The use of evidence within policy evaluation in health in Ghana: implications for accountability and democratic governance.

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Abstract

Policy evaluation is commonly considered an important stage of the policy cycle for it enables a measure of policy achievement and produces insights to guide future policy interventions. 'Evidence' is the primary instrument supporting this process, but its delineation and its use are contested. Appeals to evidence can be a powerful tool for directing policy discussions, or to validate a particular policy strategy. Hence, it is crucial to examine the use of evidence in the policy evaluation process as a vital component of the policy-making process.

In this paper, we present a case study of the use of evidence in the health sector in Ghana. We found that the use of evidence for policy-making is especially promoted by international donors, as a key component of democratic governance and as a way of increasing accountability and stakeholders' involvement in policy decisions. We argue that analysis of the policy evaluation stage provides additional understanding of the stakeholder dynamics that revolve around the use of evidence to guide policy making. The added value of considering the policy evaluation stage lies in the fact that it captures interactions between key policy actors who influence how evidence shapes policy agendas. Only at those moments it is possible to appreciate how evidence use becomes an indicator of the relationships of power between different policy actors and the allocation of responsibilities between government agencies.

In this paper we look at Ghana's evidence advisory system to understand the way evidence is produced and utilised for health policy-making and how the uses of evidence within policy evaluation processes reflect democratic deliberation. Drawing on qualitative interviews with a range of policy actors, including representatives of the Ministry of Health (MoH), government agencies, donors and civil society organizations, we find that it is possible to classify two evidence advisory streams: 1) capturing the flow and distribution of local information, particularly issued from routine data sources but also other forms of locally generated health sector information; and 2) capturing the review of evidence within policy evaluation processes. The first of these is meant to rally the three levels of governance (local, regional and national) under a common accountability structure, which still shows problems in terms of clearness of accountability lines. The second, instead, is built around a different logic of information use, where international donors appear to be the principal interlocutor – and

arguably, the principal accountee for the MoH. The review process is formally integrated in the system of evidence-based policy-making in Ghana's official Common Management Arrangement (CMA), yet we argue it provides a separate "public space" of decision-making in which the rules for evidence use and participation change from those built into the decentralized structure of governance.

We discuss how evidentiary practices used in policy evaluation in Ghana, purportedly intended to improve democratic decision-making, may actually produce outcomes that undermine democratic accountability. We reflect on the rules of the game for evidence review and describe a disconnect between two accountability systems seen to be built into two separate streams of evidence advice. We further note local perceptions of the problem in terms of local democratic principles.

1 Introduction

In a recent editorial in the *International Journal of Health Policy and Management* Jeremy Shiffman points out a need to question and challenge the exercise of power in global health policy – particularly when that power arises from claims of expertise (Shiffman, 2014). His concern revolves around the lack of consideration of the epistemic and normative dimensions of power which are relevant to the production of meaning and categories that shape world views (productive power) and to the structuring of interpersonal perceptions that guide our actions within a certain world (structural power).

In this editorial, Shiffman points to global institutions establishing their power through their capacity to perform research and produce expert advice, under the remit of supporting 'sound' decision-making in countries with limited local capacity. He argues that such power is often seen as legitimate due to its grounding in knowledge or humanitarian motives, but that legitimacy needs to be questioned.

From a purely technical perspective, that decisions are of higher quality when they are informed rather than non-informed by evidence, is an assumption that needs little discussion. Especially in health policy, it is widely accepted that the choice of clinical treatment or intervention must be taken on the basis of rigorous evidence review to maximise benefit and minimise potential harms (Chalmers, 2003). However, the assumption that evidence-based decisions are *better* than non-evidence-based decisions goes beyond pure instrumental considerations of technical assistance. Besides being widely recognised that health policy decisions are more than simply exercises in technical decision making (Russell et al., 2008), the assumption that evidence-based decisions are *better* implicitly touches upon issues of political responsibility to use evidence, to take it into account, and to account for it. But what does political responsibility over evidence use mean in practice? Who is responsible for evidence use, and to whom should users of evidence be responsible and accountable?

These are questions that are often overlooked and left implicit within current calls for 'evidence based policymaking' (EBP), even when discourses over EBP include claims that evidence can somehow improve accountability practices and democratic decisions (c.f: Petrosino et al., 2001, Clarence, 2002). Evidence use and accountability are generally held as inherent values of policy-making and most of the time they are seen to be functional to each other. As much as the use of evidence serves to inform decisions, accountability serves to make account of the use of evidence as a practice of political responsibility. However, what this practice of responsibility (i.e. to use evidence in an accountable way) consists of remains vague, and so democratic considerations over the accountable use of evidence (Strassheim and Kettunen, 2014). We here propose to explore precisely the practical applications of an 'accountable use of evidence' in order to advance theoretical considerations over the use of evidence for democratic decisions.

We use a case study of the system for evidence informed health policy making in Ghana. We focus on the stage of policy evaluation for both practical and conceptual reasons. Conceptually, policy evaluation relies on the idea that decisions are 'better' when they can be *tested* (Weiss, 1999), with evidence playing a prominent role in enabling this test and validating the value of decisions according to their outcomes. Indeed, evidence used in evaluation to inform future policy choices can serve as a powerful tool for translating the *technical* measurement of policy achievements into a

political value for shaping policy directions. This translation is a political act that shapes future policy choices while being supported by evidence use. However, the political character of this process can also go unobserved under the language of 'evidence informed policymaking' obscuring the ways in which evidence use brings about political decisions within the evaluation process. The link between evidence use and policy decisions, instead, should not be underestimated, especially when claims to the use evidence – such a precisely in policy evaluation – raise issues of authority relations between knowledge production (epistemic) and knowledge use (political authority) (Hoppe, 2009). From a practical point of view, Ghana is an aid-depended country[1] and as such it is subjected to constant requirements to improve its governance structure in order to contribute to 'aid effectiveness' (Pallas et al., 2015). Strictly speaking, aid effectiveness is tested in the phase of policy evaluation; more largely, this test is diffused through the practice of 'monitoring and evaluation' (M&E) of health policies operationalization. Hence, following Shiffman's lead, policy evaluation is an interesting terrain of inquiry due the institutionalized presence of international donors and expert institutions in this stage of the policy-making process. The donor-state relationship can be characterised by asymmetries of power, which, besides disparity in financial resources, also arise from claims to knowledge. We shall see that asymmetries of power run along practices of evidence production and use, making the use of evidence an exercise of power relationships.

In the perspective of investigating the practical applications of the 'accountable use of evidence' in policy evaluation in Ghana, we first set the theoretical basis of our discussion. In section 2 we explain how the principles of evidence use and accountability have been associated and left unseparated within a managerial understanding of decision-making; we will then describe, logically, how such association has found application in democratic considerations over policy-making and how policy evaluation has accordingly acquired a prominent role in improving policy-making. The result of this theoretical reflection will be the current employment of principles of evidence use and accountability in policy-making left untreated an inherent tension – or duality – that exists in both as informative and justificatory of policy choices. We will then set the exploration of these series of dualities in section 3, in which we provide an empirical analysis of the evidence advisory system in health in Ghana. We will describe how evidence production and use is structured within accountability mechanisms and how policy evaluation drives the whole process through an institutionalized process of interagency review assessment. In light of this description, we will see that little issues emerged as to the accountable use of evidence in the health sector in Ghana. However, we shall see in section 4 how the link between evidence use and accountability becomes more unstable and questionable in light of international donors participation into the evaluation of the health policy section in Ghana. Informed by interviews conducted in Ghana to public officials within the Ministry of Health, international organizations, NGOs and donors, our analysis will show that the practices of evidence use in health policy evaluation reveal important aspects on the accountability structure actually in place. The duality of evidence use as both an informative and justificatory tool of policy-making will become apparent; in the same line, the role of accountability mechanisms will gain relevance beyond vague statements of reporting and including stakeholders (section 5). In light of our empirical findings over the use of evidence and its connection to accountability mechanisms, we will finally

[1] A recent estimate from the US Global Health Initiative in Ghana of 40% of the national budget coming from development assistance (available at http://www.ghi.gov/wherewework/docs/ghanastrategy.pdf).

conclude by advancing theoretical considerations over the democratic content of policy evaluation in Ghana.

2 Theoretical approach

2.1 Accountability, evidence and democracy

While there have been assertions within the EBP field that better uses of evidence improves governance (c.f.: Commission of the European Communities, 2007, OECD, 2013, BBC Newsnight, 2015), the connection between evidence use and democracy appears to rests upon a very general understanding of accountability. In its simplest form, accountability corresponds to the capacity to *control* political agency and ***evaluate*** decision outcomes (Dubnick and Frederickson, 2011). This view of accountability derives from managerial concerns of performance evaluation, which has subsequently been expanded to include the oversight of delegated administrative agents in policy settings. What has to be overseen is precisely the *discretion* of the *delegated* 'agent' to apply the directives of the *elected* 'principle' (Pratt and Zeckhauser, 1991). This expansion of the concept of managerial accountability to political accountability has assembled together the idea of *delegation* (of power to implement public interests) with the idea of *representation* (of public interests) (Brown, 2009), while often leaving them indistinct. Accordingly, policy evaluation has been increasingly considered a fundamental stage of the policy cycle as it produces a measure of policy achievements, constitutes an important process to give account of them, and ensures democratic representation of policy actions.

Given these premises, the connection between *accountability* and *democracy* has remained quite elusive in the public policy and administration literature: accountability has been praised mainly as a democratic value in itself, ensuring that the delegation of power from elected authorities to administrative ones reflects the will of public representatives – hence the common/public will (Bovens, 2010, Flinders, 2011, Heidelberg, 2015, Koppell, 2005, Salminen and Lehto, 2012). But as much as the idea of democracy as aggregation of individual preferences has been partly overcome by new forms of public participation and deliberative decision-making (Heidelberg, 2015, Brown, 2009, Hajer, 2003), the principle of accountability needs to be reconsidered as more than a value in itself. Accountability serves primarily a mechanism (Bovens, 2010) by which decisions get exposed to some public test of legitimacy (Rosanvallon 2011), to evaluation and to judgment (Urbinati 2014). These, we hold, are the key features of democratic decision-making, which are directly connected to accountability structures in place and which deserve preliminary attention if considerations over the democratic nature of decisions are to be issued.

In this framework, the use of evidence appears as an important ingredient of the accountability structure, possibly supportive to the legitimacy tests, hence to democratic decision-making. In principle, evidence helps operationalize accountability rules by informing decisions within the range of discretion that authorities have over decisions, and by defining the legitimacy of decisions within specific jurisdictional frontiers. This double use of evidence for accountability is generally regarded as implying that decisions can be at the same time efficient – because they are informed – and legitimate – because they are taken by the competent authority. However, the combination of these principles is only partly correct as the legitimacy of decisions is confused with their *legality;* accordingly, their democratic content is only linked to a practice of authoritative decision-making.

Instead, two points should be considered: first, an authority is such so long as it can be contested, hence accountability structures are supportive of democracy to the extent that they allow decisions to be contested. Nadia Urbinati (2014) refers to this point in her claim that the democratic mechanism of representation is based on the diarchy of the 'common will' as in the Rousseauian tradition on the one hand, and judgment as the capacity to contest decision on the other (Urbinati, 2014). As a second point, it is recognised that democracy can be exercised outside of the strict spaces delegated by constitutional authority, with stakeholders having access to the polity through various forms of participation within the policy making process (Dryzek, 1996, Ingram and Schneider, 2006). Therefore, accountability rules are important insofar as they allow stakeholders to participate to the public space of decision-making, provide them with the capacity to judge and influence final policy outcomes. As conceptualisations of democracy are generally based on an idea that political power is ultimately derived from the citizenry, accountability systems are important insofar as they ensure that citizen's participation influences policy-relevant deliberations.

2.2 Evaluation as a policy space

Under this reconsidered framework of accountability, democracy and evidence use, the process of evaluating decisions becomes more complex; certainly it loses a purely managerial connotation of policy implementation as in line with a technical understanding of accountability and evidence use. Under this framework actually, the main idea of policy evaluation as a test for decisions, hence an opportunity for improvement (Weiss, 1999), becomes more apparent. Indeed, once reconsidered that accountability also implies the capacity of decision-makers to expose decisions to judgment and contestation (Heidelberg, 2015), it becomes easier to appreciate how crucial in the process of policy evaluation is the phase of translating evidence into policy insights for guiding future interventions. Evidence use, in turns, acquires a prominent role in both enabling this test by informing performances and validating the value of decisions by allowing judgements and reflections on policy performances. Evidence use in policy evaluation is a powerful tool for testing the achievement of policy objectives, directing policy discussions, validating a particular policy strategy and rewarding it by allocating more funds or prolonging its life cycle.

Precisely for these reasons of multiple functionality of evidence use, the passage operated by the use of evidence from *evaluation* to *valuation* of policy must be subject to scrutiny. We are particularly interested in how this shift can often occur within a specific policy space created by formalised evaluation processes. These insights provide a framework in which we can analyse how the policy evaluation process provides space for participation and contestation among stakeholders over the use of evidence to judge policy value. It further allows reflection on how rules of accountability within those evaluation processes serve to establish power relations and set the spaces through which such contestation takes place. In the sections that follow, we will present the case of health policy evaluation in Ghana to investigate this phenomenon and to critically reflect on challenges to the assumed relationship between evidence use, improved accountability and democratic decision-making.

3 Evidence and health sector assessment in Ghana

Ghana is a lower-middle income country located in Western Africa. It is often considered one of the more democratic and developed of sub-Saharan African nations, but it still suffers from significant resource limitations. The structure of the health system in Ghana follows the basics of functional separation between decision-making and implementation in policy-making (Cassels, 1995). Primarily instructed by concerns over efficiency, some functions traditionally concentrated in the Ministry of Health (MoH) were deconcentrated to technical agencies benefitting from a certain degree of independence and discretion with respect to the MoH. The Ghana Health Service (GHS) is an autonomous Executive Agency of the MoH and represents one of the most important policy implementation body in the health sector, responsible to manage and operate all public health facilities and tasked with planning, implementation, monitoring and performance assessment of health programmes and services (Adjei, 2003).

The GHS has considerable power in the health sector that goes beyond pure operational and managerial activities. The process of its constitution testifies to the concern of deconcentrating the vertical programmes under the MoH (e.g. HIV, TBA, etc.) into a parallel structure of hierarchical governance in which the GHS would have integrated the operationalization of health policies through local units of management and implementation (Cassels and Janovsky, 1992).

The goals of managerial improvements of service delivery in Ghana was also driven by a broader political objective to bring coherence into the health system. In this perspective, the enhancement of the health management information system became part of the game (Adjei 2003). The Health Information Management Department (IMD) of the Policy, Planning, Monitoring and Evaluation (PPME) division was established within the GHS as the focal unit responsible for the collection, analysis, reporting and presentation of health service information in. Its creation was meant to specifically support the a decentralisation process conducted across regional and district levels of management: Regional and the District level offices were established with each having their own Health Administrations (RHAs and DHAs) and each supposed to report to the higher hierarchical level. Despites lines of accountability formally exist among the three levels of governance, it has been reported that they suffer some confusion and overlapping responsibilities at times (Couttolenc, 2012).This is mainly due to the fact that the deconcentration of health services as under the Ghana Health Service and Teaching Hospitals Act 525 of 1996, has not yet produced full delegation of power to the local assemblies representing the political authority at the district level as in the Local Government Act 462 of 1993. For instance, one of our key informants in Ghana explained us that, as consequence of incomplete decentralisation, there exists a dual hierarchy in the lines of accountability of the DHA, which has to report back to both the district assembly and to the regional director. In spite of these elements of confusion, there still remains a fairly well established and formal system of accountability within the GHS and between the GHS and the MoH, corresponding to the systematic practice of reporting and reviewing performances of implementation policies as widely acknowledged by our interviewees at the GHS.

The connection between evidence use and accountability in the Ghana health system can be seen in the integration of the IMD within this national system of accountability. The IMD's specific task is to gather health information such as administrative, demographic and clinical data – typically collected through desk review, although at times accompanied sometimes by interviews (Zakariah, 2014). This is fed upwards from facility to district to region and, ultimately, to central health management levels

in order to inform health sector performances (for more detail see Ghana Health Service 2012, pp. 30). The Centre Health Information Management system collects the data from the district level through the District Health Information Management Information System and then sends it to the Regional level. The aim of this procedure is to collect information from the district up to the national level in order to support each Ministerial Agency within the health sector – not only the GHS – with the implementation of their respective Programmes of Work (POWs). As the assessment of progress in achieving POWs' objectives is key to support its implementation, each Agency has an in-house Monitoring & Evaluation (M&E) plan relying on the information produced by the IMD. The results of M&E outcomes are finally meant to converge annually into the Interagency or Health Sector Performance Review.

Therefore, a combined mechanism of information diffusion and evaluation of performance exists in Ghana that ties the whole health governance structure into a coherent system based on a systematic review process: operating internally at each administrative level and vertically between district, regional and headquarter managers via peer-review meetings. Hence, we can see that policy evaluation in Ghana is practiced through an institutionalized system of health sector performance review, conducted at the levels of agencies and departments.

Considering that the logic of policy evaluation is to inform future policy choices, we should ask how the review of performances translates into policy directions. As our interviews indicated, there exists a missing story in the description just made. Interviews conducted with both administrative officials of the MoH and development partners confirmed that, besides the Senior Managers Meeting at the GHS, the main venue for research dissemination and evidence use and discussion was the Health Summit – the annual meeting in which development partners and government discussed the so-called 'Holisitic Assessment' (Gh-9, GH-13, GH-23). That was, in the words of one MoH official, "the key policy-making structure within the sector" (Interview GH-9).

4 The accountability system and its tools: how evaluation reveals power relationships

On the top of the process just described combining information and evaluation, the 'Holistic Assessment Tool' guides interagency performance review. The existence of this policy tool further ties the structure of the health sector as it exposes its evaluation outside the national frontiers of health sector. The 'Holistic Assessment Tool' indeed functions as interface between the MoH, responsible for the health sector performance, and international development partners, which demand accountability of performances to the MoH.

4.1 The use of evidence in policy evaluation: the Holistic Assessment Tool

The Holistic Assessment tool was established within the framework of the Common Management Arrangement (CMA), which governs and set the rules for partnership between the MoH and international donors. The GHS explains the 'Holistic Assessment' within its documentation on the

'Common Management Arrangements' (CMA) in place for implementation of the national health sector plan. They explain:

> The holistic assessment of performance in the health sector is a structured methodology to assess the quantity, quality and speed of progress in achieving the objectives of the programme of work. The primary objective of the assessment is to provide a brief but well informed, balanced and transparent assessment of the sector's performance and factors that are likely to have influenced this performance. The assessment is based on indicators and milestones in the PoW and is presented and discussed at the April Health Summit and negotiated and agreed upon by the Ministry of Health and partners at the subsequent business meeting. The outcome serves as input into the [Multi-Donor Budget Support Performance Assessment Framework] (Ghana Health Service, 2012, p.20).

The CMA was conceived to address the problem of parallel donor systems and increased aid transaction costs. Now in its third iteration (CMA III), The CMA itself was originally introduced in 1997 with the national health sector reform of decentralizing service delivery – the creation of the GHS being one of the main outcomes – under the sponsorship of the WHO as part of 'cooperation for health' programme, setting out "arrangements for effective collaboration and coordination within the health sector" (Ghana Health Service, 2012, p.5). As a solution, a health-sector-wide approach was established along with a pooled funding account (Pallas et al., 2015).The method to govern this new framework of collaboration was precisely identified in the Holistic Assessment (IHP+, 2003) which is used to inform joint government-donor planning meetings, assess their partnership and provide input into future donor planning activities.

The use of sector-wide indicators, milestones and targets are a key component of the 'Holistic Assessment Tool'. Sector-wide indicators, targets and milestones are established at the national level within the four-year Health Sector Medium Term Development Plan (HSMTDP) and are (re-)formulated each year with the POW that the MoH prepares in lines with the objectives of the national health strategy as set in the HSMTDP.[2] In relation to decentralization, milestones, targets and indicators at the local level are derived from national ones. The data generated by the IMD from the district to the national level are indeed devoted to fill sector-wide indicators specified in the HSMTDP from which health sector agencies draw their programmes of works and implementation strategies (Nyonator et al., 2014).[3] Targets, on the other hand, are negotiated at the decentralized level between the GHS and the budget and management centres (BMC) at the district level. These latter reflect the organizational units for administrating development partners' funds at the national, regional and district level. [4] Precisely because indicators are pre-established for all types of

[2] The HSMTDP is prepared by the MoH and its Ministries, Departments and Agencies under the guidance of the National Development Commission and sets the objectives of the national health strategy over a period of four years.

[3] The strategic objectives of the GHS POW, are set according to indicators and the role of the IMD (Information Management Department) is to "fill" these indicators with the data they produce.
In the HSMTDP the stewardship of the GHS to the implementation of POW set in the same document (HSMTDP)

[4] There are several BMC disseminated at the three administrative and facility levels. The headquarters of the GHS is managed as one BMC; 10 Regional Health Administration, 8 Regional Hospitals, 110 District Health Administrations and 95 District Hospitals.

performances at any agency and administrative level, indicators have the potential to perform as a 'holistic tool' of evaluation.

However, as suggested, the Holistic assessment as policy evaluation tool is also directed to international partners to *test* health sector performances. As part of this participation, international donors are involved in the process of selecting indicators, targets and milestones. We do not have data to report on how the process develops in practice, but information shows that at least performance indicators get established and revised each November of the year during the Business Meeting between the MoH and development partners (Ghana Health Service, 2012).[5] Based on these indicators, the Holistic Assessment reports a score for each health sector objective established within the annual POW, e.g. bridging equity gaps in health care, improving efficiency and effectiveness in the health system. A score of +1 is attributed if the indicator has attained the set target, 0 if it just show a good trend, -1 if the target has been missed.[6]

The presentation of the Holistic Assessment to the Health Summit is to provide the venue for all sector partners to review performances and assess the level of compliance with the CMA. Formally speaking, the objective of the CMA that governs the Holistic Assessment framework is to support the implementation of the Health Sector Medium Term Development Plan (HSMTDP). However, we should expand on the simple evidence that the Ghanaian mechanism of evidence production and use described in the previous section responds to the policy needs of informing interventions and evaluating health sector performances. This mechanism of evidence generation serves another purpose besides bringing coherence to the decentralized system of health governance; it makes the system evaluable by external reviewers. These two drives are functionally linked and theoretically harmonized through the use of the same tools for national and external assessment, i.e. the Holistic Assessment tool; in this, common indicators and milestones in principle guarantee that the interagency evaluation and MoH-donors evaluation be aligned. However, the CMA clearly states that the use of the Holistic Assessment tool should be made 'in line with the principles of *mutual accountability*' between the MoH and the donors (our emphasis, pp. 5-6)(Ghana Health Service, 2012a) showing that the Health Summit represents not only an additional venue of evaluation, but also an additional system of accountability in which the MoH is accountable to development partners for the whole performance of the health sector.

[5] There are three business meetings. The business meeting during the April health summit will assess the sector Performance Assessment Framework (PAF) to feed into the MDBS dialogue. The second business meeting in August will review the sector's progress from the beginning of the year to date and provide an opportunity to table new issues. The business meeting in November will be devoted to planning and budgeting. The meeting will discuss and agree on health sector plans and associated budget for the ensuing year. It will also agree on indicators for the PAF based on the sector program that was presented and discussed. Finally, and 'Aide Memoire' will be signed by the Ministry of Health and representatives of Development Partners that records the decisions taken during the business meeting of November.

[6] The process is divided into three steps: first, each indicator and milestone is assigned a numerical value of -1, 0 or +1 depending on realization of milestones and trend of indicators. Second, the indicators and milestones are grouped into Goals and Thematic Areas as defined in the Programme of Work and the sum of indicator and milestone values are calculated. Goals and Thematic Areas with a positive score are assigned a value of +1, -1 if the total score is negative and 0if the total score is 0. Third, after assigning a numerical score to each of the Goals and Thematic Areas the scores are added to determine the sector's score. A positive sector score is interpreted as a highly performing sector, a negative score is interpreted as an underperforming sector and a score of zero is considered to be sustained performance (IHP+, 2003 pp. 37-38).

4.2 The use of evidence and the alignment of distinct spaces of accountability: one-fits-all evidence?

In principle, the creation of a second system of accountability external and parallel to the hierarchical structure of management of the Ghana health system, should raise no issue, as the use of common tools for evaluation should ensure the alignment and coordination between the two systems of accountability (and evaluation). Simply, the evidence inscribed into the Holistic Assessment tool would federalize these two spaces of accountability into one inclusive space of policy evaluation in which evidence would guide the translation of the interagency assessment into some future policy directions while including development partners. However, as any policy evaluation process implies, any label attached to the review process – for instance, in our case, the scores attributed to each target in the Holistic Assessment – entails some political statement of success and failure and raises issues of responsibility and liability (Bovens et al., 2006). In fact, the conflation between the two accountability spaces makes it unclear to whom responsibility and liability issues should be referred.

As a general reply, we may think that the MoH is responsible for the health sector performance and should be equally accountable to all the stakeholders composing the space of policy evaluation, including NGOs (and especially the Health coalition of NGOs), international donors (better defined as 'partners'), health agencies, academics, health associations, etc. In practice, this is not the case, as each stakeholder has its own power to influence the outcome of policy evaluation and, accordingly, influence or bypass accountability structures in place. Such power, in turn, depends very much on the capacity of each stakeholder to use evidence as a tool for applying its scrutiny to policy performances and defining its discretion in guiding future policy directions; hence, evidence appears as a powerful tool for stakeholders to negotiate their own position with respect to the other participants.

5 The instability between technical evaluation and accountability relations

According to the CMA framework and the use of the Holistic Assessment tool, the use of evidence reflects a functional effort to combine two systems of accountability, namely by aligning them within a common evaluation process. However, this functional solution does not assure that practices of evaluation are harmonized across the policy spaces in which they are employed, namely the decentralized structure of peer review and the international partnership structure of mutual accountability; in this regards, critiques within the Ghanaian health governance structure have been issued that the donor driven nature of policy evaluation may create a "potential threat" to the effectiveness of agency's M&E plans (Ghana Health Service, 2012b)p. 13). Nor does this functional solution assure that the policy spaces converge into one common space of decision in which the participation of multiple stakeholders be taken as a proxy of democratic decision-making. This is due both to the multidimensional logic of evidence use in policy-making, which policy evaluation makes particularly apparent as soon described; and to the nature of accountability relationships, which imply more than simply reporting on policy choices and achievements. We shall see how these two aspects of evidence use and accountability are related.

5.1 Evidence use and accountability relationships

On a general epistemological level, indicators come from a process of elaboration, namely of data, and aim to 'indicate' (rather than prove) whether some programmatic situation is still relevant to be considered within a certain policy perspective or whether new situations have emerged that affect policy trajectories. As in the case of Ghana, the IMD has primarily the duty to 'fill' – rather than create – indicators; however, our interviews clearly stated that some margin of discretion over data selection always exist, especially when data lack. Also, discretion exists in the very use of indicators to produce reports and draw political attention on them. So for instance, an interview indicated that the Director General of the GHS can request specific data or indicators that do not fall into the HSTMDP, for instance as was apparently being done to inform the next HSMTDP of 2014-2018. The discretion over data and indicators could also be seen in the way that particular pieces of data, or particular results of analysis, could be promoted by bureaucrats within the IMD to influence policy makers. One senior official explained that the use of particular pieces of information could depend on the capacity of specific individuals (e.g. within the PPME) to get policymakers interested in their data – e.g. with members of the IMD drawing attention to well-packed information, such as through policy briefs and one-pager documents to try to influence the Director General of the GHS (Interview GH-5). Similarly it was said that visualised data through maps was also effective to generating interest in the data (Interview GH-5).

The discretion in filling indicators with data is not a problem per se, nor is it about selecting specific indicators to promote political awareness over certain issues; on the contrary, discretion is a typical characteristics of technical agencies supposed to simplifying very complex situations and enhance the quality and pace of policy decisions. However, discretion raises questions if it is exclusively driven by the bureaucracy in the absence of political engagement to use information in a way reflecting political priorities. As a general consideration, this is a technical problem of managerial accountability relationships, in which, in a typical principal-agent perspective, the 'principal' should guide the 'agent' in the implementation of policy objectives (Pratt and Zeckhauser, 1991). In the case of Ghana, this consideration upgrades to an additional concern related to the fact that the production of indicators and the political values built into them will be used as a policy tool for negotiation (i.e., the Holistic Assessment Tool) during the Health Summit. The Holistic Assessment of Progress is indeed meant to be *presented* and *discussed* during the Health Summit and *negotiated* and *agreed* upon by the MoH and Partners at the immediately subsequent business meeting in April (Ghana Health Service, 2012a, pp. 20). Indeed, the outcome of the health sector assessment serves as the basis for discussing the Performance Assessment Framework (PAF) for Multidonor Budget Support during the Business meeting following the Health Summit (Ghana Health Service, 2012a).[7] Therefore, the CMA sets the framework for both constructing evidence - by specifying how the Holistic Assessment tool should be used – and deciding which evidence should be taken as relevant for future planning.

Therefore, evidence use becomes extremely sensitive from a political point of view. As a general consideration, the case of Ghana shows that the use of evidence does not respond to a purely *informative* concern of enhancing the quality of decisions and anticipating the consequences of actions; it also responds to the need to *justify* decisions at the moment of the Health Summit, hence to negotiate the value of the actions that may follow (Boltanski and Thévenot, 2006). As a second

[7] See *supra* note 5.

consideration, the power of development partners to influence the selection and evaluation of indicators proves to be important in influencing the outcome of the negotiating process and in setting future policy directions. Indeed, the capacity that stakeholders have to influence each other's views and, *in fine*, policy evaluation, often reflects an adversarial process of meaning constitution between competing views over the reasons of policy performances and the subsequent judgements on policy directions (Bovens et al., 2006). Evidence can be used to arbitrate such adversarial process, but at the same time, where disparity emerges as to the capacity to employ it, evidence can end up determining policy directions. Excluding coercion, the power that each actor has to influence the process in which policy value get shaped partly vests in the way accountability structures establish common rules for participation and values discussion. These rules, in turn, get activated or operationalized by stakeholders through the selection, activation and evaluation of policy evaluation tools (Pearce et al., 2014). And indeed these tools are truly 'instrumental' to create different types of public spaces of discussion while realistically admitting only those participants with the capacity to provide insights and feed-back. For instance, one of our interviewee from the MoH complained about the superior technical capacity of development partners to produce evidence of performances and, especially, raising issues of political relevance connected to them, with little capacity of Ghanaian officials to enter the discussion due to a lack of counteracting arguments (GH-5). Also, the use of evidence through policy evaluation tools can *de facto* annul the elaboration of policy directions in policy evaluation. This is what happens in the wording of one interviewee (Gh-23c), claiming that health policy in Ghana is only conceived in operational and strategic terms by the government and never in terms of policy objectives; accordingly, he reiterated, indicators are set only in the form of outcomes (e.g. how many new hospitals have been built) rather than impacts (e.g. how much child mortality has diminished). On a different level, the Coalition of NGOs in Health in Ghana has recently decided to challenge the government on health priorities by creating a concurrent space of advocacy and evidence use; the objective is to produce an alternative evidence-based report and submit it to the parliament select committee on health in order to influence health financing (GH-17). However, according to the majority of our interviewees, the Parliament has very little power in influencing the government, especially in the approval of sectoral budgets (Kan-Dapaah).

Therefore, evidence use reflected mainly in the use of common indicators, might fail to be performative in linking policy evaluation to 'accountable' – and potentially more democratic – decisions. The reason draws precisely on the duality of evidence use as both an informative and justificatory policy tool, and on the duality – almost symmetrical - of accountability relationships, which envisage at the same time reporting on performances and policy achievements, and exposing performances to some judgments and deliberation.

5.2 Accountability structures matter to democratic outcomes

As much as a practical investigation on the use of evidence in policy evaluation has revealed the existence of structures of power, it has also revealed that policy evaluation is not only a technical process of assessment but most importantly a political process of value formation and judgment. In the case of Ghana, the health policy-making process sees the two typical phases of policy evaluation, i.e. evidence synthetization and learning, evaluation and valuation, disjointed into two separate spaces of accountability. One is structured around a decentralized structure of governance, whereas

the other relies on the partnership between donors and MoH. Whereas the use of evidence – inscribed in the Holistic Assessment Tool – is in principle envisaged to bring these two spaces together, these in fact stay separated. This situation demonstrated that the relation between technical evaluation and political accountability is unstable and certainly cannot be expected to be fixed by advocating, vaguely, for some accountable use of evidence. At the same time, this situation demonstrates that, despite the vagueness of accountability claims, looking at the systems of accountability in place along with the practices inscribed into them is important to understand the democratic implications of evidence use – in our case, the democratic implications of evidence use in policy evaluation. In conducting policy evaluation, accountability relationships are important in that they either stabilize the interactions between stakeholders and decision-makers or provide the former with an opportunity to renegotiate their power to influence decision-makers. For how mechanical and innocuous the principle of accountability might resemble, it is instead a quite elusive but powerful concept that, broadly speaking, indicates how policy-makers should respond to stakeholders as their interests and ideas, get unveiled during – and in contribution to – policy evaluation. This is indeed a moment in which stakeholders have the opportunity to make personal interests and ideas actionable by assessing policy outcomes, reassessing connected policy trajectories and possibly reconsider policy perspectives (Rose and Davies, 1994).

Therefore, the determination of the value of a policy intervention is more than just a simple mathematical operation of performance assessment, in the same way as the determination of policy values operates along a mechanism of accountability that goes beyond the control of policy performances (Koppell, 2005). The determination of policy values consists of a process of participation in which different actors variably contribute to their appreciation and variably influence their final judgement. In connection to the use of evidence in policy-making, Champagne et al. (2005) provide views of evaluation as a social process consisting of "making a judgment on the worth of an intervention by implementing a deliberate process for providing scientifically valid and socially legitimate information on an intervention or any of its components in such a way that the various stakeholders, who may have different bases for judgements, are able to take a position on the intervention and to construct a judgment that could translate into action"(pp. 143-144). We can then conclude that the determination of the political values of decisions is a process in which accountability meets the vows for improved democratic practices based on the constitution of values – more than their representation – and especially on the contestability of these values (Heidelberg, 2015). In this sense, accountability structures are important not only to shape authority relationship, but also to activate a social mechanism of participation in which the principles of an ideal relationship between the 'governors' and the 'governed' are tested (Salminen and Lehto, 2012, Lascoumes and Le Galès, 2007, Koppell, 2005) against legitimacy considerations (Rosanvallon, 2011). In turn, the capacity to use knowledge and evidence becomes crucial to (re-)organize such principles through mechanisms of responsiveness and degrees of scrutiny over policy-makers' decisions; hence, crucial to operationalize accountability.

6. Conclusions

In this paper we have tried to capture the concerns over the legitimacy of knowledge-based institutions and international organization by looking at a case study based on health policy evaluation in Ghana. We have explored the practices of performing policy evaluation in light of the use of evidence and the systematization of evidence use into the national structure of governance and accountability. By first concentrating on the national structure of evidence use and then on the governance framework of policy evaluation, we were able to explore how the use of evidence, generally advocated as an unquestioned virtue of policy-making, has in fact theoretical implications in promoting democratic decisions. We explained why these implications are difficult to appreciate when they rely on a general and vague understanding of accountability relationships and on the way the use of evidence plays a role in shaping them. In particular, the Health Summit in Ghana has revealed how powerful is the stage of policy evaluation within policy-making to issue judgements on the use of evidence in policymaking, as policy evaluation is precisely devoted to translate technical considerations into policy orientations. In this process, we showed that use of evidence becomes a clear issue of power relations. Also, the process of policy evaluation within the Health Summit reveals with particular clearness the duality of evidence use in informing and justifying decisions and its relevance for understanding how accountability relationships matter in structuring power relationships. The structure of accountability relationship, therefore, provides the basis for discussing issues of democratic decision-making connected to the use of evidence in policy-making. Indeed, we have showed that the involvement of international donors as responsible for funding a significant amount of health services can challenge and destabilize the national structure of authority and accountability relationships within existing constitutional parameters or the existing governance structure of the state. Hence, the exploration of the use of evidence in health evaluation in Ghana has proved to be fundamental to determine the nature of the accountability mechanisms outside those established within formal constitutional governance relationships and reveal the existence of two policy spaces of decisions. These in turns, have informed democratic considerations on the use of evidence in policy-making insofar as accountability structures provide the political space for stakeholders' participation *in* the policy evaluation process, along with their power to influence decisions outcomes.

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