

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

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*The use of evidence in policymaking is commonly considered a good practice of democratic governance by improving accountability, effectiveness, and stakeholders' involvement in policy decisions. The features of this practice, however, remain vague in the general discourse of evidence-based policymaking (EBPM) with the risk of obscuring important governance and legitimacy implications. In policy evaluation especially, the use of evidence can be critical to translate technical measurements of policy achievements into political values for shaping future policy directions. We present a case study based on the health policy review process in Ghana in order to discuss how institutionalized evidentiary practices used in policy evaluation affect structures and processes of democratic governance. Drawing on qualitative interviews with international and local actors, we reflect on how the evidence review process—a process agreed in collaboration with development partners—links to the evidence advisory system and the accountability systems in place. We find that the uses of evidence promoted by international donors within the evaluation process actually creates disconnect with the national accountability system in place, with implications for democratic governance.*

**Keywords:** evidence-based policymaking; accountability; policy evaluation; Ghana; health policy; democratic governance; international donors.

## 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 con-

sideration 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). Drawing from international relations scholars such as Barnett and Duvall (2005), Shiffman points to international organizations

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in global health establishing their power through their capacity to perform research and produce expert advice. In an earlier contribution, Barnett and Finnemore (1999) explained that this power endows such organizations with the legitimacy to intervene in public affairs. Following Weber's theory on the power of bureaucracies (e.g., Weber 1947), these authors claim that the mounting power of international organizations relies on the same rational-legal authority that bureaucracies possess in their exercise of technical expertise and control of information. As a consequence, the authority of these organizations simultaneously generates an alternative power with respect to that of the state and legitimacy to act independently from it.

Global health organizations usually gain their legitimacy to intervene under the remit of supporting "sound" decision making in countries with limited local capacity, and are increasingly couching their recommendations for action within a discourse of "evidence-based" policymaking (EBPM). From a purely technical perspective, that decisions are of higher quality when they are informed rather than uninformed 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 maximize benefit and minimize 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 validity. Besides being widely recognized that health policy decisions are more than simply exercises in technical decision making (Russell

et al. 2008), decisions based on evidence may have governance implications on the structure of power within and among policy actors. Such implications, however, go beyond re-organizing public policies and improving their efficiency. A number of authors drawing strongly on the work of Michel Foucault have explored the emergent ways in which the act of governing and the operation of bureaucratic policymaking techniques also have "governmentality" effects, namely by reconstructing power relationships in the direction of precise strategies and rationales (Miller and Rose 1995; Pellizzoni 2015; Foucault [1978] 1991). These type of reflections, in turn, have increasingly inspired the study of the performative effects of particular evidence-utilization tools such as reviews, guidelines, or economics analyses (cf. Ferlie, Mcgovern, and FitzGerald 2012; Smith and Stewart 2015)—tools that Fiere et al. have also referred to as "technologies of governance" (Ferlie, Mcgovern, and FitzGerald 2012). We argue that if the strategies and rationales for evidence utilization are only seen through the prism of technical performances, evidence-based decisions risk eluding the detection of important governmentality effects. Addressing this starts by recognizing that any assumptions (or statements) that evidence-based decisions are *better* than non-evidence-based decisions implicitly touch 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 policymak-

ing” (EBPM), even when discourses over EBPM include claims that evidence can somehow improve accountability practices and democratic decisions (cf. Clarence 2002; Weisburd and Neyroud 2011). In fact, the way such improvement should occur remains vague and under-investigated. From a general decision-making perspective, the use of evidence serves to inform decisions and to make them more “rational”. In addition, explicit use of evidence potentially improves transparency and along with it the accountability of decisions. However, accountability is not an inherent property of decisions. It is a practice put into being by policy agents and procedures. We therefore believe that there is a need to explore what an “accountable-use of evidence” looks like in practice, especially in terms of what political effects the pursuit of evidence in specific bureaucratic settings can produce. Investigating the link between evidence use and accountability in policymaking in this way can provide a solid basis for advancing informed theoretical considerations over the use of evidence for democratic decision making.

To explore these issues, we use a case study of the system for evidence-informed health policymaking in Ghana, with a particular analysis of the policy evaluation process. The study of the democratic implications of evidence use in policymaking has traditionally been applied to more developed (high-income) countries where the expansion of the administrative machine raises concerns over the balance between governance improvements and

legitimacy decisions. However, we believe that the case of Ghana proves a particularly interesting case over which to expand this line of enquiry. Ghana is considered as one the most stable and democratic countries in Africa, but furthermore, its status of aid-recipient country<sup>1</sup> evokes the same concern that Barnett and Finnemore (1999) raise in relation to the mounting power of transnational organizations, that is, the expansion of expert-based decision-making structures outside national polities. Hence, the context of an aid-recipient country such as Ghana provides an interesting arena in which to investigate how governance and legitimacy relate to each other in light of the involvement of global actors, with particular questions over how accountability and evidence play out within this delicate relationship. Foucauldian-inspired analyses of emergent power relationships from the operation of the development apparatus are also not new to the field of critical development studies (cf. Ferguson 1994; Escobar 1995; Rahnema and Bawtree 1997), yet there has not been extensive application of these lenses to the question of evidence use in policymaking. Building on the concern that development studies generally overlook the distinction between governance and policymaking (Hyden and Court 2002), we recognize that the promotion of evidence use in developing countries may exacerbate the confusion between governance needs for more efficient policy outcomes and legitimacy quests for more democratic decision processes and outcomes. Despite their connections, the

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<sup>1</sup> A recent estimate from the U.S. Global Health Initiative in Ghana shows that 40% of the national budget comes from development assistance (available at <http://www.ghi.gov/wherewework/docs/ghanastategy.pdf>).

two needs are distinct and should not be conflated through an imprecise semantics of evidence use. Especially in relation to its status of aid-dependent country, Ghana is continually subjected to “tests” over the effectiveness of aid (Pallas et al. 2015) in which the use of evidence provides a fundamental tool for aid performance. The use of “monitoring and evaluation” (M&E) of health policies is one diffused governance practice supporting these tests, which has its counterpart in the policymaking process through policy evaluation.

Policy evaluation itself has an established legacy in public policy studies through the idea that decisions are “better” when they can be *tested* (Weiss 1999). Evidence plays a prominent role in enabling such tests 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. We argue that the link between evidence use and policy decisions, instead, should not be underestimated, especially when claims to the use of evidence—such as precisely in policy evaluation—raise issues of authority relations between knowledge production (epistemic authority) and knowledge use (political authority) (Strassheim and Kettunen 2014).

In order to investigate the practi-

cal applications of the “accountable-use of evidence” in policy evaluation in Ghana, this paper combines theoretical and empirical considerations as follows: we first review theoretical arguments drawn from public administration and policy studies to understand how the concepts of accountability and evidence use have been associated in governance and policymaking studies (Section 2). We then investigate such association through empirical analysis of health policy in Ghana (Sections 3 and 4). Finally, we discuss the theoretical contributions in light of both our empirical findings (Section 5.1) and sociological approaches to policymaking (Section 5.2). Hence, we first set the theoretical basis of our discussion in Section 2, in which we explain how a managerial understanding of evidence use and accountability has found its way onto democratic decision making and the role that policy evaluation has accordingly acquired in policymaking. We particularly highlight that the current employment of principles of evidence use and accountability in policymaking has left untreated the inherent tension—or duality—between *informing* and *justifying* policy choices. This sets up Section 3, in which we explore the duality through an empirical analysis of the evidence advisory system in health in Ghana. We describe how evidence production and use is structured within existing internal accountability mechanisms, and how policy evaluation plays a key role in the whole process through an institutionalized process of interagency review assessment.

Our analysis for our empirical sections is principally informed by a set of 24 in-depth interviews conducted in 2014 with a set of stakeholders in Ghanaian health policy—including representatives of the Ministry of Health (MoH),

the Ghana Health Services (GHS), international development partners (DP), local nongovernment organizations (LNGOs), and members of parliament (MP). When specific interviewees are cited in this paper, they are designated by an anonymous number and one of these acronyms. Interviews followed a semi-structured approach and were conducted as part of a broader study investigating the political and institutional factors shaping the use of evidence in a range of country cases. The interviews aimed to understand the institutional role and position of each interviewee with respect to other actors in the health sector, as well as their perception and understanding of evidence use in health policymaking. Data analysis partly benefitted from the use of qualitative tools, such as Nvivo coding, and from the triangulation with other sources of data including official documents from the MoH and the GHS. Section 4 then discusses 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 sector in Ghana. Findings from our analysis illustrates that the practices of evidence use in health policy evaluation reveal important aspects on the accountability structure actually in place beyond formal arrangements. At this point, the duality of evidence use as both an informative and justificatory tool of policymaking becomes apparent; in the same vein, the role of accountability mechanisms gain relevance beyond vague statements of reporting and including stakeholders (discussed in Section 5). In light of our empirical findings over the use of evidence and its connection to accountability mechanisms, we 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 EBPM field that better uses of evidence improves governance (cf. Commission of the European Communities 2007; OECD 2013; BBC Newsnight 2015), the connection between evidence use and democracy appears to rest 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 1985). 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 (Koppell 2005; Bovens 2010; Flinders 2011; Salminen and Lehto 2012; Heidelberg 2015). 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 (Hajer 2003; Brown 2009; Heidelberg 2015), 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 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 of legitimacy tests (Rosanvallon 2011), and 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<sup>2</sup>. 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, combining these principles risks confusing the legitimacy of decisions 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). The second point is the recognition 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 policymaking process (Dryzek 1996; Ingram and Schneider 2006). Therefore, accountability rules built into broader decision-making systems 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.

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<sup>2</sup> For instance, the use of evidence by administrative agencies in the United States is particularly embedded in their accountability and decision-making practices due to the presence of extensive judicial review (Vecchione 2016).

## 2.2 - Evaluation as a policy space

Under this conceptualization of accountability, democracy, and evidence use, the process of evaluating decisions becomes more complex. In addition to the perspective that evaluation serves a managerial or technical function, the idea that it also serves as a test for decisions, and hence an opportunity for improvement (Weiss 1999), becomes more apparent. Indeed, once it is recognized that accountability built into evaluation systems exposes decisions to judgment and contestation (Heidelberg 2015), it becomes easier to appreciate the importance of the phase of evaluation in which evidence is translated into policy insights to guide future interventions. In this way, evidence use informs policy performances and validates the value of decisions by allowing judgments and reflections on those performances. Evidence use in policy evaluation therefore serves as 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, it is critical to analyze how pieces of evidence shift from measuring (*evaluation*) to judging (*valuation*) of policy. We are particularly interested in how this shift can often occur within a specific policy space created by formalized evaluation processes. These insights provide a framework in which we can analyze 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 policymaking (Cassels 1995). Primarily instructed by concerns over efficiency, some functions traditionally concentrated in the MoH were delegated to technical agencies benefitting from a certain degree of independence and discretion with respect to the MoH. The 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 programs, 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 programs 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 were also driven by a broader political objective to bring coherence into the health system, which also led to development of the health management information system (Adjei 2003). The Health Information Management Department (HIMD) 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. Its creation aimed to support the decentralization 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 is supposed to report to the higher hierarchical level (Adjei 2003) (see Figure 1). Some elements of confusion still exist in the system of accountability for health services, with overlapping responsibilities at times across managerial units and local political authorities (Couttolenc 2012)<sup>3</sup>. Yet in

spite of these problems, a fairly well formalized structure of accountability exists (within the GHS and between the GHS and the MoH), integrated with a 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 Health Information Management Department (HIMD) within this national system of accountability. The HIMD'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 details see Ghana Health Service 2012, 30). The Centre for Health Information Management within the HIMD collects the data from the district level through the software called 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 im-

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<sup>3</sup> Confusion and overlapping responsibilities are 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 (Couttolenc 2012). For instance, one local key informant explained that, as consequence of incomplete decentralization, 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.



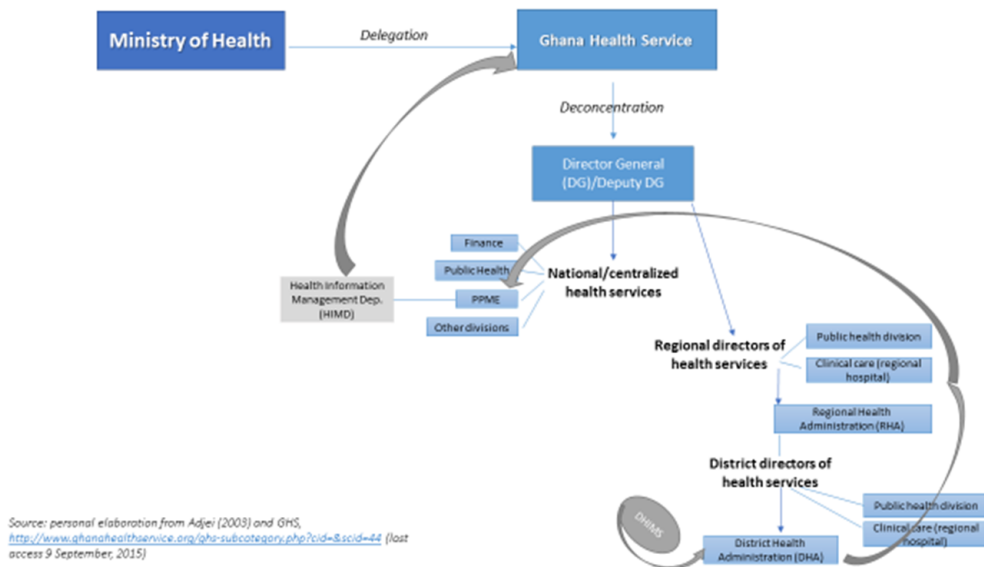


Figure 1 —The governance structure of health policy in Ghana

plementation of their respective strategies established in their “Programmes of Work” (POWs). Each Agency assesses its progress in implementing the POWs through an in-house Monitoring & Evaluation (M&E) plan, which relies on the information produced by the HIMD. The results of M&E outcomes should finally converge each year into the Interagency/Health Sector Performance Review.

Therefore, a combined mechanism of information diffusion and evaluation of performance exists in Ghana that ties the health governance structure into a system based on a structured review process: operating internally at each administrative level and vertically between district, regional, and headquarter managers via peer-review meetings.

Considering that one key goal of

policy evaluation is to inform future policy choices, this begs the question of how the review of performances translates into policy direction. Our interviews indicated, however, that there exists a significant missing element in this description of the formal structure. Interviews conducted with both administrative officials of the MoH and DP confirmed that, besides the senior managers meeting at the GHS, the main venue for research dissemination and discussion of evidence was the Health Summit—the annual meeting in which DP and government discussed the so-called “Holistic Assessment” of the health sector (Interviews MoH-1, DP-1, DP-2, DP-3). Indeed, according to one MoH official, the Health Summit is “the key policymaking structure within the sector” (MoH-1).

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

On the top of the process described above combining information and evaluation within the Ghanaian hierarchy, a “Holistic Assessment tool” has been developed to guide interagency performance review. The existence of this policy tool further binds the structure of the health sector together as it exposes its evaluation outside the existing boundaries of the health sector. As we will discuss, the Tool functions as interface between the MoH, responsible for the health sector performance, and international DP, 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 this within its documentation on the “CMA” in place for implementation of the national health sector plan. It states:

“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 perfor-

mance 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 Sector 2012, 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 World Health Organization as part of “cooperation for health” program, setting out “arrangements for effective collaboration and coordination within the health sector” (Ghana Health Sector 2012, 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. These are established at the national level within the four-year Health Sector Medi-

um Term Development Plan (HSMTDP)<sup>4</sup> and are (re-)formulated each year with the program of work (POW) that the MoH prepares in lines with the objectives of the national health strategy as set in the HSMTDP. In relation to decentralization, milestones, targets, and indicators at the local level are derived from national ones. The data generated by the HIMD 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 own POWs and implementation strategies (Nyonator et al. 2014). Targets, on the other hand, are negotiated at the decentralized level between the GHS and the cost centers (called Budget Management Centres) present at the different governance levels to administer DP's funds across the national, regional and district level<sup>5</sup>. Precisely because indicators are pre-established at the national level for all types of performances at any agency and administrative level, indicators have the potential to perform as a "holistic tool" of evaluation.

However, as suggested, the Ho-

listic Assessment is also used by 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 performance indicators get established and revised each November of the year during the Business Meeting between the MoH and DP (Ghana Health Sector, 2012)<sup>6</sup>. 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 (IHP+ 2003, 37-38).

The presentation of the Holistic Assessment to the Health Summit is to provide the mechanism for all sector partners to review performances and assess the level of compliance with the CMA.

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<sup>4</sup> 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.

<sup>5</sup> There are several Budget and Management Centres spread throughout the three administrative and facility levels. The headquarters of the GHS is managed as one of them; 10 Regional Health Administration, 8 Regional Hospitals, 110 District Health Administrations, and 95 District Hospitals (GHS, available at <http://www.ghanahealthservice.org/ghs-subcategory.php?cid=&scid=43>).

<sup>6</sup> 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 Multi-Donor Budget Support 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.

Formally speaking, the objective of the CMA that governs the Holistic Assessment framework is to support the implementation of the HSMTDP. However, 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 (Ghana Health Sector 2012) 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 DP for the overall performance of the health sector.

#### *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 use of the Holistic Assessment tool would federalize these two spaces of accountability into one inclusive space of policy evaluation at the

national level. As such, evidence would guide the translation of the interagency assessment into some future policy directions while including DP. However, the scores attributed to each target in the Holistic Assessment entails some political statement of success and failure, raising questions of responsibility and liability for these outcomes (Bovens, 't Hart, and Kuipers 2006). In fact, the conflation between the two accountability systems makes it unclear to which responsibility and liability issues should be referred.

Many might assume 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 (often referred to as “partners”), health agencies, academics, health associations, etc. In practice this is not the case, however, 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 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**

**A**ccording 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 regard, concern has been raised 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 2012, 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 to both the multidimensional logic of evidence use in policymaking, particularly apparent through policy evaluation; 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 HIMD has primarily the duty to “fill”—rather than create—indicators; however, our inter-

views clearly stated that some margin of discretion over data selection always exist, especially when data are lacking. Also, discretion exists in the very use of indicators to produce reports and draw political attention on them. So for instance, one interviewee 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 (GHS-1). 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 HIMD to influence policymakers. And indeed, the utilization of data might depend on the capacity of specific individuals (e.g., within the PPME) to get policymakers interested in those data—e.g., with examples of policy briefs, maps, and one-pager documents used for generating interest from the Director General of the GHS (GHS-1).

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 simplify 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 that reflects 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 1985). 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 Sector 2012, 20). Indeed, the outcome of the health sector assessment serves as the basis for discussing the Performance Assessment Framework (PAF) for Multi-Donor Budget Support during the business meeting following the Health Summit (Ghana Health Sector 2012)<sup>7</sup>. 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 consideration, the power of DP 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 often reflects an adversarial process, in which the construction of policy meaning occurs through negotiation between competing views over policy performances and the subsequent judgments on future policy directions (Bovens, 't Hart, and Kuipers 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 operationalized by stakeholders through the selection, activation, and evaluation of policy evaluation tools (Pearce, Wesselink, and Colebatch 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 feedback. For instance, one of our interviewees from the MoH complained about the superior technical capacity of DP to produce evidence of performances (GHS-1). This asymmetry is problematic in two respects: on the one hand, Ghanaian officials have little capacity to enter the technical discussion due to a lack of

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<sup>7</sup> See *supra* note 6.

counteracting arguments, hence to raise issues of political relevance connected to them. On the other hand, the absence of clear problem setting and policy directions established by the MoH makes the discussion dominated by technical considerations of policy implementation performance. Interviewees from both DP and NGOs (DP-3 and LNGO-1) recognized such absence as problematic. In the wording of one representative of an international agency (DP-3), 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, an NGO representative (LNGO-1) explained us that the “Ghana Coalition of NGOs in Health” (<http://www.ghanahealthngos.net/>) has recently decided to challenge the government on health priorities by creating a concurrent space of advocacy and evidence use; the objective being to produce an alternative evidence-based report and submit it to the parliament select committee on health in order to influence health financing. However, the Parliament has very little power in influencing actual health policy outcomes (Ayee 2002) as some of our interviewees confirmed. It was explained, for instance, that the Parliament lacks the financial resources to commit its own inquiries and studies which could allow it to have greater say in the direction of health policy. This makes Parliament’s influence over domestic policy dependent on external aid provided directly to the legislature, for instance for organizing meetings with the civil society

(DP-3, MEP-1 DP-1); at the same time, such dependence renders the Parliament practically impotent to have a say in the approval of sectoral budgets (Ayee 2002).

Therefore, evidence use reflects mainly on the use of common indicators, which might fail to link evaluation to “accountable” (and potentially more democratic) decisions. The reason draws precisely on the duality of evidence use as both informative and justificatory policy tools, 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 policymaking process sees the two typical phases of policy evaluation, i.e., evidence synthesis 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 in bringing 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 policymakers 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).

As much as the control of policy performances does not exhaust the whole process of determining the value of policy performances (Koppell 2005), such value is determined through a process of participation in which different actors variably contribute to the appreciation of policy interventions and variably influence their final judgment. In connection to the use of evidence in policymaking, Champagne, Contandriopoulos, and Ta-

non (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” (143-44).

From this perspective, the determination of the political values within decisions is a process in which accountability meets the vows for improved democratic practices: by making these values exposed to public judgment and contestation (Heidelberg 2015), accountability goes beyond simplistic checks of interests’ representation and enables a process of continuous reconstruction of political values. In this sense, accountability structures are important not only to shape authority relationships, but also to activate a social mechanism of participation in which the principles of an ideal relationship between the “governors” and the “governed” (Koppell 2005; Lascoumes and Le Galès 2007; Salminen and Lehto 2012) are continuously recreated and “tested” 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 policymakers’ 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 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 policymaking, has implications, at least theoretically, for democratic decision making. These implications are difficult to appreciate when there is only a general and vague understanding of accountability relationships, or of way the use of evidence plays a role in shaping those relationships. In particular, the Health Summit in Ghana has revealed the importance of the policy evaluation stage within the policymaking process to understand the performative effects of 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. Also, the process of policy evaluation within the Health Summit reveals with particular clarity 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 the accountability relationship, therefore, provides the basis for

discussing issues of democratic decision making connected to the use of evidence in policymaking. Indeed, we have showed that the involvement of international donors as responsible for funding a significant amount of health services can challenge the national structure of authority and accountability relationships within existing constitutional parameters or the existing governance structure of the state.

These findings may prove challenging to international DP who champion the language of EBPM, while simultaneously embracing the language of good governance and democratic representation in aid-recipient countries. As the case of Ghana has showed, it is important that donors involved in processes of evidence use to inform policy—either by extracting local data to generate their own assessments or in constructing indicators to serve as evaluation tools—consciously consider the potential implications these practices have over local accountability mechanisms along with possible “governmentality” effects and legitimacy concerns.

This 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; indeed, it has revealed the existence of two policy spaces of decisions that would otherwise remain unclear. These accountability mechanisms in turn, have informed our theoretical reflections on the link between democracy and evidence use in policymaking insofar as accountability structures provide one important mechanism for stakeholders’ participation in the policy evaluation process, along with their power to influ-

ence decision outcomes. These findings can help inform future work in Ghana by helping identify where in the policymaking process the use of governance tools and mechanisms are most influential; these findings can also provide an example for other countries of how the investigation of accountability mechanisms and practices can help detect emergent governance relationships along with their legitimacy implications.

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