# MEETING REPORT:

# Consultation on a proposed Global Network for Anti-Corruption, Transparency and Accountability (GNACTA) in Health Systems

**Geneva, 26-28 February 2019**

## EXECUTIVE SUMMARY

Anti-corruption, Transparency and Accountability (ACTA) measures are central components of health systems strengthening for Universal Health Coverage (UHC). They are also essential for upholding the right to health and other indivisible rights. Without ACTA measures, resources meant to deliver on health goals can be wasted, trust in the health system can be weakened and, most importantly, human lives can be lost.

The rationale for the proposed Global Network for Anti-Corruption, Transparency and Accountability (GNACTA) is to help unify the multisectoral approaches to corruption and identify shared problems that demand collective action and clear outputs that are implemented at the country level, supported by the research and policy communities.

Accordingly, the WHO, Global Fund and the UNDP convened a multi-stakeholder GNACTA Consultation [1] on February 26- 28 2019 in Geneva, with co-funding from UK Aid. Participants included over 130 representatives from countries, academia/researchers, NGOS, service providers, civil society, international health aid agencies, and governance/anti-corruption organizations.

The Consultation aimed to seek a consensus on the need to establish the network, produce a draft action plan for the proposed Network during the 2019-2023 period. It also sought inputs on a draft outline for an appropriate Network governance structure as well as working methods.

Much of the Consultation was participatory in its approach. For example, participants were placed into working groups for exercises that included a patient pathway exercise, where corruption risks were determined from the point of view of a patient in a family health center, and then at the district hospital level. In addition, working groups did a mind-mapping exercise[2] that focused on core areas in the health system: supervision of donor funded projects at all levels, health products, health financing, health information systems, human resources for health, and the design of health programmes.

Throughout the Consultation, participants reflected on whether ACTA mechanisms were currently focusing on the right level of risk. Much of the attention was on the question of where the proposed Network can have the biggest impact in terms of reducing corruption risks in health systems? Participants emphasized, as examples, that we need to stop oversimplifying corruption in health, using ineffective controls, ignoring power issues, working in silos, and thinking about corruption as an individual or moral problem. They also advocated for adopting a risk-based approach, to measure the impact of ACTA before implementation, move to results-based financing with several prerequisites, invest in capacity building and multi-stakeholder processes, and to situate ACTA in the scope of the Sustainable Development Goals (SDGs) to leverage wide-spread interest and achieve desired results.

[1] This is in keeping with the 13th General Programme of Work of WHO, the UNDP Strategic Plan 2018-2021, and existing cooperation agreements between WHO and UNDP and between WHO and Global Fund.

[2] Mind mapping is a visual form of note taking that allows for an overview of a topic ('helicopter view") and its complex information and allows participants to create new ideas and make connections.

The Consultation also included an *Experience Exchange Market Place* during which 16 participants showcased their work on ACTA[3].

All of the participants also were invited to think about what would mean success for the Network in the 2023, which included desired outcomes such as: different sectors would meet often on ACTA, there would be more country involvement in the discussions and the implementation of ACTA initiatives in the health sector.

By using open spaces, participants developed their own agenda items for part of the Consultation. Topics of interest were related to ways of working with the proposed Network (communication strategies and tactics), what to consider when establishing the proposed Network (e.g. citizen empowerment, buy-in from actors that are needed to build bridges between the health and ACTA communities) and content areas (e.g. monitoring and evaluation of ACTA in health, fraud risk management, and integration of ACTA in health education).

The participants, furthermore, provided content for suggested core Network outputs. These are: (1) rationalizing internal control and assurance models in health systems using fraud and corruption risk assessment methodologies; 2) monitoring and evaluation of ACTA measures for health; 3) capacity development on ACTA in the health sector for multiple stakeholders; and, 4) integration of ACTA into health systems strengthening normative guidance.

Moving forward, the proposed Network will seek to foster increased coordination and collaboration among stakeholders engaged in existing and new initiatives. It will also include new catalytic partnerships including knowledge sharing. It will also seek support for its work plan through in-kind and financial contributions. It will also include efforts to bridge the research-to-practice divide, across disciplines and stakeholder groups, draw learning from other sectors, raise global awareness and enhance accountability for ACTA in health.

Next steps include generating options for a governance model for the proposed Network, communication and awareness raising activities, upcoming events and satellite sessions, refining the GNACTA workplan, aligning GNACTA to existing work on anti-corruption and fielding expressions of interest for contributions to workstreams, and seeking network resources. These steps will lead to the launch of the proposed Network.

[3] The Experience Exchange Market Place will be featured in the new and forthcoming newsletter of the GNACTA Proposed Network.

## BACKGROUND

Anti-corruption, Transparency and Accountability (ACTA) measures are central components of health systems strengthening for Universal Health Coverage (UHC). They are also essential for upholding the right to health and other indivisible rights. Without ACTA measures, resources meant to deliver on health goals can be wasted, trust in the health system can be weakened and, most importantly, human lives can be lost. Researchers estimate that 1.6% of world deaths in children, or 140,000 child deaths per year, could be indirectly attributed to corruption[4].

Evidence suggests that corruption in the health sector has a disproportionate effect on disadvantaged populations[5],[6] and hence is driver of health inequities and an obstacle that must be contended with if truly "no one is to be left behind" on the path towards UHC. To date, ACTA work related to the health sector has been largely fragmented and disparate. There has been an absence of a coordinated and coherent approach to ACTA amongst stakeholders working in global health, as well as between those working on ACTA at cross-sectoral levels and the global health community. This has undermined the contribution of ACTA work to UHC.

## GNACTA CONSULTATION AIMS AND OBJECTIVES

In view of global commitments to both Sustainable Development Goals[7] 3 and 16, the WHO, Global Fund and the UNDP convened a multistakeholder Consultation on a proposed Global Network for Anti-Corruption, Transparency and Accountability (GNACTA) in health systems [8] on February 26- 28 in Geneva, , with co-funding from UK Aid. Participants included over 130 representatives from countries, academia/researchers, INGOS, service providers, civil society, international health aid agencies, and governance/anti-corruption organizations.

The rationale for the proposed Network is to help unify the multisectoral approaches to corruption and identify shared problems that demand collective action and clear outputs that are implemented at the country level, supported by the research and policy communities.
The Consultation aims were to:

- Produce a draft action plan for the proposed Network during the 2019-2023 period.
- Seek inputs on a draft outline for an agile and output-oriented Network governance structure, as well as working methods.

[4] Hanf M, Van-Melle A, Fraisse F, Roger A, Carme B, Nacher M. Corruption kills: Estimating the global impact of corruption on children deaths. *PloS one.* 2011;6(11):e26990

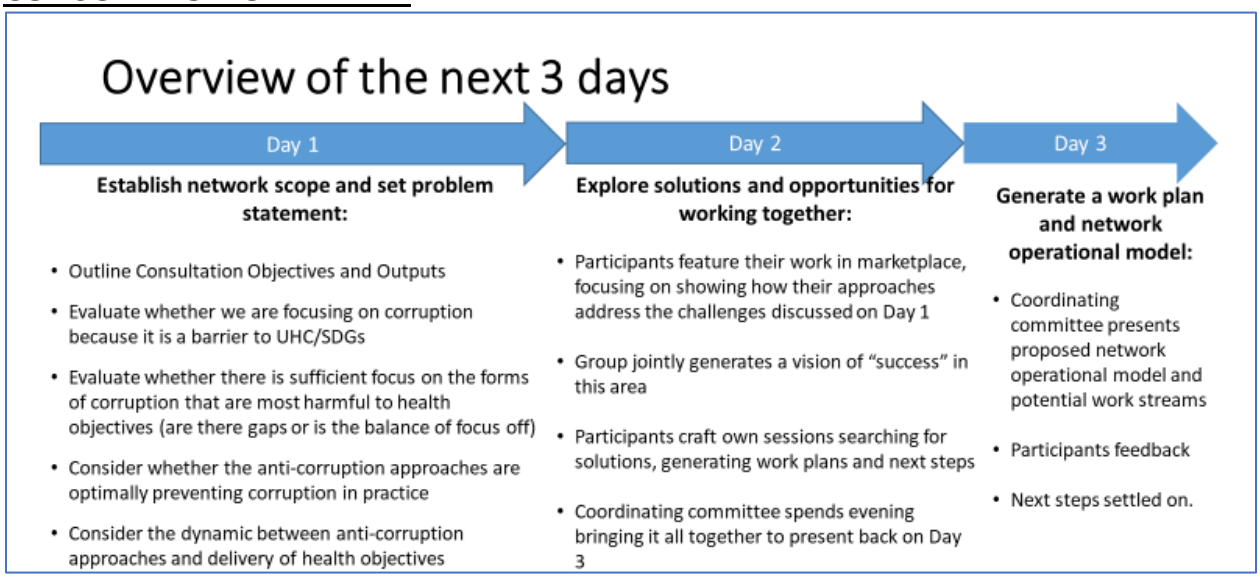
[5] Transparency International, ed. *Global Corruption Report 2006: Special Focus on Corruption and Health*. London, UK: Pluto Press; 2006

[6] Fighting Corruption in the Health Sector: Methods, Tools and Good Practices. New York, UNDP, 2011.

[7] Goal 3 – Health and Well-Being and Goal 16 – Peace, Justice and Strong Institutions.

[8] This is in keeping with the 13th General Programme of Work of WHO, the UNDP Strategic Plan 2018-2021, and existing cooperation agreements between WHO and UNDP and between WHO and Global Fund.

## CONSULATION OVERVIEW




As illustrated above, **Day One** aimed to establish scope and problem statement of the proposed Network. **Day Two** involved the exploration of solutions and opportunities for working together (including group work that involved "blue-skying" what a successful Network would entail and identifying key next steps). Lastly, **Day Three** consisted of further development of a workplan and a proposed Network operational model and potential work streams, participants' feedback, and next steps.

## DAY ONE OVERVIEW

In the beginning of Day One, participants were divided into sociometric groups depending on their professional affiliation, such as anti-corruption experts, donors, auditors and researchers. They were then placed into working groups (composed of a mix of participants from the various groups) to work on two exercises with the help of facilitators[9]: First, the patient pathway exercise where corruption risk was determined from the point of view of a patient in a family health center and then at the district hospital level. Second, working groups were moved into a mind-mapping exercise[10] that focused on core areas in the health system.

During the patient pathway exercise, the groups identified a number of possible scenarios where a patient entering first into a family health center and then into a district hospital could be subject to corruption. The groups came up with many detailed examples throughout the pathway. Some groups first addressed the definition of corruption, along with the importance of separating the definition from the impact of corruption. The need to contextualize the problem of corruption was also a common theme, specifically

[9] Facilitators were: Claudia Baez-Camargo and Timothy Mackey (Health Information Systems), Manuel Balan and Philip McMinn Mitchell (Supervision of Donor Funded Projects) Tomas Chang Pico, Elizabeth David-Barrett and Monica Kirya (Design of Health Programs) Rick Feeley and Karen Hussmann (Health Financing), Eleanor Hutchinson and Sarah Steingrüber (Human Resources for Health), Jillian Kohler and Nathalie Dewulf (Health Products).

[10] Mind mapping is a visual form of note taking that allows for an overview of a topic ('helicopter view") and its complex information and allows participants to create new ideas and make connections.

the importance of distinguishing private from public healthcare sector concerns, and how corruption particularly affects vulnerable populations.

Groups also considered how medicines may be stolen, or even sold to a private provider to whom the patient is referred for purchase; how substandard or falsified medicine may reflect corruption in other points in the healthcare system (such as licensing or the procurement process); and, how drugs may be siphoned off by health professionals and sold or used outside the public health system.

Bribes and informal payments were too discussed. For example, a facility may charge fees for materials required for hospital services. The participants discussed fraud, including upcoding, unbundling of charges to increase reimbursement (and possibly patient cost share) when not medically justified, and billing for inpatient days when the patient was treated on an outpatient basis. Accounting fraud was another cited risk—as when multiple sources (donors, government programs) may be billed for the same input or service, or funds earmarked for necessary but uncovered costs are taken by administrators.

Corruption opportunities in the procurement process were noted. This may involve kickbacks, bid collusion, bid rigging, and the purchase and receipt of substandard goods. It may also include the same supplier concealing the fact that different facilities may receive different contract rates for the same products. Health worker corruption, such as when a nurse may guide a patient through a particular care pathway for incentives/rewards, was identified as a risk. Additionally, collusive practices between providers and special interests (e.g., pharmaceutical companies) are a common risk. For instance, doctors may prescribe of multiple diagnostics tests or unnecessary medications due to collusion or receiving kickbacks from corrupt pharmaceutical company representatives. Special interests can also seek to skew decisions of health professionals by financing experts to do particular research or to publish particular data that favours their products or treatments. Access to information about prices, treatment availability, rights, and entitlements was cited as critical for anti-corruption efforts.

***Highlights from working group mind-mapping exercises***

**Supervision of donor-funded projects at all levels**. This working group examined how contextual conditions before the intervention of a donor-funded program provides greater or lesser risks for corruption. The program itself may generate new opportunities for corrupt behaviour; even though the supervision process is supposed to fix these corruption problems. The group emphasized that there were possible corruption issues from the inception of the program and not as an add-on. Consideration should also be given between acts of corruption that emerge out of people trying to navigate the system through corrupt means and those who look to corruption as a way to enrich themselves.

**Health products**. Discussion focused on pharmaceuticals, vaccines, and medical devices. Some examples the groups discussed included how drug inspectors may be paid off by manufacturers; pharmaceutical companies may pay a bribe to a drug selection committee in order to win a procurement bid; customs officials may ask for payoffs at the border in order for medicines to enter into a market; and non-registered drugs may be available in the market if regulators are paid to turn a blind eye to product entry. The group also pointed out that corruption in the distribution of medicines can involve regulatory capture, undue influence in political decision making.

**Health financing**. The group identified that budgeting/planning or "determination of need" for services of low or no medical need may be done by politicians and higher-level Ministry of Health personnel. This may include the use of funds for construction purposes, instead of for higher impact medical service, due to political reasons or for kickbacks. Health insurance related schemes were discussed too, as they may have risks of private entrepreneurs colluding with politicians or senior health officials, as well as inflated costs as a result of kickbacks. Another risk is the unbundling or upcoding done by providers themselves or by way of their instruction to their staff. The risk of corruption may also include the charging of more than one funder for the same service or input, which can be initiated by a provider as a coping mechanism for inadequate budget/rates but can also be fraud. Informal payments for necessary services can also take place.

**Health information systems**. Three major pillars on which policy should be grounded were deliberated: healthcare access; information integrity; and data protection and privacy, with attention to how data can be manipulated. The group isolated the following issues regarding health information systems: how to integrate ACTA into management information systems; how the health workforce is impacted by a lack of information; the need to have data to influence evidence-based policy making; the importance of contextualizing the problem; and lastly, the interconnection of the health system pillars, necessitating a systemic view of the healthcare sector.

**Human resources for health**. The discussion in this working group focused on a number of corruption types in human resources: absenteeism (which may be driver by low wages rather than a pernicious intent to corrupt public funds), ghost workers, inappropriate referral, embezzlement of products, manipulation of patients' data, fraudulent qualification, and substandard products. What constitutes corruption at the service delivery point was also discussed. Procurement was viewed as being particularly subject to corruption. The group concluded that there is not enough research being done on human resources and ACTA, and underlined the context-specific nature of ACTA, insisting that the constraints of the health system deeply influence on how corruption occurs. Whistle-blowers, in addition, need protection. Strong monitoring mechanisms, the group noted, are needed to monitor health workforce performance.

**Design of health programmes.** How the regulatory function could be subject to corruption for three principal reasons was examined by this group. First, there a regulatory agency may not even exist. Second, if there is indeed a regulatory body, it may be non-functional, because of improper influence on or bribery of the regulators. Third, evidence used in regulatory decisions (for example, related to licensing) can be manipulated or falsified. The working group also explored how deficient social norms and a lack of accountability can perpetuate corruption. Programmes may be designed with procurement corruption in mind—that is, to ensure that certain goods and services will need to be purchased from particular suppliers. Corruption may appear in the design of a governance programme through intentional loopholes or weak monitoring so as to facilitate future corrupt transactions (capture of legal process or policy process). Corruption infiltration in the design of monitoring and evaluation frameworks as well as staffing and human resources were also examined.

*Health Product Working Group Session*

***Highlights from panel on "Are ACTA measures effective?"***

The Consultation afterwards focused on the topic of fraud risk theory in Plenary. Participants were then asked to reflect on whether ACTA mechanisms were currently focusing on the right level of risk? Are we focusing on high or low value targets? The extreme complexity in corruption and in health systems was underscored along with the importance of context specificity. Fraud risk theory was noted as useful to apply to corruption investigation when time and resources are limited. A fundamental question was additionally raised: How to better prevent the most harmful forms of corruption? It was recognized that even though corruption at all levels is undesirable, we need to consider: where the proposed Network can have the biggest impact in terms of ACTA in health systems?

The next session involved a discussion with four participants, who simulated one of the following roles: a donor, a non-governmental implementer, a representative from a Ministry of Health and an auditor. They were asked to answer the following questions: (1) Are national and donor-driven ACTA measures effectively preventing and deterring the right corruption? (2) Do ACTA measures such as reporting requirements, input-based controls, and audits excessively stymie delivery of health objectives?

The four participants were asked to assume a risk averse view on ACTA first and then take on a broader approach about change. In the second round, the representatives were asked to adopt a change of perspective and put forward a proposition for change.

Pursuant to this, Consultation participants then responded to the question: what are your additional experiences of things being difficult? Answers were reported via an online tool and were anonymous. Examples include: "*too many layers of verification, strong focus on accounting for every dollar as opposed to results achieved*" "*generating good data on corruption issues*" and "*getting health community and anti-corruption community to speak a common language and agree on common goals*", amongst others.

Then participants worked in groups to answer the questions: what do we need to stop doing and what do we need to start doing in terms of ACTA in health systems? For the former question, answers included: stop oversimplifying, using controls that are forgeable, meaningless bureaucratic processes, ignoring power issues, working in silos, accepting "quick-fix"/"one size fits all" solutions, ignoring corruption, politicizing ACTA issues, thinking about corruption as an individual or moral problem. For the latter question, answers included: adopting a risk-based approach, to measure the impact of ACTA before implementation, move to results-based financing with several prerequisites, invest in capacity building and multi-stakeholder processes, and to situate ACTA in the scope of the Sustainable Development Goals (SDGs) to leverage wide-spread interest and achieve desired results.

## DAY TWO OVERVIEW

Day Two commenced with an *Experience Exchange Market Place* during which 16 participants showcased their work on ACTA[11]. The Market was an opportunity for informal exchanges in small groups amongst the participants. The presenters were given twenty minutes to share their experience through dialogue and a poster and a further five minutes of interactive dialogue and engagement with a small group. After twenty five minutes, a new small group would visit. There were four rounds in total. The presenters and their topics are listed in the below table.

| MARKET PLACE PRESENTER(S) | EXPERIENCE |
|---|---|
| **BAEZ CAMARGO, Claudia**, Head of Governance Research, Basel Governance Institute | How social norms and behavioral drivers affect provision of health services in East Africa. |
| **BALABANOVA, Dina**, Associate Professor, London School of Hygiene and Tropical Medicine<br>**HUTCHINSON, Eleanor**, Assistant Professor, London School of Hygiene and Tropical Medicine | SOAS-ACE Consortium - Anti-Corruption Evidence. Understanding the formal and informal drivers of corruption and openings for change in Bangladesh, Nigeria and Tanzania. |
| **DIMANSCESCO, Deirdre**, World Health Organization | ACTA and health products: WHO work to support countries. |
| **ELSAYED, Sammer**, Independent Expert | A risk management-based approach to prevent corruption in the supply cycle of medical products in public hospitals - country experiences. |
| **FOUKARA, Yassine**, Director of Strategy and Studies at the National Authority for Integrity, Prevention and Fight Against Corruption in Morocco | Methodology for corruption risk assessment based on a mix of techniques used to prepare a corruption risks map as well as specific anti-corruption strategies and action plans. |
| **HUNTER, Mostafa**, Consultant, United Nations Development Programme<br>**DIBIASE, Mark,** Policy Specialist<br>United Nations Development Programme | Making anti-corruption work at the country level: elements for success. |

[11] The Experience Exchange Market Place will be featured in the new and forthcoming newsletter of the Network.

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|---|---|
| **KUMWENDA, Rosemary**, Regional Team Leader Eastern Europe and Central Asia, UNDP | Addressing anti-corruption, transparency and accountability - Experience from UNDP projects. |
| **MACKEY, Tim,** Associate Professor UC San Diego, University of Toronto, WHO Collaborating Centre for Governance, Accountability and Transparency in the Pharmaceutical Sector | Leveraging artificial intelligence for "big data" based corruption surveillance: a multidisciplinary pilot study. |
| **MEFTEH, Dr. Mohamed**, Chief of Staff, Ministry of Health, Tunisia | The Tunisian experience on the management of corruption risk in the health sector and the implementation of the executive programme related to this experience. |
| **MUSIIAKA, Svitlana**, Head of Ministry of Health, Anti-Corruption Unit | The Ukrainian experience in fighting corruption in healthcare sphere. |
| **SAVADOGO, Ida**, Project Manager, RAME (Réseau D'Accès aux Médicaments Essentiels) | OCASS: a regional citizen observatory on access to health services. |
| **SULAIHMAN, Jimoh**, Independent Corrupt Practices and Other Related Offences Commission Chief, Nigeria | Corruption Risk Assessment of Nigerian Primary Health Care Development Agency (NPHCDA). |
| **TIRDEA, Marcela**, Head of Analysis, Monitoring and Evaluation Department of the Ministry of Health, Labor and Social Protection, Moldova | Developing Anticorruption Action Plan in the field of Health and Compulsory Health Insurance in the Republic of Moldova. |
| **UWAYDAH MARDINI, Rania**, Lecturer, American University of Beirut | The role of cost analytics in identifying and preventing fraud & corruption risks in public hospitals (including case studies). |
| **WIERZYNSKA, Aneta**, Senior Specialist, Anti-Corruption and Impact, Ethics Office, Global Fund<br>**DUA, Rajiv,** Country Representative, Liberia Population Services International | Case study: Applying Fraud Risk Assessment methodology to rationalize control model of AIDS prevention program for better corruption prevention and faster, higher quality program delivery. |
| **ZAMAN, Iftekhar**, Executive Director, Transparency International Bangladesh | ACTA in health through social accountability. |

***Participant feedback on what would define success for the proposed network in 2023?***

Next, participants worked in groups to "Blue Sky" on what they would define as success of the proposed Network in 2023. Examples of responses are featured in Box 1.

**BOX 1. Examples of the proposed Network success in 2023**

- UHC and other health goals would be achieved because corruption in the health sector would be reduced.
- Different sectors would meet often on ACTA.
- More country - level involvement would take place in the discussions and implementation of ACTA initiatives in the health sector.
- Structural change is evident in the health sector.
- More NGOS would monitor ACTA measures at the country level.
- More context-specific methods are used in ACTA and health.
- A multidisciplinary approach is take up.
- Sufficient resources (financial and human) for the Network to make real change happen.
- There is a willingness amongst stakeholders to take collective action in ACTA and health issues.
- Political actors are involved so effective policy change takes place.
- The Network working groups are productive and disseminate information.
- The Network would have a clear mandate, common language.
- Key stakeholders view the Network as a value-added initiative in terms of helping to achieve health goals.
- Knowledge management is in place.
- The creation of a framework, methodologies, standard setting and other ACTA tools has happened.
- Country-specific assessments are in place to understand priority risks and solutions to these risks.
- Country priorities (determined by country representatives) are linked up with academics specialized on developing solutions for the relevant issues.
- Citizens are empowered and can hold policy makers to account.
- ACTA work is preventative, coordinated, targeted, integrated, and prioritized.
- The role of donors and NGOs are reduced because there is more accountability in the health system and better health outcomes.

Afterwards, through an open space exercise, participants were Invited to develop their own agenda topics for discussion with interested participants from the Consultation. Topics included:

- **WAYS OF WORKING WITH THE NETWORK:** Communication strategies and tactics.

- **WHAT TO CONSIDER WHEN ESTABLISHING THE NETWORK:** Citizen empowerment; How to get buy in of the actors that are necessary to build bridges between the health and the ACTA communities; Governance of the Network.

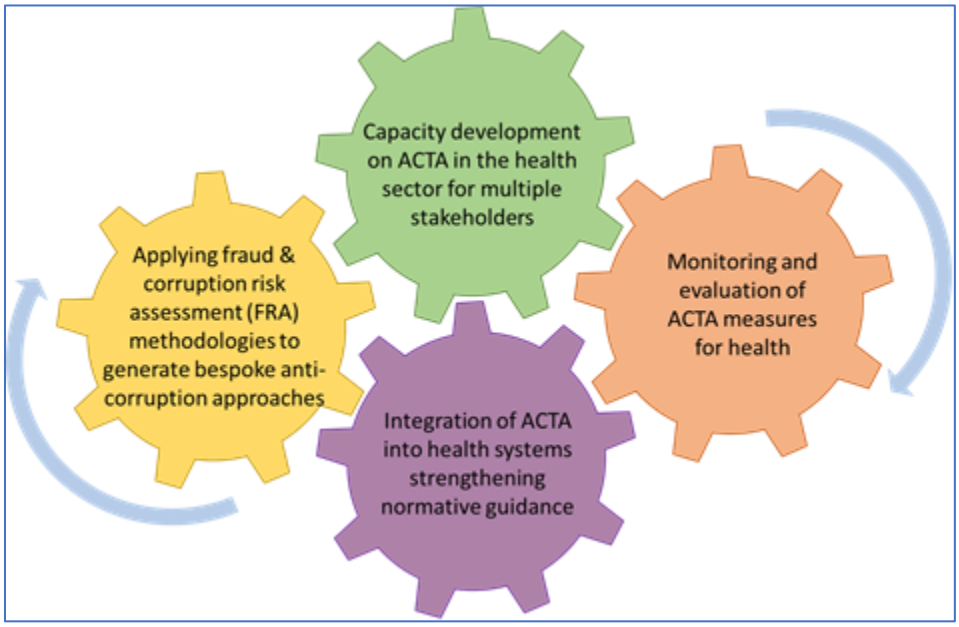
- **NETWORK CONTENT AREAS:** Development of a framework for monitoring and evaluation in ACTA in health; Fraud risk management; Terms of reference for donors and auditors; Establishment of

an ACTA in pharmaceuticals working group; Integration of ACTA in health education; Human rights and ACTA; Addressing gaps in knowledge and evidence in corruption and health research.

## DAY THREE OVERVIEW

***Suggest core outputs for the proposed network***

On Day Three, the Steering Committee reported back in Plenary about what was proposed by the participants (during the past two days) for the proposed Network's workplan. Suggested core Network outputs (and hence workstreams) were divided thematically into four categories: (1) generating bespoke corruption prevention measures by utilizing fraud and corruption risk assessment methodologies; 2) monitoring and evaluation of ACTA measures for health; 3) capacity development on ACTA in the health sector for multiple stakeholders; and, 4) the integration of ACTA into health systems strengthening normative guidance.




Next steps in workplan development would include quick wins which align GNACTA to existing work on anti-corruption. It also includes synthesizing feedback from the Consultation on the ACTA workstreams and will include an online survey to Consultation participants and other interested stakeholders about opportunities to align existing work with ACTA, refining the ACTA work plan, fielding expressions of interest for contributions to work streams, offers of help and resources as well as upcoming events and satellite sessions where the proposed Network could be present and its members could meet.

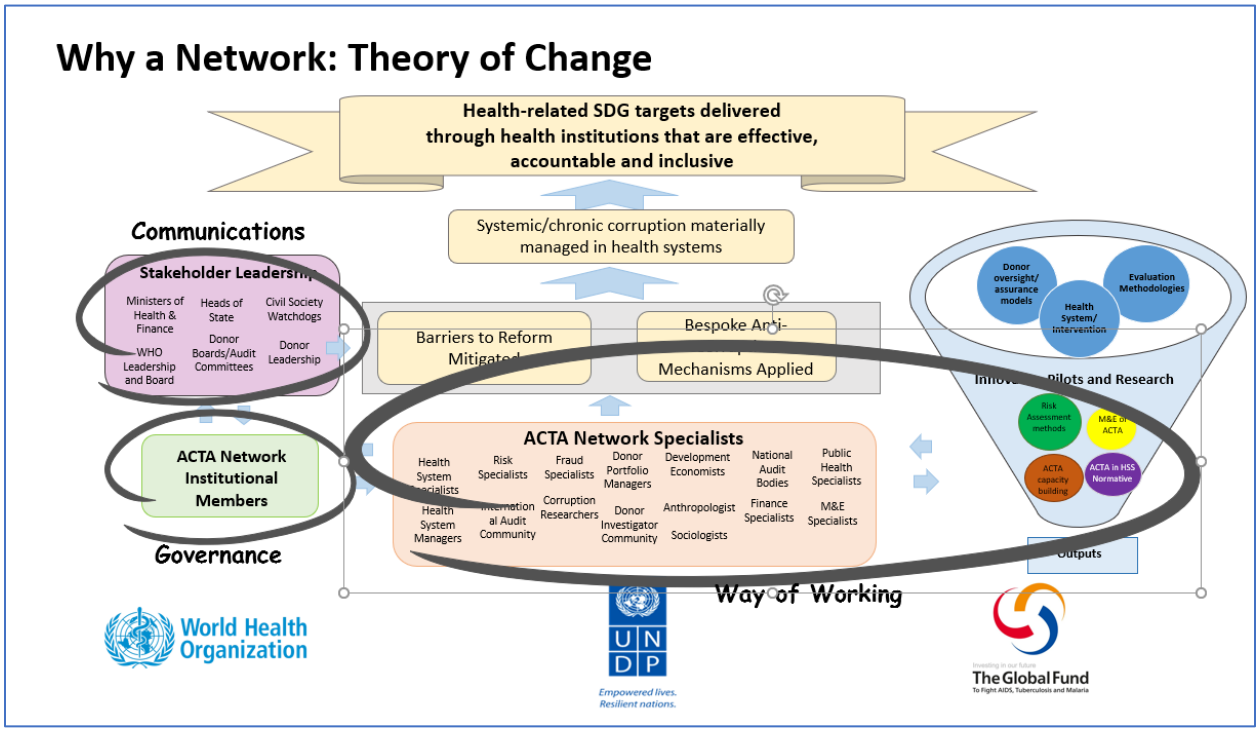
***Suggested core ways of working for the proposed network***

Looking ahead, the proposed Network will seek to foster increased coordination and collaboration among stakeholders engaged in existing and new initiatives. It will also include new catalytic partnerships including knowledge sharing. It will build support through in-kind as well as financial contributions.

The proposed Network will be results-driven. It will have an impact at the country level by way of building up strong national ACTA capacity in the health sector through key partnerships (e.g. Ministry of Health, civil society and donors). It will also aim to bridge the research-to-practice divide, across disciplines and stakeholder groups, and draw learning from other sector (e.g. education). It also will focus on raising global awareness and enhance accountability for ACTA in health (through SDG-related processes, UNGA, human rights mechanisms, etc.).

Participants also recommended the need to ensure that there are persons assigned to the proposed Network outputs, work is very much focused at the country level, working groups are small, nimble and can meet regularly (virtually or in person), avoid bureaucracy, and the value of "plugging" into existing platforms.

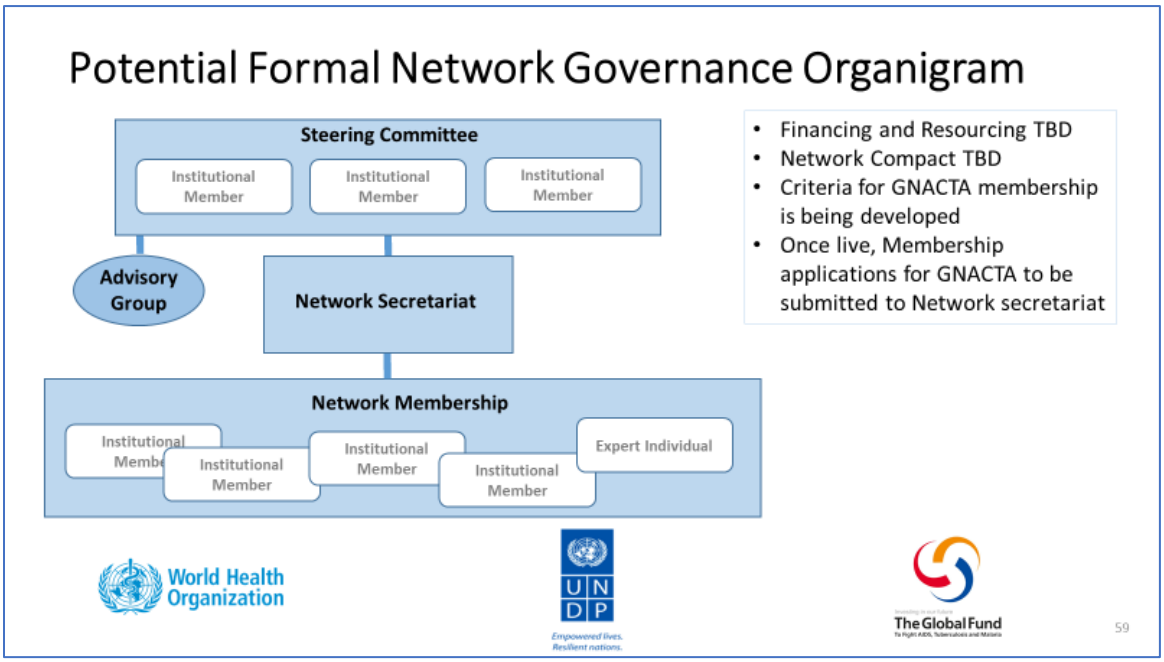
How the Theory of Change (ToC) (see diagram below) influenced the rationale for the Network was described. TOC is described as "*…a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context. It is focused in particular on mapping out or "filling in" what has been described as the "missing middle" between what a program or change initiative does (its activities or interventions) and how these lead to desired goals being achieved. It does this by first identifying the desired long-term goals and then works back from these to identify all the conditions (outcomes) that must be in place (and how these related to one another causally) for the goals to occur. These are all mapped out in an Outcomes Framework*[12]*."*




[12] https://www.theoryofchange.org/what-is-theory-of-change/

***Next steps for the development of the governance model for the proposed network***

Next steps will include using the feedback from the Consultation to generate options for a governance model and presenting those to Executives of the respective institutions of the Steering Committee. A potential organigram, subject to change during the pre-launch period, for Network governance is detailed below:




***Resourcing of the proposed network***

Financial resources to advance the proposed workstreams, particularly in light of decreasing external financing, is needed. Existing resources as well as what resources are available from existing programs will be identified, and a plan for coordination of fundraising will be developed. Members will also be asked to contribute resources in kind and financial.

***Ideas for communications and awareness raising for the proposed network***

- **Early activities (March-April 2019):** Efforts will be made to sustain the momentum and to invite more stakeholders to engage with the future network. To achieve this, the first Network newsletter will be disseminated and will share sharing experiences from the Consultation's *Experience Exchange Marketplace*. Blog posts of the Consultation will be published on the UNDP website and the Governance Collaborative websites. Video interviews of participants and a

consultation 'highlights' video and social media campaign will be launched as well as a joint UNDP-WHO-Global Fund blog post or op-ed, published on external site (e.g. the International Anti-Corruption Conference blog).

- **Pre-launch of the proposed network (2019):** A stakeholder mapping to prioritize communications objectives and outreach opportunities (including interest at country level) will be conducted. Network branding development will too take place (and discussions are already underway with a UNDP-funded health communications firm).

- **Network launch and beyond (Q1 2020 and after):** A robust communications strategy – defining the who, what, where, why, why to guide all communications activities and messaging will be developed. Communication campaigns and a potential event for the formal Network launch will also take place. A Network website for sharing lessons, research, stories etc. will also be created. Lastly, the production of ongoing outreach and communications activities (e.g. newsletter, side events at high level conferences, strengthening synergies with existing research networks and multi-stakeholder partnerships, sharing case studies and success stories of Network members) will be underway. Lastly, based on the ground work above, a key next step is to launch the proposed Network officially in order to create an effective multi-stakeholder partnership to work on solutions for the complex problem of health systems corruption.

*Photo: Participants at the 26-28 February consultation on Day 3, so a few had already departed.*

## ANNEX 1. Agenda for the *Consultation on a proposed Global Network for Anti-Corruption, Transparency and Accountability (GNACTA) in Health Systems*, 26-28 February, Geneva

### Day 1 Tuesday, 26th February 2019

### The Approach to Corruption in Health Systems Today

**Corruption is a barrier to achieving health-related Sustainable Development Goal (SDG) targets, including SDG 3. 8 - Universal Health Coverage (UHC), as well as SDG 16 to build effective, accountable and inclusive institutions at all levels. Are traditional anti-corruption, transparency and accountability (ACTA) approaches fit for purpose, will they affirmatively advance access to quality health services and ensure sustainable health systems? How can we do this better?**

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|---|---|
| **8:00** | **Participant Registration** |
| **9:00** | **Welcome and Opening**<br>Agnès Soucat, Director for Health Systems Governance and Financing, WHO/HQ<br>Mandeep Dhaliwal, Director, HIV, Health and Development Team, UNDP<br>Mark Edington, Head of Grant Management Division, The Global Fund |
| **9:15** | **GNACTA Background and Meeting Objectives**<br>GNACTA Steering Group representatives present the proposed network background, work to date, objectives of this meeting, and proposed thematic areas for the network moving forward.<br>Theadora Swift Koller, Technical Officer for Equity, Gender, Equity and Human Rights Team, World Health Organization/HQ<br>Arkan El-Seblani, Regional Manager, Anti-Corruption, UNDP Arab States<br>Aneta Wierzynska, Senior Specialist on Anti-Corruption and Impact, Ethics Office, Global Fund |
| **09:50** | **The Proposed Network Revealed: Who is here and why?**<br>Participants explore respective expectations for and perspectives on ACTA in health systems. |
| **10:30** | **Coffee Break** |

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| **10:55** | **Interactive exercise: Are we focusing on the right corruption, from the perspective of the patient and the health system?**<br>Are we targeting the forms of corruption that are most critical to address from the perspective of maximizing health outcomes, closing coverage gaps, assuring financial protection and contributing to sustainable health systems?<br>Participants map corruption along the patient pathway and along building blocks of health systems (e.g., Health Information Systems, Human Resources for Health) and core health processes (e.g., national disease program design, supervision from national to local level, and applications for donor aid), exploring the impact of corruption on progress towards UHC. |
| **13:00** | **Lunch** |
| **14:00** | **Which ACTA measures are effective and which ones are not, and in which contexts?**<br>Interview rounds and discussion between a representative from a ministry of health, a donor, a non-governmental implementer, and an auditor, along the following questions:<br>Are national and donor-driven ACTA measures effectively preventing and deterring the right corruption?<br>Do ACTA measures such as reporting requirements, input-based controls, and audits excessively stymie delivery of health objectives? |
| **15:30** | **Coffee Break** |
| **15:50** | **The Turning Point**<br>Participants bring their experience to bear, jointly exploring opportunities for smarter alignment of anti-corruption, accountability, and transparency measures with health targets included in the SDGs. |
| **16:50** | **Closing Remarks and Announcements** |
| **17:00** | **End of Day** |
| **18:00** | **Evening Social Event at Starling Hotel** |

## Day 2 Wednesday, 27th February 2019

## The Proposed Global Network in Action

**9:00** **Welcome and Overview of the Day**

**9:05** **The Power of the Proposed Network: Experience Exchange Market Place**

Visit experience exchange stalls that present the experiences of fellow participants, exploring the proposed network's expertise and experience, to date. Stalls include practitioners' and researchers' experience on ACTA in health systems.

*Tea and coffee served throughout the interactive session

**11:00** **Defining "Success" in 2023**

Participants jointly outline their vision of success for the proposed Network by 2023, exploring the impact of an effective ACTA approach to SDGs' targets impacting on health systems; the inputs, outputs and outcomes that underpin it; and the challenges overcome.

**12:00** **Forging a Plan of Action**

To achieve the vision of success, what actions should we collectively undertake in our approach to anti-corruption, accountability, and transparency?

Facilitators introduce participants to the Open Space modality of working for the remainder of the day.

**12:55** **Open Space Sessions**

Participants define the agenda for the remainder of the working day, setting topics for discussion for one-hour periods (15 sessions in total). The sessions aim to generate concrete approaches and outputs for the proposed Network Working Groups, including in areas such as (1) In-country work (2) alignment of donor approaches and (3) the strengthening of the evidence base and the development of normative guidance.

*Food and refreshments will be available throughout the Open Space sessions, please take care to replenish yourselves.

**15:55** **Report Back**

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| | Meeting convenors report key points from meetings to the plenary. |
| **16:55** | **Closing Remarks and Announcements** |
| **17:00** | **End of Day** |

## Day 3 Thursday, 28th February 2019

## The Proposed Global Network as a Future Driver of Change

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| **9:00** | **Welcome and Overview of the Day** |
| **9:05** | **Steering Group Reports Back**<br><br>Bringing it all together, the Steering Group outlines a proposed working model for the proposed Network, namely:<br><br>A. A proposed GNACTA's Operational Model, including (1) a conceptualization of how the GNACTA can act as a driver of change and (2) the outlines of the proposed Network's governance model.<br><br>B. Proposed workplans for the GNACTA Work Streams, drawing inputs from the previous day. |
| **10:05** | **Optimizing the ACTA Network's Operational Model**<br><br>Participants suggest improvements to the draft GNACTA Operationalization Model, focusing on outlining the opportunities and challenges of working together as an effective network. |
| **11:00** | **Honing Impactful and Actionable Work Plans**<br><br>Participants provide feedback to proposed work plans, generating concrete next steps.<br><br>*Tea and coffee served throughout this session |
| **12:00** | **Next Steps**<br><br>The Steering Group summarizes participant feedback in the form of S.M.A.R.T* Next Steps over the coming month, quarter, and year. |

*Specific, Measurable, Attainable, Relevant and Timely

**12:50** **Words of Closing and Thanks**

The meeting is formally closed with final remarks from steering group representatives:

David Clarke, Team Leader, UHC and Health Systems Law; Health Systems Governance, Policy & Aid Effectiveness; World Health Organization/HQ
Tracey Burton, Executive Coordinator a.i., Global Fund/Health Implementation Support Team, UNDP
Nick Jackson, Ethics Officer, The Global Fund

**13:00** **End of Day**

## ANNEX 2. LIST OF PARTICIPANTS

*Apologies for any omissions – for any changes, please send additional information to Aurélie PAVIZA (pavizaa@who.int).*

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