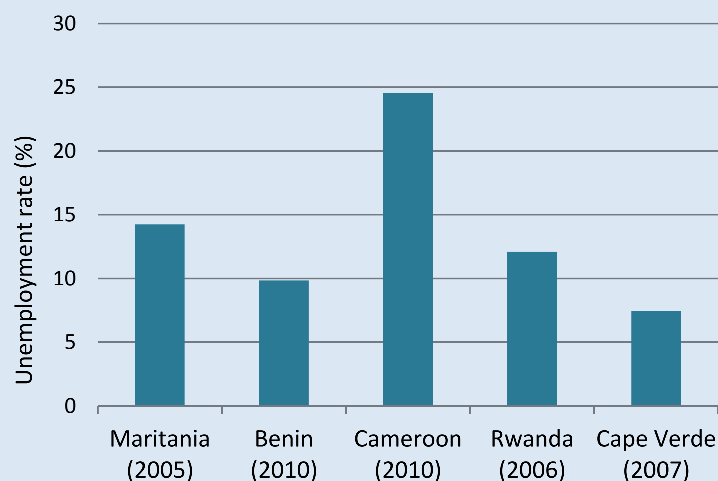
is not often globally competitive. For example, in international comparisons of student achievement, such as the Trends in International Mathematics and Science Study, African students have generally performed worse than non-African students.[22] In some cases it is not so much the quality as the relevance of the services that presents a problem. Skills mismatches between the outputs of education and the skills that employers demand have contributed to high youth unemployment and underemployment, even among those who have reached higher levels of education. A quarter of tertiary-educated young adults in Cameroon are unemployed (figure 28.7).

In 2010 a set of metrics on the performance of African schools and health clinics—referred to as Service Delivery Indicators—was piloted in Senegal and Tanzania, which demonstrated the reasons for African countries' poor performance in education and health (table 28.2). In Tanzania staff absenteeism is high, with around a quarter of all teachers missing on the survey day. Moreover, fewer than half of all teachers possess the minimum basic knowledge required to teach their subject, students spend only two hours a day at school and learning materials are in such short supply that there is less than one textbook per student. Given these constraints, it is hardly surprising that learning outcomes in Tanzania are poor. In Senegal only two in five health clinics have access to electricity, water and sanitation facilities, and only half have access to the three basic pieces of equipment (thermometer, stethoscope and weighing scale). In Senegal 22% of clinics were out of stock of the drugs considered essential, and one in five health workers was absent during the random spot check. Perhaps inevitably diagnoses are accurate in only a third of all cases and health outcomes remain poor.

Weak capacity and poor management

Lack of public management capacities and other key skills is one factor affecting the performance of social service delivery at all levels. Availability of competent managers, policies and procedures, quality-improvement systems, costing and a cost-analysis culture, financial management as well as human resources management are not high on the agenda in health or education. Administration functions are mainly held by technical staff (teachers and doctors), who lack the basic training and information necessary to monitor, plan, identify and solve problems.[23] For example, most staff members do not

Figure 28.7 **Unemployment rate among tertiary-educated people ages 25–34**



Source: Mauritania Core Welfare Indicators Questionnaire; Cape Verde Education Country Status Report 2011; Cameroon Employment and Informal Sector Survey; Benin Integrated Survey on Household Living Conditions; and Rwanda Integrated Household Living Conditions Survey.

Table 28.2 **Summary results for Service Delivery Indicators pilot survey, 2010**

	Senegal	Tanzania
Education		
At the school		
Infrastructure[a]	0.17	0.03
Children per classroom	34.23	74.05
Average number of students per teacher	28.74	48.71
Textbooks per student	2.55	0.94
Teachers		
Absence rate	0.18	0.23
Time children are in school being taught (minutes)	195	124
Share of teachers with minimum knowledge	0.52	0.42
Funding		
Education expenditure reaching primary schools[b]	153.59	124.54
Delays in salaries[c]	0.002	0.020
Health		
At the clinic		
Infrastructure[a]	0.39	0.19
Medical equipment per clinic[d]	0.53	0.78
Stock out of drugs[e]	0.22	0.24
Medical personnel		
Absence rate	0.20	0.21
Diagnostic accuracy in outpatient consultations[f]	0.34	0.57
Time spent counseling patients per clinician (minutes)	39	29
Funding		
Health expenditure reaching primary clinics[g]	1.78	7.01
Delays in salaries[c]	0.05	0.02

a. Percentage of facilities with electricity, water and sanitation.

b. Education expenditure reaching primary schools per primary school age student (purchasing power parity USD).

c. Proportion of employees whose salary has been overdue for more than two months.

d. Health facility's access to all three basic pieces of equipment (thermometer, stethoscope and weighing scale) (=1), or lack of one or more of them (=0).

e. Percentage of 15 basic drugs that during the survey were experiencing stock-out in the facility.

f. Average score 1 if correct diagnosis is reached, 0 otherwise, during patient case simulations.

g. Primary health expenditure reaching primary clinics per capita (purchasing power parity USD).

Source: Bold and others 2011.

have the skills to interpret and use data for decisionmaking, particularly at lower levels. At higher levels, policymakers and social services planners do not always have the management, analytical or communication skills for policy formulation and implementation.

Failures in forward planning have also affected service delivery outcomes. Across Africa there is a shortage of qualified health workers and teachers, with the problem stemming partly from past investment shortfalls in preservice training and weak human resource management.[24] Sub-Saharan Africa on average has two doctors and 11 nurses/midwives per 10,000 people—compared with 19 doctors and 49 nurses/midwives in the Americas, and 32 doctors and 78 nurses/midwives in Europe.[25] According to some estimates, the African health workforce would need to expand by around 140% to achieve enough coverage to have a positive impact on health and life expectancy in their countries.[26] In some countries low domestic production has resulted in shortages in medical supplies; in other cases poor supply chain management has resulted in drug shortages. In Malawi drug shortages have reached critical levels, with only 9% of health facilities (54 of 585)

possessing the full Essential Health Package list of drugs for treating common diseases.[27]

Poor allocation of resources and targeting of benefits

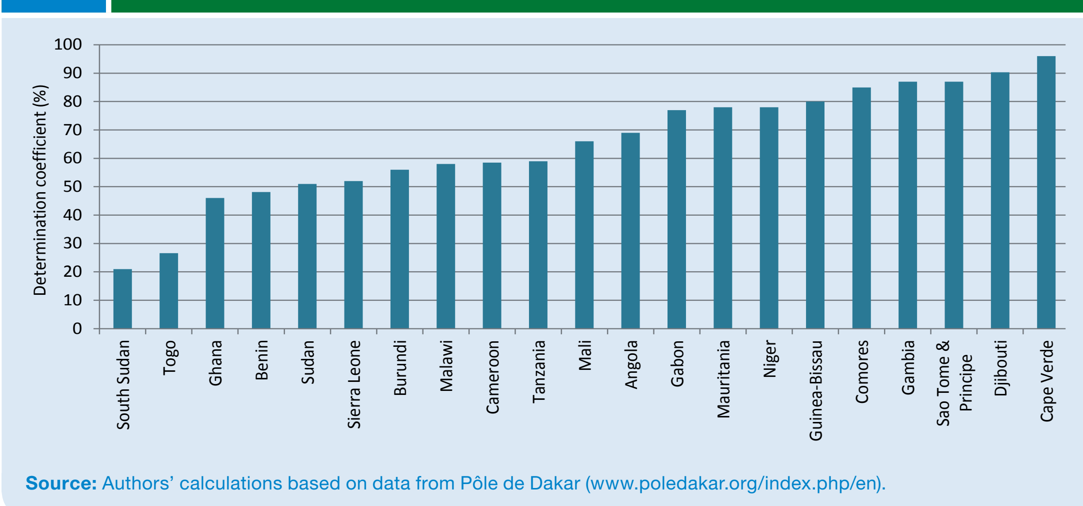
Poor planning and management mean that resource allocations often do not follow a logical pattern. In education the allocation of teachers largely reflects the distribution of public expenditures, since salaries are a major component of spending. In a consistent and fair system, the number of teachers available to a school should be higher when the number of students is larger. From a statistical point of view, this implies that the coefficient of determination that reflects the relationship between the number of students and the number of teachers should be close to 100%. In reality, however, this statistic varies from one country to another (figure 28.8). More than half of the countries in figure 28.8 have a coefficient below 70%. In Benin it is 48%, in Ghana 46% and in South Sudan only 21%. In Togo, for public schools with 200 pupils, the number of teachers varies between 2 and 16. Given that people are the main resource in social sectors, their equitable distribution among units of production is an important aspect of governance.

Additionally, within countries, resources are often unevenly distributed and not carefully targeted, so that those most in need of government assistance—the poor—do not receive the greatest benefits of social service provision. The wealthiest tend to capture the bulk of public social spending benefits, because governments allocate the greatest resources to the areas where the rich live (for example, urban centers) or to the sectors that they use the most (for example, tertiary education or specialized health care). In Guinea 48% of public spending on health goes to the richest quintile, and only 4% trickles down to the poorest quintile.[28] In Madagascar the poorest quintile receives only 8% of the education budget, the richest quintile receives 41%.[29] In Egypt nonpoor consumers receive 80% of the value of government food subsidies, and 93% of the benefits of state-subsidized gasoline go to the richest quintile.[30] Inequities in service delivery have led to widening income inequalities and contributed to intergenerational poverty. Many of the poor are women or single mothers.

Weak citizen voice and low transparency

In most African countries, service users (the citizens/clients shown in figure 28.1) have weak voice and no strong instrument to influence the allocation of resources or the planning and implementation of social service delivery. They are not involved in some or all of policy formulation, planning, implementation or monitoring of budget use and quality of services. Hence accountability by service providers to either communities or technical

Figure 28.8 **Determination coefficient (%) of the relationship between number of pupils and number of teachers in public primary schools in Africa, various years (2006–2011)**



Source: Authors' calculations based on data from Pôle de Dakar (www.poledakar.org/index.php/en).

ministries is very weak. Moreover, ordinary citizens often lack experience in negotiating or consulting with public institutions on service quality, which contributes to their institutionalized passive behavior on poor performance in service delivery. The fact that citizens do not generally have the capacity to hold their administrations and service providers accountable for inefficient social service delivery leads to exclusion of marginalized communities that have weak citizen and civil society organization capacity to demand accountability. This issue is particularly critical in fragile states where the rule of law is generally poor.

Most service users also have inadequate awareness of their rights or a poor capacity to ask for and exercise their rights. The common way to express citizen's voice is through local or national elections in countries where democracy is just emerging. Once elected, leaders are so overwhelmed by various urgent and competing priorities that they neglect pro-poor social services. Since the poor have few prospects to strongly express their voice, civil servants are not held accountable for effective delivery of basic social services. In addition, most service users lack the experience to negotiate or consult with public institutions. This contributes to passive behavior, poor service quality and weak accountability by service providers to communities.

Moreover, weak information reporting requirements in many countries mean that there are low (or no) flows of information from service providers to either beneficiaries or financiers. Communication infrastructures and information systems are weak in most countries, and private data are poorly captured, despite legal requirements. Thus there is little information exchange between the private and public sectors in most countries, and policymakers have difficulty in enforcing implementation of their policies and regulations down the chain of command.[31] This communication deficiency among central government, local authorities and citizens hurts the provision of basic social services to disadvantaged groups. These issues could be overcome if governments made use of tools such as citizen report cards or community score cards (see below), established community consultation mechanisms or included communities on social services governing boards.

Lack of information on service delivery performance provides citizens with little leverage for applying pressure on governments or service providers to improve performance. In most African countries there is little robust data on the quality of service delivery, which is critical for holding providers accountable for service delivery. Budget allocations alone have proven to be weak indicators of the quality of services. Furthermore, depending on the public sector to address service delivery failures may not be realistic.

What have African countries done to improve governance and accountability?

Some African countries have taken steps to collate and make available information on social services provision, and in some cases this has led to improved governance systems. Information matters: it clarifies issues for people wishing to hold service providers and governments accountable, and it elucidates problems that agencies committed to reform will take steps to resolve. With data, the case to demand good governance becomes easier to make. For example, the Service Delivery Indicators (see above) allow for a broad understanding of the quality of services being provided and for results to be compared across countries.

More than 30% of African countries have implemented diagnostic public expenditure tracking surveys (PETSs) to better understand the apparently weak link between resource allocations and outcomes (table 28.3). PETSs provide an indication of leakages in funding by tracing the path between central government allocation and receipt by social service providers. By collecting and disseminating data highlighting at what point funds go missing, PETSs empower citizens/clients and strengthen accountability in social services provision (box 28.1). Sometimes the information that emerges from PETSs reveals

Table 28.3 **Summary table of PETS carried out in education and health sectors across Africa**

Country	Education	Leakage	Health	Leakage
Cameroon	2004	No firm estimates	2003	No firm estimates
Chad	—		2004	73% nonwage 99% local allocation
Congo, Dem. Rep.	2007	No firm estimates	—	
Ghana	2000	50% nonwage 20% salary	2000	80% nonwage 20% salary
Kenya	2004	36% of bursary funds	2004	38% health center level 25% user fees at facility level 37% community development funds at facility level
Madagascar	2003 2006	9% of cash contributions	2003 2006	No firm estimates 15% petroleum and registers sent
Mali	2005	60–90% allocated textbooks	2006	No firm estimates
Mozambique	—		2002	No firm estimates
Namibia	2003	No proof	2003	No proof
Niger	2008	No firm estimates	2008	No firm estimates
Nigeria	—		2002	No firm estimates
Rwanda	2000 2004	No firm estimates	2000	No firm estimates
Senegal	—		2002	No firm estimates
Sierra Leone	2001	No firm estimates	2001	No firm estimates
Tanzania	1999 2001 2004	57% overall 18% nonwage 5%	1999 2001	41% 18% nonwage
Uganda	1996 2002	87% on average 18%	1996 2000	Not defined
Zambia	2002	10% fixed-rule grants 76% nonwage	2007	No firm estimates

Note: — denotes that no PETS was carried out. "No firm estimates" means that a PETS was carried out but there were no percentage estimates of the level of leakages.

Source: PETS/QSDS Data Portal (http://pets.prognoz.com).

Box 28.1 **Reducing leakages in educational funding through a PETS in Uganda**

In 1996 Uganda was the first country to carry out a PETS focused on its education sector to see how much of funding reached intended end-users. The survey showed that, between 1991 and 1995, only 13% of all funding and 22% of nonwage funding reached schools. The remaining 87% was leaked at the district official level and went to purposes unrelated to education. Following these results, the government launched a publicity campaign to inform citizens of how much money was actually being spent on education. Monthly intergovernmental transfers of funds were made public knowledge through newspapers. This action went a long way to decreasing the leakages in education funding from 78% to 20%, as evidenced in the follow-up PETS conducted in 2002.

Source: Reinikka and Smith 2004.

why government spending does not achieve expected outcomes: a PETS in education carried out in Zambia in 2002 showed that increased government spending on education had little effect on outcomes, because parents reduced their private spending on education by an equivalent amount.[32] However, PETSs may not be able to be implemented in all settings: in Mozambique the complexity of financing and logistical systems in the health sector rendered estimation of leakages during its 2002 PETS difficult and led to the conclusion that lack of government control provided little incentive against fraud and corruption.[33]

Staff absence surveys have also served as a powerful tool for highlighting deficiencies in the quality of public sector service

provision. By providing information on how many service providers (teachers, doctors, nurses) do not show up to work when they are supposed to be on duty allows for measures to be taken to counter absenteeism.[34] The data in figure 28.2 indicate that Uganda was able to reduce absenteeism in the health sector from 37% in 1996 to just 3% in 2000.[35]

Citizen report cards (CRCs) and community score cards (CSCs) are also powerful tools in promoting transparency and public accountability. CRCs and CSCs gauge the quality and performance of public services, and the results of these surveys are normally made available to the public. However, there is little evidence of their widespread use across African countries. Some of the countries that have documented their use include the Gambia, Ghana, Kenya, Malawi, Rwanda, South Africa, Tanzania and Zimbabwe. However, in 2011/12 the Transparency Accountability Program of the Results for Development Institute issued requests for proposals from nongovernmental organizations (NGOs) to design and implement CRCs and CSCs in the health and education sectors in Burkina Faso, Ghana, Kenya, Mali, Rwanda, Senegal, Tanzania and Uganda—so these tools are gaining ground. Evidence from the Gambia shows how CSCs allowed for greater client power in decisionmaking, including a new public governance approach to policymaking in the health sector (box 28.2). Implementation of CRCs in Uganda led to improvements in both the quantity and quality of primary health care in Uganda (box 28.3).

Ethiopia and Senegal have launched several programs with the technical and financial support of bilateral donors' agencies to try and improve the quality of health care. Although none of these programs is specific to the issue of quality of care in the hospitals, they all have been implemented in hospitals and have shown that it is possible to improve results. A project in Ethiopia mobilized hospital management teams to enhance the performance of the hospital.[36] A similar approach has been undertaken in Senegal to develop quality awareness at the level of management teams.[37] These examples demonstrate that quality improvement is possible in hospitals.

Tunisia has recently addressed deficiencies in the outputs and outcomes of its education system—particularly the low quality and relevance of its offerings, which have contributed to difficult education-to-employment transitions and high graduate unemployment—by creating a Quality Assurance and Accreditation Authority (QAAA) (box 28.4). The QAAA has only recently become functional, so it is too early to report results on its effectiveness. However, it is expected to greatly boost the quality of higher education in the country, thereby tackling one of the main sources of youth unemployment, which was a main cause of the Arab Spring in 2010–2011.

Ethiopia's Protection of Basic Services program has substantially improved the access to and quality of basic service delivery through an institutionalized system for transparency, accountability and community voice

Box 28.2 Increasing client power through use of CSCs in the Gambia

In the Gambia CSCs found that teachers received more than 70% approval ratings across regions, while school facilities such as furniture, core textbooks and toilets ranked below 40%. These results led to lobbying by parents and school administrations to the Ministry of Education for the timely and adequate supply of teaching materials and equipment, as well as the establishment of a reward program to attract and retain qualified teachers.

In the health sector, the survey indicated less than 30% satisfaction with staff capacity and less than 15% satisfaction with the availability of essential health equipment. It was recommended that a health committee including community representatives be established for increased voice and accountability, through immediate feedback and mutually developed action plans. The CSC process also revitalized the self-help spirit among communities with individuals making voluntary financial contributions, and the emphasis on community roles in addressing problems with facilities in the community.

Source: Dedu and Kajubi 2005.

Box 28.3 Improving health outcomes through use of CRCs in Uganda

Experimental design. Uganda was the site of a randomized field experiment, where 50 rural communities were selected for intervention (treatment areas) and then compared against nonselected communities (control group). Surveys (or CRCs) were conducted to collect baseline information on health service provision: 50 service providers and 5,000 households were surveyed separately. The report card results were then disseminated to the two survey groups in three stages. During the first stage trained local health NGO workers organized community meetings to report results, provide information on patient rights and assist in the drawing up an action plan to address community concerns. During the second stage the same NGO representatives reported results to health staff. The third stage was an interface meeting between community groups and health workers; a shared action plan was drawn up outlining steps to be taken by whom and within what time frame. The community contract was strengthened by measures to enable monitoring by citizens. At the end of one year the same respondent pool was re-surveyed to measure the impact of the CRC scheme.

Outcomes. Treatment area facilities showed marked improvement over control group facilities in the following ways.

Facilities saw an increase in quantity and quality of primary health care:

- 20% expansion in the utilisation of general outpatient services.
- 33% reduction in under-five mortality.
- 0.14 z-score increase in infant weight.
- Significant increase in child immunizations.

Additionally, there was an improvement in staff behavior and treatment practices:

- Absenteeism fell by 13 percentage points.
- Waiting times were 12 minutes lower than in control group facilities.
- Fewer drugs were leaked.
- Treatment group facilities were better maintained.

Cost. At a cost of only USD3 per household, or USD160,000 overall, the CRC scheme signified high value for money. The main expense related to collecting data for the report cards.

Source: Bjorkman and Svensson 2009.

Box 28.4 Improving higher education outcomes through quality assurance mechanisms in Tunisia

Context. Over the past decade Tunisia has experienced deterioration in the quality and effectiveness of higher education, with high leakages of funds and unprecedented graduate unemployment, which reached 33% in 2012. Apart from a poorly performing economy, factors contributing to this situation include a dramatic increase in student flows, insufficient number of consistent investment plans for infrastructure and equipment, degradation of teaching and learning conditions, and the absence of a quality monitoring system at process and product levels. Indeed, lack of accountability and performance audit mechanisms inevitably leads to poor quality and inefficient outcomes.

Major issues and challenges. An analysis of the determinants of quality education highlights the need for setting minimal performance standards in education and improving the definition of curricula. The absence of quality assurance hampers the professional mobility of graduates and thus limits regional integration prospects for the mutual professional recognition of diplomas and degrees. This jeopardizes youth employability in the long run.

Quality Assurance and Accreditation Authority. To address these challenges, in 2008 Tunisia passed a law to create a National Authority for Evaluation, Quality Assurance and Accreditation in higher education. The Quality Assurance and Accreditation Authority (QAAA) became functional in 2012. Its mission is to ensure better higher education and to enhance excellence among universities. Specifically, the QAAA will assess university curricula and learning outcomes, as well as graduates' employability and creativeness; promote quality assurance; and conduct accreditation through certifying public and private higher education institutions to ensure that academic and administrative services are provided in accordance with standards. The QAAA is expected to greatly boost the quality of higher education institutions by making them more accountable for the quality of their outputs in line with citizen expectations and the needs of the labor market.

(box 28.5). Civic engagement in the country has been strengthened through participatory budgeting, citizen monitoring of public service delivery and grievance redress mechanisms.

In sum, the measures that African countries have implemented to improve governance and accountability are laudable, and it appears that some governments have made headway in improving their social services governance systems. But as the foregoing discussion shows, only a few countries have taken steps to empower citizens' roles in service delivery—so there is more work to be done. The next section highlights measures that can improve governance and accountability and thus lead to more relevant, higher quality and more equitable service delivery outcomes.

What future actions and policies can lead to better governance and accountability in service delivery?

Across Africa, peoples' welfare has been threatened by poor health and education outcomes and limited access to social protection. Often this is not because of a lack of commitment to these goals, but rather because of inefficiencies, weak oversight and low standards of performance. Demand-side governance interventions focused on service delivery areas are needed to ensure that money spent in social sectors translates into improved human outcomes. Well-skilled and healthy people can contribute to more rapid, sustained and inclusive growth in Africa, as well as enabling the poor to escape from poverty.

Strengthening value for money, accountability and voice

Problems of poor performance and low accountability may be overcome by strengthening the compact between policymakers and service providers (see figure 28.1) through mechanisms such as reporting requirements, performance criteria/benchmarks and sanction/incentive systems. Increasing client power relative to service providers by

Box 28.5 Promoting governance in Ethiopia—Protection of Basic Services program

The Protection of Basic Services (PBS) program was established in June 2006 by the government of Ethiopia and international development partners. PBS supports Ethiopia's progress toward the Millennium Development Goals. Its goal is to expand access to and improve the quality of decentralized basic services in education, health, agriculture, water, sanitation and rural roads; strengthen local government systems by supporting financial transparency and accountability; and enhance social accountability to enable service users to influence policy and monitor service delivery.

The emphasis of PBS is on financial transparency and accountability; social accountability; and support of grievance redress mechanisms. The objective is to improve the quality of service delivery at woreda and kebele levels through an institutionalized system for transparency and accountability that is socially inclusive and responsive to local needs. Supported by targeted capacity building and systems strengthening, the three components are to contribute to the following key outputs:

- *Financial transparency and accountability:* information and communication activities with citizens on expected service standards, budgets and budget use, and public education on budget processes.
- *Social accountability:* continuing assessments of service delivery and budget use by service users/citizens, and development of joint action plans by service users and providers to improve services.
- *Support of grievance redress mechanisms:* strengthened opportunities for complaints and redress by citizens in cases of maladministration related to service delivery, and public education on existing opportunities.

Two subcomponents—public financial management and citizen engagement—integrate aspects of the supply and demand sides of governance. Strengthening these linkages will improve local accountability and transparency systems.

The expected outcomes of the project are that, by 2014: the percentage of citizens informed about the *woreda* budget will increase from 19% to 23%; the percentage of citizens who report that woreda officials have sought their views on improving the quality of basic services will increase from 48% to 50%; and an updated interim report on the social accountability component should demonstrate continued government commitment to demand-side accountability.

enhancing mechanisms for monitoring, evaluation and grievance redress—for example, by including citizens on decisionmaking bodies or using CRCs and CSCs—can also lead to higher quality outcomes by strengthening provider incentives to serve the poor.

Community involvement in social audits can lead to increased transparency and accountability, better quality decisionmaking and more effective use of budget funds.[38] It can also act as a control on corruption through improving monitoring functions. Social audit experience has grown in Africa over the past decade, but its use remains far behind that of other regions. While Latin American and the Caribbean is considered at the forefront and numerous examples can be found in Asia, social audit remains relatively undeveloped in both North African and Sub-Saharan countries.[39]

Open and transparent information flows and feedback between the providers and users of services on topics such as the use of resources, the quantity and quality of services and the attendance of teachers and health workers can support social accountability mechanisms. Increasing e-government practices in financial reporting, strengthening public monitoring through the Service Delivery Indicators and PETSs and promoting participatory budgeting would not simply increase accountability and support voice within the service delivery system, but would also likely result in better value for money. Measures that promote greater access to and transparency of information—such as Freedom of Information Acts—support accountability mechanisms.

Initiatives that explicitly tie spending to outcomes, such as results-based financing or performance-based financing, can fast-track improvements in value for money. Performance-based financing, a credible and innovative funding alternative that ties the allocation of resources to final system outputs, works as a service delivery system in which public service managers and staff work with communities to plan and produce the performance they desire. Programs such as the Quality Education in Developing Countries initiative work to link education funding to results.[40]

Information and communications technology (ICT) plays a strong role in securing better governance and service delivery. ICT has the potential to deliver more services for the same (or lower) cost and to deliver them to people that have had little or no access. Improved service delivery eliminates bottlenecks and, through e-government, minimizes personal contacts while enhancing transparency—which helps reduce corruption and improve value for money. The information revolution gives Africa opportunities to leapfrog conventional barriers to access in education and health at fairly modest cost. Technology can also reduce fiduciary risks and promote multiplier effects by involving the private sector as a partner. E-health is, for example, enabling African countries to develop vital registration and medical records, essential for improved management and delivery, while mobile technology can help transmit information rapidly, from medical alerts to remote diagnostics.

Capacity building and skills development

Capacity building is a key aspect of improved governance in service delivery. Training policy makers and service providers to better manage public resources and deliver public services will in many cases result in improved social outcomes. The evidence provided in the previous section points to the need for skills development in data collection, analysis and use of critical information, as well as procurement and allocation of equipment and commodities (for example, school books and medical products).

Capacity building and skills development is also required to overcome shortages in the supply of high-quality teachers and health workers (including pharmaceutical industry workers). Dedicating resources to higher education—and more specifically teacher and medical training—is one way of addressing this gap.

Capacity and capability development is likely also necessary for activating citizens' voice, to help ordinary people—and especially poor and marginalized groups—to better

understand their rights and to know how to access and process information. Community education programs, budget literacy courses and ICT training are some of the measures that can be implemented to achieve this goal.

More inclusive financial and social systems

Administrative, financial and political decentralization of social service delivery is critical for fostering inclusive growth. Greater citizen participation in and control of service delivery can improve its quality and efficiency. Specific governance programs may be needed to bolster the voice of women in policymaking and service delivery. Women's participation in policy processes that influence their children's education (such as parent–teacher associations) and health is crucial for breaking the cycle of intergenerational poverty.

Involving the private sector and households in delivering services can result in greater efficiency and effectiveness, leading to better human development outcomes. Including a greater number of partners in service delivery can also provide access to a wider range of expertise and resources than could be provided by government alone, thus overcoming inefficiencies in service provision from capacity, capability and resource constraints. Moreover, increased competition among service providers alters the incentive structures by widening consumer choice and allowing service users to "vote with their feet" and punish bad performance.[41]

Replacing central allocation of resources with citizen allocation—for example, by financing social services through conditional cash transfers rather than direct allocations to service providers—also boosts client power. Tightly targeted cash transfer programs are also more equitable, since funds are transferred directly to the poor, making it difficult for nonpoor groups to reap the greatest benefits of social service provision.

Conclusions

The issue of governance is central to Africa's development goals, particularly the continent's focus on achieving sustained and inclusive economic growth and poverty reduction. Over time, there has been an ideological shift from "government" to "governance"—that is, from viewing state actors as the sole and legitimate source of political authority in a country toward seeing the benefits of more participatory and diffuse power-sharing arrangements. The recent focus on "new public governance" highlights the view that the best way to ensure citizen welfare is to involve communities and service users in the design, implementation and evaluation of public service delivery.

In Africa today, social service delivery is characterized by insufficient decentralization, inadequate regulation, low value for money, weak capacity, poor management, uneven resource allocation, weak citizen voice and low transparency. While some African countries have implemented measures to tackle these issues, only a few have taken steps to strengthen the role of citizens in service delivery. It is only through empowering citizens to voice their demands and ensuring that the public sector and service providers can be held accountable for service delivery that good governance can be secured.

Some African governments have made headway in improving their social service governance systems through use of instruments such as PETSs, staff absence surveys, CRCs and CSCs. However, Africa still has a long way to go in securing value for money, voice and accountability in social service delivery. Specific measures that have been shown to improve service performance include results-based financing, e-governance, capacity building and tightly targeted cash transfer programs.

Administrative, financial and political decentralization combined with more pluralistic power structures is now viewed as the route to optimizing human development outcomes, and the new public governance paradigm offers two main benefits and opportunities. First, the different bases of authority depicted in table 28.1 are complementary, as each participant offers specific value added to the policy process: authority (the state), efficiency (the market) and effectiveness (civil society). And second, new public governance

may politically be a more saleable concept than its predecessor, new public management: "Politicians prefer words such as 'network' and 'participation' to words such as 'efficiency' or 'responsibility.' This seems to be partly attributable to the nature of political communication."[42]

While the approach here favors new public governance and policy networks because citizens/clients are included in the service delivery process, there are potential risks and challenges that also need to be recognized and addressed. First, policy networks, like any other decisionmaking forum, may be subject to capture by self-referential actors—and may thus not serve the wider collective interest.[43] Mechanisms need to be put in place to offset this risk. Innovative solutions must be introduced, especially in fragile or weak states—which, when they devolve power, leave space for capture by vested interests.[44] This may explain why studies have found a link between fiscal decentralization and corruption.[45] Second, nonstate actors in policy networks may seek to obstruct government introduction of unpalatable measures, such as budget cuts, and may be successful in blocking such measures, since government is simply another policy actor, rather than the strongest actor in the network.[46] Under such circumstances, service delivery may not result in value for money—not because of the outcomes of policy but because of the inputs. Again, there is a need for offsetting measures, such as subjecting policy decisions to wider community consultation. Third, new public governance tends to be more popular with center-left parties than with the political right, at least when viewed from a developed country perspective. This may limit the practical application of the new public governance model in specific African country contexts.

Notes

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2. Chandy and Gertz 2011, 4
3. The Corruption Perceptions Index ranks countries on a scale of 0 (highly corrupt) to 100 (very clean).
4. Rhodes 1996.
5. Pierre and Peters 2000; Rhodes 1996; Hodges, Wright and Keasey 1996; Santiso 2001.
6. Mehrotra 2006.
7. Pierre and Peters 2000.
8. Mehrotra 2006.
9. Lack of will to challenge authority generally arises from a sense of powerlessness or a lack of influence (or "voice") in political processes. It is often a problem for poor, vulnerable and marginalized groups.
10. World Bank 2004.
11. Lee 2011.
12. Castro-Leal and others 2000. The statistic on health excludes South Africa, which has developed private sector medical care.
13. Taylor 2008.
14. The Kenya education PETS website states: "It is found that some schools are receiving more allocation than required and that funds are diverted for personal gains" (see http://pets.prognoz.com/prod/CountryProfile.aspx?c=104&su=418).
15. Malen 2006.
16. Castro-Leal and others 1999.
17. Poverty Action Lab 2009.
18. Hagen-Zanker and McCord 2010. Six sectors are covered in this estimate: education, health, social protection, water and sanitation, agriculture and infrastructure. This reflects the fact that social service delivery is linked to wider service delivery issues. For example, energy, water and sanitation are directly related to health outcomes, while agriculture contributes to nutrition.
19. Albers and Peeters 2011.
20. WHO 2013; Curtis 2013. However, in absolute terms the level of resources allocated per capita is low

compared with other parts of the world (Malarcher, Olson and Hearst 2010).
21. Curtis 2013.
22. Nkosi 2012. Information on results can be found at http://timss.bc.edu/ or in individual reports at http://timss.bc.edu/timss2011/downloads/T11_IR_M_Chapter2.pdf.
23. Mills, Rasheed and Tollman 2006
24. Nyoni 2008. Other issues include international migration, career changes among health workers, premature retirement or mortality, morbidity and the challenges to education and health provision from Africa's "youth bulge" (Kinfu and others 2009).
25. Naicker and others 2010.
26. Anyangwe and Mtonga 2007.
27. Oxfam GB 2012.
28. Castro-Leal and others 2000.
29. Castro-Leal and others 1999.
30. Jones and others 2009; Iqbal 2006.
31. Malen 2006.
32. Winkler 2005.
33. Gauthier 2006. In this case, PETS highlighted poor record management systems, which inhibited control of corruption.
34. Chaudhury and others 2006.
35. However, Uganda's 2000 absenteeism rate should be treated with some care, since apparently health staff had prior warning of when the random spot check would be taking place.
36. Bradley and others 2008.
37. Details of this initiative can be found here: http://info.worldbank.org/etools/docs/library/233097/Reform%20Hospitaliere/htm/143_Domaines.htm.
38. Kay 2011.
39. World Bank Social Accountability Sourcebook electronic resource (www.worldbank.org/socialaccountability_sourcebook/).
40. For details, see www.hewlett.org/programs/global-development-program/quality-education-in-developing-countries. The initiative focuses its support on Ghana, Kenya, Mali, Senegal, Tanzania and Uganda.
41. Tiebout 1956.
42. Fattore, Dubois and Lapenta 2012.
43. Pierre and Peters 2000.
44. For example, a comprehensive and well-targeted technical assistance program combined with support for building state capacity and accountability is essential in sustaining the recovery process of postconflict or transition countries, but may not be possible where a country is still experiencing active conflict or prolonged crisis. Very weak states require tailored programs according to their multiple reconstruction objectives (Brinkerhoff 2007).
45. Fisman and Gatti 2002.
46. Fattore, Dubois and Lapenta 2012.

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