policy

March 2015

ANNOTATED BIBLIOGRAPHY ON HEALTH POLICY IMPLEMENTATION AND EVALUATION

This publication was prepared by Laili Irani, Karen Hardee, Stephanie Welsh, Mariela Rodriguez, and Matthew Hamilton of the Health Policy Project.

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EXECUTIVE SUMMARY

This annotated bibliography, prepared by the USAID-funded Health Policy Project, is a collection of hundreds of articles, reports, books, and tools for communicating the available knowledge, evidence, and best practices for health policy. Health-related policy is the critical first step along the way to strengthening health systems and improving health outcomes, so it is important for policymakers to understand the processes and complexities involved in health policy. This bibliography contains the necessary knowledge for understanding the various components of the policy process, including policy development, implementation, and evaluation.

Policy Development

The first two steps in the policy cycle are problem identification and policy development; both require significant attention to the environment in which one is working. The working environment includes the current political agenda, the economic situation, the sociocultural context, the previous policies and systems in place, the local institutional capacity, and more. To develop objectives and methods for a new policy, one must be familiar with the playing field.

Policy Implementation

Once the agenda has been set and the policy developed, implementation is the next nuanced step. Even the most well-planned protocols can fail because of incomplete or incorrect implementation. Policy implementation incorporates many factors: interorganizational power dynamics, varying institutional capacities, financing, accountability and transparency, and countless possible barriers. Learning from both successful and unsuccessful policies is invaluable for good implementation.

Social Participation

One of the many interacting variables in the policy process is the level of social participation within the work environment—how and how often local organizations, civil society groups, and community members interact with policy. Social participation and collaboration are important to recognize when entering a new policy environment.

Measuring Health Systems Strengthening

A key objective of most health-related policies is strengthening health systems. Health systems are the networks of individuals, organizations, and resources that work together to promote and restore health to populations.

Methodologies to Study Policy Implementation

The study of policy and subsequent dissemination of findings improves future policies and ensures that common mistakes are avoided. The references in this section examine the ins and outs of policy research, from complex adaptive systems and path dependence to implementation science and evaluation designs. Also included are specific examples of policy evaluations, in the hope that policymakers will use these recommendations and conclusions in the future.

Tools for Policy Development and Implementation

The final section of the bibliography contains toolkits, handbooks, software, checklists, and spreadsheets that policymakers can use for comprehensive and effective policy development and implementation.

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy/treatment
CAS	complex adaptive systems
CBO	community-based organization
CCM	country coordinating mechanism
CPR	contraceptive prevalence rate
CPT	cotrimoxazole preventive therapy/prophylaxis
CSO	civil society organization
DCE	discrete choice experiment
DFID	Department for International Development
DHS	Demographic and Health Survey
DOTS	directly observed treatment, short-course
ECDPM	European Centre for Development Policy Management
EPHF	Essential Public Health Functions
FP	family planning
GDP	gross domestic product
GHI	Global Health Initiative
HIV	human immunodeficiency virus
HPP	Health Policy Project
HPSR	health policy and systems research
HRH	human resources for health
HS	health system
HSG	health system governance
HSV-2	herpes simplex virus type-2
ICPD	International Conference on Population and Development
IMCI	integrated management of childhood illness
IPC	Implementing Policy Change Project
IPT	isoniazid preventive therapy
IS	implementation science
ITN	insecticide-treated net
LiST	Lives Saved Tool
LMICs	low- and middle-income countries
MAP	Multi-Country AIDS Program
MCE-IMCI	Multi-Country Evaluation of IMCI Effectiveness, Cost, and Impact
MCH	maternal and child health
MDG	Millennium Development Goal
M&E	monitoring and evaluation
MOH	Ministry of Health
MSM	men/males who have sex with men
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
PAHO	Pan American Health Organization
PEPFAR	The U.S. President's Emergency Plan for AIDS Relief
PIBA	Policy Implementation Barriers Analysis
PMTCT	prevention of mother-to-child HIV transmission
RH	reproductive health
RHCS	reproductive health commodity security

S&D	stigma and discrimination
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
SW	sex worker
TB	tuberculosis
TG	transgender
UNDP	United Nations Development Programme
UP	Uttar Pradesh
USAID	U.S. Agency for International Development
WHO	World Health Organization

INTRODUCTION

Policies are statements of intent or blueprints for action. They contain the overarching outcome goals and the step-by-step protocols for implementation, monitoring, and evaluation, including details about resources, actors, and environment. For the realm of global health, good health policies are invaluable as building blocks toward good health systems, health programs and, ultimately, health outcomes.

Purpose of the Annotated Bibliography

Because the development of effective policy is the first step toward improving population health, this annotated bibliography seeks to focus attention on each step of the policy process—problem identification, policy development, policy implementation, and evaluation—and provide information on other aspects of health policy, such as social participation and health systems strengthening. The latter half of the bibliography presents evidence on methodologies and tools for studying policy implementation. Although the policy development process is generally well understood, this bibliography shines light on the more difficult and unpredictable areas of policy implementation and its related aspects.

Conceptual Framework: Linking Health-related Policy to Health Systems and Health Outcomes

This annotated bibliography works in conjunction with the conceptual framework developed by Hardee et al. of the Health Policy Project—Linking Health-related Policy to Health Systems and Health Outcomes—as shown in Figure 1. In one all-encompassing graphic, this framework describes the relationships between health-related policies and programs, and health systems and outcomes. It approaches these relationships through the lens of an enabling environment, including good governance and enabling political, social, cultural, and economic contexts. The framework then shows how, in a nonlinear process, policy development, implementation, monitoring, and evaluation can contribute to health systems strengthening and improved health outcomes.

This annotated bibliography serves as part of the literature base for the conceptual framework by presenting articles, reports, and tools explaining and examining the steps of the conceptual framework.

Methodology

The references in this annotated bibliography are the result of an extensive literature review of articles and grey literature examining the health policy process or its challenges, outcomes, or related factors. We scanned several search engines for peer-reviewed and grey literature to find examples of policy implementation spanning 15 years and theories around policy implementation from as early as the 1950s. We located many references using snowball sampling, in which we searched the reference lists of Health Policy Project deliverables and articles and reports already cited in this bibliography for new applicable references.

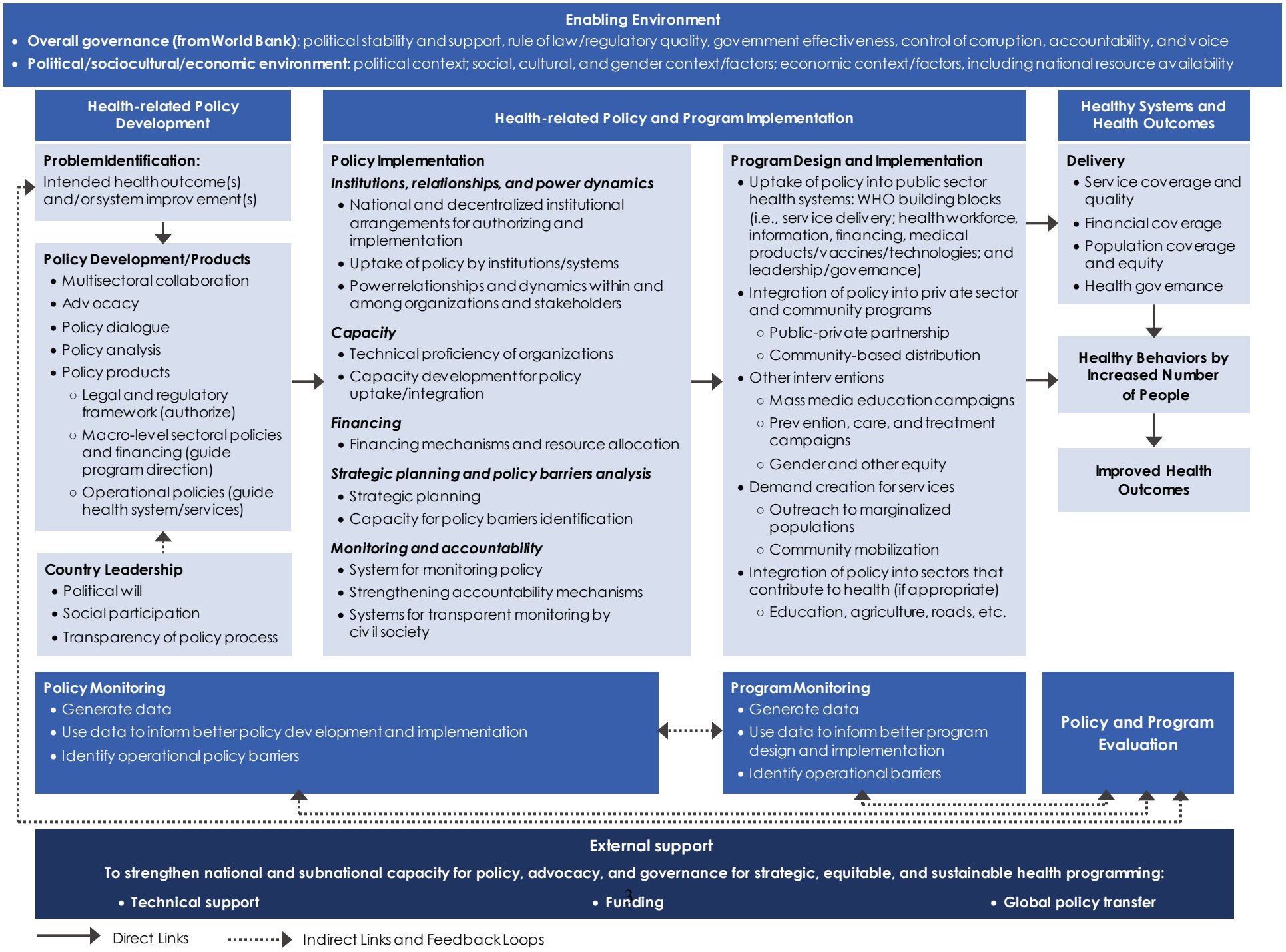
Each reference in this bibliography is followed by a description of its key messages. In most instances, we took abstracts of journal articles and summaries directly from the original articles. In some instances, we summarized the article, book, chapter, report, or tool. We note a full description of the various summaries used in the bibliography below, along with the description of the source.

Table 1: Bibliography Title and Description Outline

Title of Summary in Bibliography	Description
Abstract	An exact transcription of an abstract
Excerpt	An excerpt may be taken from any of the following: executive summary, abstract, summary, foreword, introduction, or report
Summary of Article (self-written)	A self-written summary of a journal article
Summary of Book (self-written)	A self-written summary of the contents of the book
Summary of Chapter (self-written)	A self-written summary of a chapter of a book
Summary of Report (self-written)	A self-written summary of a report
Summary of Tool (self-written)	A description of an analysis tool

Figure 1: Conceptual Framework: Linking Health-related Policy to Health Systems and Health Outcomes

Source: Hardee, K., L. Irani, R. MacInnis, and M. Hamilton. 2012. *Linking Health Policy with Health Systems and Health Outcomes: A Conceptual Framework*. Washington, DC: Futures Group, Health Policy Project.



1. POLICY DEVELOPMENT

The following is a collection of guiding literature for developing policy, analyzing the political environment, reforming existing policy, and using evidence effectively. This guidance is of great importance, as there is a complex debate over the most effective policy-making influences, practices, and goals, and more than one popular theory exists. These theories have been detailed by a number of researchers and authors, as examined in this guide. These articles follow the political process from policy design to implementation. They document the effectiveness of using evidence-based analysis for creation of health policies, and take into consideration the motivations of policymakers and their long-term impact on the direction of future policies. As well as these theoretical assertions on the best ways to create policy, it is also important to document historical explanations for how certain policy spheres developed, how political priority can be gained, and why various policies exist in the way they do. Providing guidelines and real-world examples, this section adds to the existing knowledge on every aspect of policy development.

Author and title	Year of publication	Type of reference	Country of focus
Bardach, E. *A Practical Guide for Policy Analysis*	2012	Book	Global
Buse, K., N. Mays, and G. Walt. *Making Health Policy*	2005	Book	Global
Colebatch, H. "What Work Makes Policy?"	2006	Journal article	Global
Crichton, J. "Changing Fortunes: Analysis of Fluctuating Policy Space for Family Planning in Kenya"	2008	Journal article	Kenya
Dixon-Mueller, R. "Human Rights, Women's Rights, and Reproductive Freedom: The Evolution of Ideas." In *Population Policy & Women's Rights: Transforming Reproductive Choice*, edited by R. Dixon-Mueller	1993	Book chapter	Global
Eager, P.W. *Global Population Policy: From Population Control to Reproductive Rights*	2004	Book	Global
Hafner, T. and J. Shiffman. "The Emergence of Global Attention to Health Systems Strengthening"	2012	Journal article	Global
Health Policy Initiative, Tanzania. *Analysis of Policy, Legal, and Regulatory Frameworks for Task Shifting in Tanzania*	2012	Report	Tanzania
Health Policy Initiative, Task Order 1. *Informing Equitable Health Policy Reform: Policy Implementation Assessment Inspires Action in Uttarakhand, India*	2010	Report	India
Howard, C. "The Policy Cycle: A Model of Post-Machiavellian Policy Making"	2005	Journal article	Australia
Hutchinson, E., B. Droti, D. Gibb, N. Chishinga, S. Hoskins, et al. "Translating Evidence into Policy in Low-Income Countries: Lessons from Co-Trimoxazole Prevention Therapy"	2011	Journal article	Global

Author and title	Year of publication	Type of reference	Country of focus
Hutchinson, E., J. Parkhurst, S. Phiri, D.M. Gibb, N. Chishinga, et al. "National Policy Development for Cotrimoxazole Prophylaxis in Malawi, Uganda and Zambia: The Relationship Between Context, Evidence and Links"	2011	Journal article	Malawi, Uganda, and Zambia
Kingdon, J.W. *Agendas, Alternatives, and Public Policies*	2011	Book	Global
Lasswell, H.D. "The Policy Orientation." In *The Policy Sciences*, edited by D. Lerner and H.D. Lasswell	1951	Book chapter	Global
May, P. "Policy Design and Implementation." In *Handbook of Public Administration*	2007	Book chapter	Global
Mkandawire, P., I.N. Luginaah, and R. Bezner-Kerr. "Deadly Divide: Malawi's Policy Debate on HIV/AIDS and Condoms"	2011	Journal article	Malawi
Moat, N. and J.N. Lavis. "10 Best Resources for…Evidence-informed Health Policy Making"	2012	Journal article	Global
Ogden, J., G. Walt, and L. Lush. "The Politics of 'Branding' in Policy Transfer: The Case of DOTS for Tuberculosis Control"	2003	Journal article	Global
Richey, C. and R.M. Salem. "Elements of Success in Family Planning Programming"	2008	Journal article	Global
Sabatier, P.A. *Theories of the Policy Process*	2007	Book	Global
SADC Parliamentary Forum. *Model Law on HIV & AIDS in Southern Africa*	2008	Report	Southern Africa
Shiffman, J. "Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries"	2007	Journal article	Guatemala, Honduras, India, Indonesia, Nigeria
Shiffman, J. "The Emergence of Political Priority for Safe Motherhood in Honduras"	2004	Journal article	Honduras
Surjadjaja, C. and S.H. Mayhew. "Can Policy Analysis Theories Predict and Inform Policy Change? Reflections on the Battle for Legal Abortion in Indonesia"	2011	Journal article	Indonesia
The United Republic of Tanzania Ministry of Health and Social Welfare and the United States Agency for International Development (USAID). *National Family Planning Costed Implementation Plan*	2010	Report	Tanzania

Bardach, E. 2012. *A Practical Guide for Policy Analysis. Fourth Edition*. Los Angeles, CA: CQ Press.

Excerpt

Although skilled policy development comes from experience and intuition, a structured approach can be helpful for those who are still developing their methods. This method to policy development—the Eightfold Path—serves to guide beginners and ensure that no important steps are omitted. The steps, which can be reordered to some extent, proceed as follows:

- Define the Problem
- Assemble Some Evidence
- Construct Alternatives
- Select the Criteria
- Project the Outcomes
- Confront the Trade-offs
- Decide!

Tell Your Story

The final report of policy recommendations should contain each step of the Eightfold Path, beginning with a clear description of the problem that the proposed policy seeks to solve. The second step, Assemble Some Evidence, should be carried out continuously through the Path, as it applies to several areas and contributes to smart decision making. Each alternative policy option should be provided and examined, including the likely outcomes of each option. All options and projections should be informed by evidence. Some clients may request a recommendation as to which policy option is best. In any case, each alternative option should be compared and contrasted so that the advantages and disadvantages to each are clarified.

Buse, K., N. Mays, and G. Walt. 2005. *Making Health Policy*. Maidenhead: Open University Press.

Summary of book (self-written)

This book introduces the political aspect of the health policy process to help policy developers better understand how the political environment affects policy uptake and implementation. Specifically, *Making Health Policy* teaches readers how to market health issues to make them more attractive to the policy agenda, how to better relate to and understand policymakers, and how to tell the difference between politically successful and unsuccessful policy proposals.

The authors also go on to describe the policy triangle framework, developed by Gill Walt and Lucy Gilson, which explains how politico-social context, policy-influencing actors, and processes of policy development and implementation interact in policy situations worldwide. The chapters provide an overview of the entire policy process, from institutional dynamics and public and private actors, to agenda setting and policy making, all the way to policy implementation and evaluation.

Colebatch, H. 2006. "What Work Makes Policy?" *Policy Sciences* 39(4): 309–321.

Abstract

The mainstream policy literature identifies a number of activities as part of "policy making": "policy analysis," "policy advice," "decision making," and perhaps also "implementation" and "evaluation." Describing policy in these terms is compatible with the Western cultural account, and they tend to be applied to positions, organisational segments, and official procedures. However, policy practitioners tend to find that, on the one hand, their experience of their work bears little resemblance to the assumptions in this policy-making model, and on the other, that policy outcomes seem to reflect much broader processes than the work of specialist functionaries. On closer examination, we find that our thinking about policy activity draws on several distinct and potentially conflicting perspectives, and that what is seen as "policy work" depends on the conceptualisation of the policy process. Framing the question in this way helps to understand the apparent differences between mainstream (American) accounts of policy activity and policy practice in other political systems.

Crichton, J. 2008. "Changing Fortunes: Analysis of Fluctuating Policy Space for Family Planning in Kenya." *Health Policy and Planning* 23(5): 339–350.

Abstract

Policies relating to contraceptive services (population, family planning, and reproductive health policies) often receive weak or fluctuating levels of commitment from national policy elites in southern countries, leading to slow policy evolution and undermining implementation. This is true of Kenya, despite the government's early progress in committing to population and reproductive health policies, and its success in implementing them during the 1980s. This key informant study on family planning (FP) policy in Kenya found that policy space contracted and then began to expand because of shifts in contextual factors and the actions of different actors. Policy space contracted during the mid-1990s in the context of weakening prioritization of reproductive health in national and international policy agendas, undermining access to contraceptive services and contributing to the stalling of the country's fertility rates. However, during the mid-2000s, champions of family planning within the Kenyan government bureaucracy played an important role in expanding the policy space through both public and hidden advocacy activities. The case study demonstrates that policy space analysis can provide useful insights into the dynamics of routine policy and programme evolution, and the challenge of sustaining support for issues even after they have reached the policy agenda.

Dixon-Mueller, R. 1993. "Human Rights, Women's Rights, and Reproductive Freedom: The Evolution of Ideas." In R. Dixon-Mueller (Ed.), *Population Policy & Women's Rights: Transforming Reproductive Choice*. Westport, CT and London: Praeger Publishers.

Summary of Chapter (self-written)

This chapter, excerpted from *Population Policy & Women's Rights,* details the conflicting views of population policy at the end of the 20th century. At the time of this book's publication, developmental and environmental bodies rallied for strict population control, whereas women's organizations called for a stronger focus on reproductive rights. The book seeks to respond to the population control practices of developing countries, whereas this chapter in particular outlines the background of U.S. population policy, the feminist stance on population control, and the women's rights situation worldwide. Dixon-Mueller concludes with suggestions for reproductive rights-focused population policy to promote the sexual and reproductive health of women in developed and developing countries.

Eager, P.W. 2004. *Global Population Policy: From Population Control to Reproductive Rights*. Aldershot, England: Ashgate.

Summary of Book (self-written)

Global Population Policy provides an overview of the evolving stance on global population policies, from the belief that growth was good, to the concern that developing-country populations needed to be controlled at all costs, to the current understanding of the need for reproductive rights. Developed countries, particularly the United States, have played a large role in this evolution. The book explains this role, and focuses in particular on the influence of the policies of George W. Bush and the United Nations (UN).

Hafner, T. and J. Shiffman. March 8, 2012. "The Emergence of Global Attention to Health Systems Strengthening." *Health Policy and Planning*. Advance Online publication.

Abstract

After a period of proliferation of disease-specific initiatives, over the past decade, and especially since 2005, many organizations involved in global health have devoted direct attention and resources to the issue of health systems strengthening. We explore how and why such attention emerged. A qualitative methodology—process-tracing—was used to construct a case history and analyse the factors shaping and inhibiting global political attention for health systems strengthening. We find that the critical factors behind the recent burst of attention include fears among global health actors that health systems' problems threaten the achievement of the health-related Millennium Development Goals (MDGs), concern about the adverse effects of global health initiatives (GHIs) on national health systems, and the GHIs' realization that weak health systems present bottlenecks to the achievement of their organizational objectives. Although a variety of actors now embrace health systems strengthening, they do not constitute a cohesive policy community. Moreover, the concept of health systems strengthening remains vague, and there is a weak evidence base for informing policies and programs for strengthening health systems. There are several reasons to question the sustainability of the agenda, such as the global financial crisis, the history of pendulum swings in global health, and the instrumental embrace of the issue by some actors.

Health Policy Initiative, Tanzania. 2012. *Analysis of Policy, Legal, and Regulatory Frameworks for Task Shifting in Tanzania*. Dar es Salaam: Futures Group, Health Policy Initiative, Tanzania.

Excerpt

In many sub-Saharan countries, a shortage in human resources for health (HRH) impedes the scale-up of HIV and AIDS services and the expansion of reproductive health (RH) services. To address this problem, various countries are using task shifting as a stopgap measure. In Tanzania, the Ministry of Health and Social Welfare (MOHSW) and other key stakeholders have had task shifting on their agenda for some time, but little has occurred to officially move it into practice. The main challenge in introducing task shifting is the absence or lack of conducive policy, legal, and regulatory frameworks for its implementation.

To address this challenge, the National Task Shifting Task Force asked the Health Policy Initiative in Tanzania, led by Futures Group and funded by USAID, to assess relevant policy, legal, and regulatory frameworks, and determine whether they support or hinder the adoption of task shifting in Tanzania. Two consultants were subsequently hired and used the following data collection methods to conduct the analysis: (1) a desk review of selected policies, laws, regulations, and guidelines; (2) focus group discussions; and (3) individual interviews.

Key findings of the analysis include the following:

- There is no policy that either supports or prohibits task shifting in the provision of health services.
- The legal and regulatory framework is silent on task shifting, although certain powers relegated to various positions and regulatory bodies could be harnessed for introducing task shifting for selected tasks.
- The HRH shortage is acute; all informants in the focus group discussions and interviews felt that task shifting could help alleviate this problem.
- There is limited information among policymakers and stakeholders on the advantages of task shifting.

In broad terms, task shifting cannot be implemented effectively because there is no standardized program for training and certification that guarantees essential standards of care; also, there is no clear incentive package for implementing a task shifting plan or policy.

The consultants reported that introducing task shifting in Tanzania will likely be a large and costly endeavor, but an essential one, given the country's critical shortage of human resources. This document recommends that the government put in place supportive policy, legal, and regulatory frameworks as a first step. This process should be gradual and ensure that all stakeholders, mainly those from various health sector departments, are brought on board to enhance ownership of the resulting framework, which in turn will facilitate the smooth implementation of task shifting.

Health Policy Initiative, Task Order 1. 2010. *Informing Equitable Health Policy Reform: Policy Implementation Assessment Inspires Action in Uttarakhand, India.* New Delhi, India: Futures Group, Health Policy Initiative, Task Order 1.

Summary of Report (self-written)

This case study documents how stakeholders in Uttarakhand used the Policy Implementation Assessment Tool to assess the state's 2002 Health and Population Policy. Based on the findings, the government appointed the Uttarakhand Health and Family Welfare Society to draft an addendum to the policy that updates goals through 2017 and provides guidance to promote more equitable health services. Key concerns are reducing disparities found between Uttarakhand's plains and hills districts, as well as improving health service access and use for women, children, the poor, and other underserved and vulnerable populations. The USAID | Health Policy Initiative, Task Order 1 assisted the government to assess policy implementation, facilitate policy dialogue, and analyze evidence to inform development of the addendum.

Howard, C. 2005. "The Policy Cycle: A Model of Post-Machiavellian Policy Making?" *Australian Journal of Public Administration* 64: 3–13.

Abstract

A number of theorists have recently proposed versions of the "policy cycle" as a framework for understanding contemporary public policy processes. These proposals have provoked critical responses from writers who dismiss the policy cycle as an inaccurate general description of public policy and an impractical normative model for decision making. In this article, I use an historical and interpretative method to explore the senses in which a policy cycle coheres with the experiences and values of policy analysts working in contemporary bureaucratic contexts. Drawing on Radin's notion of post-Machiavellian policy analysis, I suggest that the policy cycle has the potential to capture some of the fundamental features of current policy formulation, including the existence of numerous decisionmakers, the high degree of competition and contestability among sources of policy advice, and the substantial impact of previous policies on new efforts. Through interviews with senior Australian public servants, I

argue that the model should not be interpreted as a rigorous, formulistic guide to the policy process. I also suggest that writers must be careful to distinguish between normative and descriptive uses of the policy cycle, and that more needs to be done to clarify how the policy cycle can improve policy making in contexts in which political representatives do not give bureaucrats room to undertake good analytical work.

Hutchinson, E., B. Droti, D. Gibb, N. Chishinga, S. Hoskins, et al. 2011a. "Translating Evidence into Policy in Low-Income Countries: Lessons from Co-trimoxazole Prevention Therapy." *Bulletin of the World Health Organization* 89: 312–316.

Abstract

In the April 2010 issue of this journal, Date et al. expressed concern over the slow scale-up in low-income settings of two therapies for the prevention of opportunistic infections in people living with the human immunodeficiency virus: cotrimoxazole prophylaxis (CPT) and isoniazid preventive therapy (IPT). This short paper discusses the important ways in which policy analysis can be of use in understanding and explaining how and why certain evidence makes its way into policy and practice, and what local factors influence this process. It draws key lessons about policy development from the research evidence on CPT, as such lessons may prove helpful to those who seek to influence the development of national policy on IPT and other treatments. It encourages researchers to disseminate their findings in a clear manner, while also paying attention to how structural, institutional, and political factors shape policy development and implementation. Doing so will help them to understand and address the concerns raised by Date et al. and other experts. Mainstreaming policy analysis approaches that explain how local factors shape the uptake of research evidence can provide an additional tool for researchers who feel frustrated because their research findings have not made their way into policy and practice.

Hutchinson, E., J. Parkhurst, S. Phiri, D.M. Gibb, N. Chishinga, et al. 2011b. "National Policy Development for Cotrimoxazole Prophylaxis in Malawi, Uganda and Zambia: The Relationship Between Context, Evidence and Links." *Health Research Policy and Systems* 9(Suppl 1): S6.

Abstract

Background: Several frameworks have been constructed to analyse the factors that influence and shape the uptake of evidence into policy processes in resource-poor settings, yet empirical analyses of health policy making in these settings are relatively rare. National policy making for cotrimoxazole (trimethoprim-sulfamethoxazole) preventive therapy in developing countries offers a pertinent case for the application of a policy analysis lens. The provision of cotrimoxazole as a prophylaxis is an inexpensive and highly efficacious preventative intervention in HIV-infected individuals, reducing both morbidity and mortality among adults and children with HIV/AIDS, yet evidence suggests that it has not been quickly or evenly scaled up in resource-poor settings.

Methods: We conducted comparative analysis in Malawi, Uganda, and Zambia, using the case study approach. We applied the "RAPID" framework developed by the Overseas Development Institute (ODI), and conducted 47 in-depth interviews across the three countries to examine the influence of context (including the influence of donor agencies), evidence (both local and international), and the links between researchers, policymakers, and those seeking to influence the policy process.

Results: Each area of analysis was found to have an influence on the creation of national policy on CPT in all three countries. In relation to context, the following were found to be influential: government structures and their focus, donor interest and involvement, healthcare infrastructure, and other uses of cotrimoxazole and related drugs in the country. Regarding the nature of the evidence, we found that how policymakers perceived the strength of evidence behind international recommendations was crucial (if evidence was considered weak, the recommendations were rejected). Further, local operational research

results seem to have been taken up more quickly, while randomised controlled trials (the gold standard of clinical research) was not necessarily translated into policy so swiftly. Finally, the links between different research and policy actors were of critical importance, with overlaps between researcher and policymaker networks being crucial in facilitating knowledge transfer. Within these networks, in each country, the policy development process relied on a powerful policy entrepreneur who helped get CPT onto the policy agenda.

Conclusions: This analysis underscores the importance of considering national-level variables in the explanation of the uptake of evidence into national policy settings, and recognising how local policymakers interpret international evidence. Local priorities, the ways in which evidence was interpreted, and the nature of the links between policymakers and researchers could either drive or stall the policy process. Developing the understanding of these processes enables the explanation of the use (or non-use) of evidence in policy making, and potentially may help shape future strategies to bridge the research-policy gaps and ultimately improve the uptake of evidence in decision making.

Kingdon, J.W. 2011. *Agendas, Alternatives, and Public Policies.* Updated 2nd Edition. Boston, MA: Longman.

Summary of book (self-written)

The content of *Agendas, Alternatives, and Public Policies* stems from the knowledge gathered from key informant interviews and literature reviews. Kingdon conducted in-depth interviews with 247 public sector officials, including members of government and health and transportation policy developers. Between 1976 and 1979, he interviewed participants multiple times to illuminate their current areas of interest and future areas of concern in public policy. The literature studied for this publication included 23 case studies about topics such as public health insurance, the regulation and deregulation of transportation mechanisms, and health maintenance organizations.

Methods for effective policy making remain under debate, and more than one popular theory exist. Kingdon examines several proposed methods, including "chaos theory," which states that policy making is completely random. Kingdon, however, proposes his own theory, "organized anarchy," which states that the federal government must recognize or undertake three processes—the identification of a problem, the development of policy alternatives, and the playing out of political interests—for a problem to become part of the public policy agenda. He stresses that these processes, while interwoven and complex, are not random, but patterned.

Based on his study of the interviews and literature, Kingdon proposes a hierarchy of actors in policy making and agenda setting. He argues that while Congress and lobbyists are key players in the development of policy alternatives, the media plays a surprisingly small role. Whereas most would assume that the president would be most influential in agenda setting, Kingdon argues that, in fact, Congress has the greatest impact. Furthermore, he finds that interest groups gain power when an issue is less publicized and less ideological.

Kingdon identifies another actor whom he calls "policy entrepreneurs." Policy entrepreneurs constantly evaluate the political environment for "windows" for actions, such as when a piece of legislation has met its end date or a crisis takes place. Kingdon urges his readers to act like policy entrepreneurs and remain watchful for windows of opportunity in the public policy arena.

Lasswell, H.D. 1951. "The Policy Orientation." In *The Policy Sciences*, edited by D. Lerner and H.D. Lasswell. Stanford, CA: Stanford University Press.

Summary of Chapter (self-written)

In this chapter, Harold Lasswell explains how the policy process can be used to explain decisions of public concern and improve upon that decision-making process. He describes policy orientation as the combination of the policy process, or the development and implementation of policy, and the knowledge base needed for policy, or the information needed by policymakers to inform and interpret policy. Lasswell describes the following facets of policy orientation:

- Should be applied to "fundamental" rather than "topical" issues
- Should not entail subjectivity or case-by-case decision making
- Requires strict qualifications for the types of problems to be studied

Accounts for the local and historical context of each area in which a policy is examined

May, P. 2007. "Policy Design and Implementation." In *Handbook of Public Administration: Concise Paperback Edition*. Thousand Oaks, CA: SAGE Publications.

Summary of Chapter (self-written)

In addition to declaring a desired endpoint, policies contain objectives, methods, and details on governing bodies and resources to reach that endpoint. Policies serve as the "blueprint" for policy implementation, and the language and politics within a policy greatly affect the implementation. Because of this influence, the policy design can either support or impair policy implementation. This chapter includes insights from various literature on policy design, with the goal of resolving policy design issues to improve policy implementation.

Mkandawire, P., I.N. Luginaah, and R. Bezner-Kerr. 2011. "Deadly Divide: Malawi's Policy Debate on HIV/AIDS and Condoms." *Policy Sciences* 44(1): 81–102.

Abstract

This paper examines the dynamics of condom policy making in Malawi by analyzing debates that took place in the Malawi National Assembly between 2000 and 2004. Using content analysis and key informant interviews, and situating the overall discussion within policy and science literature, we examine how scientific evidence is being applied in the policy-making process as it relates to the place of condoms within the context of HIV/AIDS prevention. The study not only shows the extent to which the policy-making process on condoms in Malawi largely embodies a tendency to blur the conventional divide between science and politics, but also demonstrates why controversy around condoms still persists at the highest level of government in a country with one of the highest HIV prevalence rates in the world. We found that even when people are dying, consensus in HIV/AIDS policy making can be difficult to achieve in a policy climate characterized by a binary perspective to social problems, and where different actors compete for control over the policy terrain. The paper makes recommendations that may be helpful in facilitating a more inclusive HIV/AIDS policy-making process in Malawi.

Moat, N., and J.N. Lavis. 2012. "10 Best Resources for … Evidence-informed Health Policy Making." *Health Policy and Planning* 28(2): 215–218.

Excerpt

A key step in the policy-making process is the use of research-based evidence to support interventions and recommendations. The resources provided in "10 Best Resources for ... Evidence-informed Health Policy Making" include articles, toolkits, and a listserv, which guide the gathering and use of evidence. These 10 resources are organized by their relationships to the following key elements of evidence use in policy making:

- *Climate*: the extent to which researchers and funders support the use of research in policy making
- *Production of research*: the extent to which researchers respond to the needs of research users
- *Push efforts*: the extent to which research findings are used to influence action
- *Facilitating user-pull*: the extent to which research is catered to and made accessible to users
- *User-pull*: the extent to which research users support the use of research

Exchange: the extent to which researchers and users communicate about their respective needs

Ogden, J., G. Walt, and L. Lush. 2003. "The Politics of 'Branding' in Policy Transfer: The Case of DOTS for Tuberculosis Control." *Social Science & Medicine* 57: 179–188.

Abstract

How and why policies are transferred between countries has attracted considerable interest from scholars of public policy over the last decade. This paper, based on a larger study, sets out to explore the processes involved in policy transfer between international and national levels. These processes are illustrated by looking at a particular public health policy—directly observed treatment, short-course (DOTS) for the control and treatment of tuberculosis (TB). The paper demonstrates how, after a long period of neglect, resources were mobilised to put tuberculosis back on international and national public policy agendas, and how the policy then was "branded" and marketed as DOTS, and transferred to low- and middle-income countries. It focuses specifically on international agenda setting and policy formulation, and the role played by international organisations in those processes. It shows that policy communities, and particular individuals within them, may take political rather than technical positions in these processes, which can result in considerable contestation. The paper ends by suggesting that, whereas it is possible to raise the profile of a policy dramatically through branding and marketing, success also depends on external events providing windows of opportunity for action. Second, it warns that simplifying policy approaches to "one-size-fits-all" carries inherent risks and can be perceived to harm locally appropriate programmes. Third, top-down internationally driven policy changes may lead to apparent policy transfer, but not necessarily to successfully implemented programmes.

Richey, C. and R.M. Salem. 2008. "Elements of Success in Family Planning Programming." In *Population Reports, Series* J (57), edited by I. Project. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health.

Abstract

This *Population Reports* issue is the flagship publication of the "Elements of Family Planning Success" initiative that identified the top 10 elements most important to the success of FP programs in coordination with healthcare professionals from around the world. The report synthesizes online discussions about these elements and highlights program experiences, best practices, and evidence-based guidance derived from nearly six decades in international family planning. The lessons identified in this report can help FP program managers, donor agency staff, policymakers, and other FP professionals to plan new programs, improve existing programs, and prepare for future developments and challenges.

Sabatier, P.A., ed. 2007. *Theories of the Policy Process*. 2nd Edition. Boulder, CO: Westview Press.

Summary of Book (self-written)

In *Theories of the Policy Process,* Sabatier and contributors describe several existing frameworks that seek to explain the process of developing, implementing, and evaluating policy. While many of these frameworks were developed to reflect the interworkings of the policy process in the United States, all of them can be applied to other countries worldwide. The frameworks described in this publication are as follows:

1. *Institutional Rational Choice*: This is a network of multiple frameworks that describe the effects of regulations and norms within institutions on individuals and bodies, such as Congress.
2. *Multiple-Streams Framework*: This framework lays out three streams or processes within policy development and implementation—the problems, the alternative solutions, and the politics. When these processes interact, large-scale policy change is possible.
3. *Punctuated-Equilibrium Framework*: This framework proposes that the policy process in the United States consists of quick, large policy changes interspersed throughout long periods of small policy changes. Dramatic policy changes are possible when proponents are able to market policy changes in new ways.
4. *Advocacy Coalition Framework*: This framework describes how advocacy coalitions—groups of individuals and institutions with shared policy goals—work within a political system.
5. *Policy Diffusion Framework*: This framework explains patterns in the widespread adoption of various policies by multiple independent bodies, such as the states of the United States.
6. *The Funnel of Causality and Other Frameworks in Large-N Comparative Studies*: These frameworks seek to analyze why policies have different effects in different states, based on factors such as local demographics, culture, and politics.

SADC Parliamentary Forum. 2008. "Model Law on HIV & AIDS in Southern Africa." Available at: http://www.unaidsrstesa.org/sites/default/files/humanrightsstigmaanddiscrimination/Model_Law_0.pdf.

Excerpt

The Model Law aims to

a. Provide a legal framework for the review and reform of national legislation related to HIV in conformity with international human rights law standards
b. Promote the implementation of effective prevention, treatment, care, and research strategies and programmes on HIV and AIDS
c. Ensure that the human rights of those vulnerable to HIV and people living with or affected by HIV are respected, protected, and realised in the response to AIDS
d. Stimulate the adoption of specific measures at the national level to address the needs of groups that are vulnerable or marginalised in the context of the AIDS epidemic

Shiffman, J. 2007. "Generating Political Priority for Maternal Mortality Reduction in 5 Developing Countries." *American Journal of Public Health* 97(5): 796–803.

Abstract

I conducted case studies on the level of political priority given to maternal mortality reduction in five countries: Guatemala, Honduras, India, Indonesia, and Nigeria. Among the factors that shaped political priority were international agency efforts to establish a global norm about the unacceptability of maternal death; those agencies' provision of financial and technical resources; the degree of cohesion among national safe motherhood policy communities; the presence of national political champions to promote the cause; the deployment of credible evidence to show policymakers a problem existed; the generation of clear policy alternatives to demonstrate the problem was surmountable; and the organization of attention-generating events to create national visibility for the issue. The experiences of these five countries offer guidance on how political priority can be generated for other health causes in developing countries.

Shiffman, J. 2004. "The Emergence of Political Priority for Safe Motherhood in Honduras." *Health Policy and Planning* 19(6): 380–390.

Abstract

Each year, an estimated 500,000 to 600,000 women die due to complications from childbirth, making it one of the leading causes of death globally for women in their reproductive years. In 1987, a global initiative was launched to address the problem, but few developing countries since then have experienced a documented significant decline in maternal mortality levels. Honduras represents an exception. Between 1990 and 1997, the country's maternal mortality ratio—the number of deaths due to complications during pregnancy, childbirth, and the postpartum period per 100,000 live births—declined 40 percent, from 182 to 108, one of the largest reductions ever documented in such a short time span in the developing world. This paper draws on three political science literatures—constructivist international relations theory, policy transfer, and agenda setting—to explain how political priority for safe motherhood emerged in Honduras, a factor that underpinned the decline. Central to the explanation is the unusually cooperative relationship that developed between international donors and national health officials, resulting in effective transfer of policy and institutionalization of the cause within the domestic political system. The paper draws out implications of the case for understanding the political dynamics of health priority generation in developing countries.

Surjadjaja, C. and S.H. Mayhew. 2011. "Can Policy Analysis Theories Predict and Inform Policy Change? Reflections on the Battle for Legal Abortion in Indonesia." *Health Policy and Planning* 26(5): 373–384.

Abstract

The relevance and importance of research for understanding policy processes and influencing policies have been much debated, but studies on the effectiveness of policy theories for predicting and informing opportunities for policy change (i.e., prospective policy analysis) are rare.

The case study presented in this paper is drawn from a policy analysis of a *contemporary* process of policy debate on legalization of abortion in Indonesia, which was in flux at the time of the research and provided a unique opportunity for prospective analysis. Applying a combination of policy analysis theories, this case study provides an analysis of processes, power, and relationships between actors involved in the amendment of the Health Law in Indonesia. It uses a series of practical stakeholder mapping tools to identify power relations between key actors and what strategic approaches should be employed to manage them to enhance the possibility of policy change.

The findings show how the moves to legalize abortion have been supported or constrained according to the balance of political and religious powers operating in a macro-political context defined increasingly

by a polarized Islamic-authoritarian versus Western-liberal agenda. The issue of reproductive health constituted a battlefield where these two ideologies met and the debate on the current health law amendment became a contest—one that still continues—for the larger future of Indonesia. The findings confirm the utility of policy analysis theories and stakeholder mapping tools for predicting the likelihood of policy change and informing the strategic approaches for achieving such change. They also highlight opportunities and dilemmas in prospective policy analysis and raise questions about whether research on policy processes and actors can or should be used to inform, or even influence, policies in "real time."

The United Republic of Tanzania Ministry of Health and Social Welfare (MOHSW) and the United States Agency for International Development (USAID). 2010. *National Family Planning Costed Implementation Plan: 2010–2015.*

Excerpt

Family planning has for several decades been well documented as a key strategy to promote social and economic development, and improve the health of women and their children. The National Road Map Strategic Plan to Accelerate Reduction of Maternal, Newborn, and Child Deaths in Tanzania, 2008–2015 (One Plan) has set a goal to increase the contraceptive prevalence rate (CPR) from 20 percent to 60 percent by 2015 by making quality FP services more accessible to and equitable for all of Tanzania's people. Increased use of family planning has great potential to contribute to the One Plan target of reducing maternal mortality from 578 to 193 per 100,000 live births by 2015. However, Tanzania's FP program has lost momentum over the past decade because of a number of factors. As a result, the national CPR for modern methods among married women of reproductive age at the time of the last Demographic and Health Survey (DHS) in 2004–2005 had reached only 20 percent, and the annual rate of growth in CPR had slowed from a high of 1.5 percentage points to 0.6 percentage points. With the current level of investment in family planning and the current rate of growth, the One Plan target will not be reached until 2030, with considerable negative consequences for the health and well-being of Tanzania's people, and increased challenges to the country's economic development. A recent study on National Health Accounts noted that expenditures for family planning had decreased drastically, from 54 percent of RH spending in 2003 to 8 percent in 2006. Tanzania must make deliberate efforts to rectify this situation. A renewed commitment to family planning, a reinvigorated program, and significant investment of resources are required to achieve the One Plan target.

2. POLICY IMPLEMENTATION

Once a policy is developed, it is critical to plan for the implementation of that policy, which often includes both technical and relational aspects—not only specifying the institutions responsible for implementation but also ensuring that the institutions have the capacity for implementation and that relationships among institutions are conducive for collaboration. The success of policy implementation can hinge upon many factors. The processes and related aspects of policy implementation are organized here into several sub-sections for clarity.

The first sub-section, *Institutions, Relationships, and Power Dynamics,* shows examples of the effects of interorganizational dynamics on policy implementation and examines how these relationships can be used to support policy implementation. This section explores the effectiveness of promoting local political participation and possible barriers to local empowerment within a specific country's context. It also suggests recognizing the influence of the individual politician over the political process. These power relations can greatly affect the equity and outcomes of policy implementation.

The sub-section on *Capacity* includes guidance on organizational and individual technical capacity to implement policy. It also describes relational capacity to work within interorganizational structures. Documents in this section cover topics such as building capacity within the government structure and administration, increasing provision of public goods, and influencing the supply chain by building provider knowledge of treatment policies, as well as the possible mechanisms that result in implementation failures.

The following sub-section on *Financing* highlights the importance of appropriate funding and resources in the policy implementation process. It outlines the influences that determine government health budgets and how the amount of resources required are estimated. Several articles document the various constraints and dilemmas that may arise in gaining health funding, and how to overcome these barriers. In cases where health programming is underfunded, some articles show how to achieve successful implementation by mobilizing alternative resources and making creative decisions as policy implementers.

In the sub-section on *Strategic Planning and Policy Barriers Analysis,* examples show how operational speed bumps on the way to policy implementation are often rooted in policy, and that strategic planning is a crucial step in minimizing policy barriers. Possibilities for overcoming barriers include creating demand for health policies through collaboration with pharmaceutical distributors, and embracing the role of nongovernmental organizations (NGOs) in the importation of health commodities. Other works document the societal and cultural attitudes and challenges that must be addressed in specific contexts. Last, the political climate will likely have a strong influence on the ease of policy making and the prevalence of conflict.

The last sub-section, *Monitoring and Accountability,* highlights how good governance and effective monitoring at all stages of the policy process generate strong positive outcomes regarding the success of policy implementation. These programs increase transparency, equity, and accountability in health programming. Increased accountability can also be achieved by increasing the conceptual clarity and relevance of proposed policies by many means, such as decentralization and public participation in the political process.

Author and title	Year of publication	Type of reference	Country of Focus
Health Policy Initiative, Task Order 1. *The Art of Moving from Policy to Action: Lessons Learned from the USAID | Health Policy Initiative (2005–2010)*	2010	Report	Global
Hill, M. and P. Hupe. *Implementing Public Policy*	2009	Book	Global
Mazmanian, D. and P. Sabatier. *Implementation and Public Policy*	1983	Book	Global
Institutions, Relationships, and Power Dynamics			
Atkinson, S., R.L.R. Medeiros, P.H.L. Oliveira, and R.D. de Almeida. "Going Down to Local: Incorporating Social Organisation and Political Culture into Assessments of Decentralised Health Care"	2000	Journal article	Brazil
Balabanova, D., M. McKee, A. Mills, G. Walt, and A. Haines. "What Can Global Health Institutions Do to Help Strengthen Health Systems in Low Income Countries?"	2010	Journal article	Global
Behague, D.P. and K.T. Storeng. "Collapsing the Vertical-Horizontal Divide: An Ethnographic Study of Evidence-based Policymaking in Maternal Health"	2008	Journal article	Global
Brinkerhoff, D.W. and T.J. Bossert. *Health Governance: Concepts, Experience, and Programming Options*	2008	Report	Global
Burris, H., J. Parkhurst, Y. Adu-Sarkodie, and P. Mayaud. "Getting Research into Policy—Herpes Simplex Virus Type-2 (HSV-2) Treatment and HIV Infection: International Guidelines Formulation and the Case of Ghana"	2009	Journal article	Ghana
Erasmus, E. and L. Gilson. "How to Start Thinking About Investigating Power in the Organizational Settings of Policy Implementation"	2008	Journal article	Global
Exworthy, M. and M. Powell. 2004. "Big Windows and Little Windows: Implementation in the 'Congested State'"	2004	Journal article	Global
Hosman, C.H.M. "Prevention and Health Promotion on the International Scene: The Need for a More Effective and Comprehensive Approach"	2000	Journal article	Global
Jain, A., ed. *Do Population Policies Matter? Fertility and Politics in Egypt, India, Kenya, and Mexico*	1998	Report	Egypt, India, Kenya, Mexico
Khresheh, R. and L. Barclay. "Practice-Research Engagement (PRE): Jordanian Experience in Three Ministry of Health Hospitals"	2007	Journal article	Jordan
Klein, K.J. and A.P. Knight. "Innovation Implementation: Overcoming the Challenge"	2005	Journal article	Global

Author and title	Year of publication	Type of reference	Country of Focus
Lee, K., L. Lush, G. Walt, and J. Cleland. "Family Planning Policies and Programmes in Eight Low-Income Countries: A Comparative Policy Analysis"	1998	Journal article	Bangladesh, Pakistan, Thailand, Philippines, Tunisia, Algeria, Zimbabwe, Zambia
Lehmann, U. and L. Gilson. "Actor Interfaces and Practices of Power in a Community Health Worker Programme: A South African Study of Unintended Policy Outcomes"	2012	Journal article	South Africa
Lipsky, M. *Street-level Bureaucracy: The Dilemmas of the Individual in Public Services*	2010	Book	Global
Matland, R. "Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation"	1995	Journal article	Global
McIntyre, D. and B. Klugman. "The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa"	2003	Journal article	South Africa
O'Toole, L. "Interorganizational Relations and Policy Implementation"	2007	Book chapter	Global
Reichenbach, L. and M.J. Roseman. *Reproductive Health and Human Rights: The Way Forward*	2009	Book	Global
Sabatier, P.A. "Top-down and Bottom-up Approaches to Implementation Research: A Critical Analysis and Suggested Synthesis"	1986	Journal article	Global
Say, L. and D. Chou. *Universal Access to Reproductive Health. Accelerated Actions to Enhance Progress on Millennium Development Goal 5 Through Advancing Target 5B*	2011	Report	Brazil, Cambodia, India, Morocco, United Republic of Tanzania, Uzbekistan, Zambia
Sheikh, K. and J. Porter. "Discursive Gaps in the Implementation of Public Health Policy Guidelines in India: The Case of HIV Testing"	2010	Journal article	India
Simwaka, L.K. *How Power Relations Affect the Implementation of Policy on Equity in Access to Anti-Retroviral Therapy: The Case of Rural Health Centres in Malawi*	2008	Report	Malawi
Sine, J., M.E. Clyde, and Z. Baser. *A Political Economy Perspective on Achieving Contraceptive Self-Reliance in Turkey*	2004	Report	Turkey
Walker, L. and L. Gilson. "'We Are Bitter but We Are Satisfied': Nurses as Street-level Bureaucrats in South Africa"	2004	Journal article	South Africa
Capacity			
Baser, H., P. Morgan, J. Bolger, D. Brinkerhoff, A. Land, et al. *Capacity, Change and Performance*	2008	Report	Global

Author and title	Year of publication	Type of reference	Country of Focus
ECDPM. *Capacity Change and Performance: Insights and Implications for Development Cooperation*	2008	Report	Global
Fukuyama, F. *What Is Governance?*	2013	Report	Global
Gilson, L. and N. Raphaely. "The Terrain of Health Policy Analysis in Low and Middle Income Countries: A Review of Published Literature 1994–2007"	2008	Journal article	Global
Gleeson, D.H., D.G. Legge, and D. O'Neill. "Evaluating Health Policy Capacity: Learning from International and Australian Experience"	2009	Journal article	Australia
Grindle, M. "Modernising Town Hall: Capacity Building with a Political Twist"	2006	Journal article	Global
Grindle, M. and M. Hilderbrand. "Building Sustainable Capacity in the Public Sector: What Can Be Done"	1995	Journal article	Global
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Morrow, M., Q. Nguyen, S. Caruana, B. Biggs, N. Doan, et al. "Pathways to Malaria Persistence in Remote Central Vietnam: A Mixed-Method Study of Health Care and the Community"	2009	Journal article	Vietnam
National Academy of Sciences (NAS). *In Search of Population Policy: Views from the Developing World*	1974	Book	Global
Organisation for Economic Co-operation and Development (OECD). *The Challenge of Capacity Development: Working Towards Good Practice*	2006	Report	Global
Organisation for Economic Co-Operation and Development (OECD/DAC). *Sector Capacity Development*	2011	Report	Global
Potter C. and R. Brough. "Systemic Capacity Building: A Hierarchy of Needs"	2004	Journal article	Global
Pritchett, L., M. Woolcock, and M. Andrews. *Capability Traps? The Mechanisms of Persistent Implementation Failure*	2010	Report	Global
Richter, L. "Riding the Pendulum Between 'Clocks' and 'Clouds': The History of OD and its Relation to CD, In Capacity Development"	2010	Book chapter	Global
Watsierah C., R. Onyango, J. Ombaka, B. Abong'o, and C. Ouma. "Provider Knowledge of Treatment Policy and Dosing Regimen with Artemether-lumefantrine and Quinine in Malaria-endemic Areas of Western Kenya"	2012	Journal article	Kenya

Author and title	Year of publication	Type of reference	Country of Focus
Financing			
Awoonor-Williams J., E. Sory, F. Nyonator, J. Phillips, C. Wang, et al. "Lessons Learned from Scaling Up a Community-based Health Program in the Upper East Region of Northern Ghana"	2013	Journal article	Ghana
Balabanova, D., L. Conteh, and M. McKee. "The Contribution of Health Systems to Good Health." Chapter 9, edited by D. Balabanova, M. McKee, and A. Mills.	2011	Book chapter	Global
Brugha, R., M. Donoghue, M. Starling, P. Ndubani, F. Ssengooba, et al. "The Global Fund: Managing Great Expectations"	2004	Journal article	Mozambique, Tanzania, Uganda, Zambia
Burjari, P. and E. McGinn. *Influencing Government Health Budgets in Tanzania: A Guide for Civil Society*	2013	Report	Tanzania
Chen, L.C. "Good Health at Low Cost: From Slogan to Wicked Problem"	2011	Journal article	Global
FP Ouagadougou Partnership. *Family Planning: Francophone West Africa on the Move: A Call to Action*		Report	West Africa
Ghana National Population Council, Health Policy Project, and UK Department for International Development. *Estimating the Resources Required to Achieve Family Planning Targets in Ghana*	2012	Report	Ghana
Gilson, L., D. Kalyalya, F. Kuchler, S. Lake, H. Oranga, et al. "Strategies for Promoting Equity: Experience with Community Financing in Three African Countries"	2001	Journal article	Benin, Kenya, and Zambia
Health Policy Project. *The GAP Tool and Applications in Ethiopia and Nigeria*	2011	Tool	Ethiopia and Nigeria
King, G., E. Gakidou, K. Imai, R. Moore, C. Nail, et al. "Public Policy for the Poor? A Randomised Assessment of the Mexican Universal Health Insurance Programme"	2009	Journal article	Mexico
Ndavi, P.M., S. Ogola, P. Kizito, and K. Johnson. *Decentralizing Kenya's Health Management System: An Evaluation*	2009	Report	Kenya
Oronje, R.N., J. Crichton, S. Theobald, N.O. Lithur, and L. Ibisomi. "Operationalising Sexual and Reproductive Health and Rights in sub-Saharan Africa: Constraints, Dilemmas and Strategies"	2011	Journal article	sub-Saharan Africa
USAID/Health Policy Initiative, Task Order 1 and the USAID | DELIVER PROJECT, Task Order 1. *Assessing Policies and Practices that Affect Contraceptive Financing and Procurement: A Review Guide*	2010	Report	Global

Author and title	Year of publication	Type of reference	Country of Focus
Strategic Planning and Policy Barriers Analysis			
Ahmed, H.M., M. Mitchell, and B. Hedt. "National Implementation of Integrated Management of Childhood Illness (IMCI): Policy Constraints and Strategies"	2010	Journal article	Global
Blaauw, D., E. Erasmus, N. Pagaiya, V. Tangcharoensathein, K. Mullei, et al. "Policy Interventions that Attract Nurses to Rural Areas: A Multicountry Discrete Choice Experiment"	2010	Journal article	Kenya, South Africa, Thailand
Brinkerhoff, D. *Implementing Policy Change: A Summary of Lessons Learned*	1996	Report	Global
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Buse, K., N. Lalji, S. Mayhew, M. Imran, and S. Hawkes. "Political Feasibility of Scaling-up Five Evidence-informed HIV Interventions in Pakistan: A Policy Analysis"	2010	Journal article	Pakistan
Cross, H., K. Hardee, and N. Jewell. *Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs*	2001	Report	Global
Date, A., M. Vitoria, R. Granich, M. Banda, M. Fox, et al. "Implementation of Co-trimoxazole Prophylaxis and Isoniazid Preventive Therapy for People Living with HIV"	2010	Journal article	Global
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Duc, T., D. Stephens, K. Spratt, N. Kapadia-Kundu, and H. Tran. *Contrasting the Process of OVC Policy Development and Policy Implementation in Vietnam: Results from a Study on Barriers to Policy Implementation*		Report	Vietnam
Feranil, I. and M. Borda. *Achieving Uttar Pradesh's Population Policy Goals Through Demand-based Family Planning Programs: Taking Stock at the Mid-Point*	2008	Report	India
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Getahun, H. and H. Eshete. *Macro-level Operational Barriers to Family Planning Services in Ethiopia: Taxation and Importation of Contraceptives and the Role of NGOs*	2003	Report	Ethiopia

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Green, A., N. Gerein, T. Mirzoev, P. Bird, S. Pearson, et al. "Health Policy Processes in Maternal Health: A Comparison of Vietnam, India and China"	2011	Journal article	Vietnam, India, China
Health Policy Initiative and DELIVER Project. *Analysis of the Operational Policy Barriers to Financing and Procuring Contraceptives in Malawi*	2008	Report	Malawi
Hunsmann, M. "Limits to Evidence-based Health Policymaking: Policy Hurdles to Structural HIV Prevention in Tanzania"	2012	Journal article	Tanzania
Islam, M. (ed.). *Health Systems Assessment Approach: A How-to Manual*	2007	Tool	Global
National Institute for Health and Clinical Excellence. *How to Change Practice: Understand, Identify and Overcome Barriers to Change*	2007	Report	Global
Ngabaza, S. and T. Shefer. "Policy Commitments vs. Lived Realities of Young Pregnant Women and Mothers in School, Western Cape, South Africa"	2013	Journal article	South Africa
Okundi, B., C. Aloo-Obunga, R. Sanders, C. Shepherd, and C. Green. *Rapid Assessment on Policy and Operational Barriers to the Integration of FP/RH/HIV Services in Kenya*	2008	Report	Kenya
Peters, D., L. Paina, and S. Bennett. "Expecting the Unexpected: Applying the Develop-Distort Dilemma to Maximize Positive Market Impacts in Health"	2012	Journal article	Bangladesh, China, Uganda
Policy Project. *Core Package Final Report: Determining the Feasibility and Potential Scope of Integrating Reproductive Health (FP/MCH/STI/HIV/AIDS) Services in Jamaica*	2005	Report	Jamaica
Rechel, B. "HIV/AIDS in the Countries of the Former Soviet Union: Societal and Attitudinal Challenges"	2010	Journal article	Former Soviet Union
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Sonneveldt, E., T. Shaver, and A. Bhuyan. *Understanding Operational Barriers to Family Planning Services in Conflict-affected Countries: Experiences from Sierra Leone*	2008	Report	Sierra Leone

Author and title	Year of publication	Type of reference	Country of Focus
Spratt, K. *Policy Implementation Barriers Analysis: Conceptual Framework and Pilot Test in Three Countries*	2009	Report	China, Indonesia, Vietnam
Thomas, J.W. and M.S. Grindle. "After the Decision: Implementing Policy Reforms in Developing Countries"	1990	Journal article	Global
Walt, G. and L. Gilson. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis"	1994	Journal article	Global
Monitoring and Accountability			
Bhuiya, A., S.M.A. Hanifi, and S.S. Mahmood. "Action Monitoring for Equity and Gender in Health"	2008	Journal article	Bangladesh
Brinkerhoff, D. "Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance"	2004	Journal article	Global
Chambers, V. *Improving Maternal Health when Resources Are Limited: Safe Motherhood in Rural Rwanda*	2012	Report	Rwanda
Dennis, S. *Making Aid Effectiveness Work for Family Planning and Reproductive Health*	2009	Report	Global
Health Systems 2020. *Health Systems 20/20 and Measuring and Monitoring Health System Performance*	2012	Report	Global
Judice, N.R., J. Lane, E. Hunger. N. Wallace, R. MacInnis, et al. *Monitoring HIV Policy Interventions in PEPFAR Partnership Frameworks*	2012	Report	Global
Judice, N. and O. Zaglada. *Assessment of HIV Policy Development and Implementation in Ukraine*	2012	Report	Ukraine
Kickbush, I. "The Development of International Health Policies—Accountability Intact"	2000	Journal article	Global
Maluka, S. "Strengthening Fairness, Transparency and Accountability in Health Care Priority Setting at District Level in Tanzania"	2001	Journal article	Tanzania
McGee, R. and J. Gaventa. *Review of Impact and Effectiveness of Transparency and Accountability Initiatives: Synthesis Report*	2010	Report	Global
Merino, L. *Keeping Watch: Accountability for FP/RH Laws in Guatemala*	2010	Report	Guatemala
Ogden J., K. Morrison, and K. Hardee. "Social Capital to Strengthen Health Policy and Health Systems"	2014	Journal article	Global

Author and title	Year of publication	Type of reference	Country of Focus
POLICY Project. *Health Reform, Decentralization and Participation in Latin America: Protecting Sexual and Reproductive Health*	2000	Report	Bolivia, Peru, Mexico, Guatemala
WHO. *Every Woman, Every Child: From Commitments to Action. The First Report of the Independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health*	2012	Report	Global
UN. *Integrated Implementation Framework*	2013	Report	Global
USAID. *Monitoring the Policy Reform Process. Recent Practices in Monitoring and Evaluation TIPS*	2000	Report	Global

Health Policy Initiative, Task Order 1. *The Art of Moving from Policy to Action: Lessons Learned from the USAID | Health Policy Initiative (2005–2010)*. 2010. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Excerpt

Good health policies and strategies are important but not sufficient; they must be put into practice. Despite a growing body of literature on policy implementation, understanding how best to implement policies remains a challenge in real-world settings. The aim of this paper is to demystify "policy implementation" and provide user-friendly advice on translating policies into action. To do so, the paper presents experiences and lessons learned from the USAID | Health Policy Initiative, Task Order 1, organized around the project's Policy-to-Action Framework. The framework recognizes that moving from policy to action is a dynamic, iterative process that unfolds differently in different contexts. In practice, the interdependent elements must be mixed together—sometimes out of sequence, often many elements at once, and over and over again—to achieve effective policy implementation. Also, while implementation involves elements that should be carried out in a more methodical way, bringing all of the elements together is indeed an art. It requires understanding policy issues, the context, and stakeholders; anticipating potential roadblocks; seizing windows of opportunity; and building and sustaining commitment, capacity, and resources over time.

Hill, M. and P. Hupe. 2009. *Implementing Public Policy. 2nd Edition*. Los Angeles, CA: Sage.

Summary of Book (self-written)

The field of public policy implementation has been debated and developed for decades, and implementation remains a heavily discussed topic in the literature today. Hill and Hupe keep the following four facts in mind to drive their discussion of this literature:

1. Implementation was discussed and analyzed before it became a popular idea.
2. The issue of implementation applies to workers in a variety of fields.
3. The idea of implementation is often examined in useful ways in the literature without the use of the term "implementation."
4. The process of implementation is altered to fit the local cultural context and include workers from various sectors. This involves the expansion from a focus on government to governance, in which a more holistic approach is taken to implement public policy.

Mazmanian, D. and P. Sabatier. 1983. *Implementation and Public Policy*. Glencoe, IL: Scott, Foresman.

Summary of Book (self-written)

Mazmanian and Sabatier explain the process of policy implementation using a five-step framework. They examine the following case studies to demonstrate each step: clean air, school desegregation, new towns, compensatory education, and coastal zone management. In the clean air case study, the authors examine the assumption that reducing sulfur emissions will improve public health outcomes, based on more assumptions that sulfur emissions can be easily reduced and have been proven to lead to poor health. In the school desegregation study, the authors highlight the difficulty of regulating a behavior that is unprecedented or different from other usual behaviors. In the case of a new town, they explain how smaller and more unique populations make it easier to change a behavior with public policy. Regarding compensatory education, they point out the difficulty of changing behavior when both the target population and the extent of the change are large. Finally, in discussing coastal zone management, the authors discuss the difficulty of implementing a policy if the implementing bodies are unwilling or uncommitted.

Institutions, Relationships, and Power Dynamics

Atkinson, S., R.L.R. Medeiros, P.H.L. Oliveira, and R.D. de Almeida. 2000. "Going Down to Local: Incorporating Social Organisation and Political Culture into Assessments of Decentralised Health Care." *Social Science & Medicine* 51(4): 619–636.

Abstract

The social organization, and political culture of the society in which an organisation is embedded, can have major effects on the way in which organisational policy is implemented and on how that organisation functions. Research on health sector reforms has paid scant attention to this aspect. If the claims made for decentralised management in the health sector are to be evaluated seriously, it is critical to develop concepts and methods to evaluate not only the formal organisation and the outputs of the health system, but also the aspects of local social organisation and political culture within which that local health system is embedded that may mediate their relationship.

This paper explores three cases of district health systems in Northeast Brazil to identify aspects of local social organisation and political culture that appear to influence the implementation of the reforms and thereby potentially impact upon the quality of the care provided. The results of the study indicate the importance that aspects of local social organisation and political culture may exert on the operations of a decentralised health system. Key aspects identified are the space for autonomy, the space for local voice in political life, personalised and institutionalised influences on autonomy and local voice, differences of involvement of health staff with the district, and different spaces of acceptable practice and accountability.

These factors are seen to moderate the intent of the health reforms at all stages in their implementation. Three possibilities are discussed for the nature of the interaction regarding cause and effect between the formal organisation of the health system and its local context. Seeing this relationship as one of dialogue offers some cautious optimism for the potential of the reform agenda. The paper ends with suggestions on how to take this line of research forward.

Balabanova, D., M. McKee, A. Mills, G. Walt, and A. Haines. 2010. "What Can Global Health Institutions Do to Help Strengthen Health Systems in Low Income Countries?" *Health Research Policy and Systems* 8(22): 11 pages.

Abstract

Weaknesses in health systems contribute to a failure to improve health outcomes in developing countries, despite increased official development assistance. Changes in the demands on health systems, as well as their scope to respond, mean that the situation is likely to become more problematic in the future. Diverse global initiatives seek to strengthen health systems, but progress will require better coordination between them; use of strategies based on the best available evidence, especially that obtained from evaluation of large-scale programs; and improved global aid architecture that supports these processes. This paper sets out the case for global leadership to support health systems investments and help ensure the synergies between the vertical and horizontal programs essential for the effective functioning of health systems. At a national level, it is essential to increase capacity to manage and deliver services, situate interventions firmly within national strategies, ensure effective implementation, and coordinate external support with local resources. Health systems performance should be monitored, with clear lines of accountability, and reforms should build on evidence of what works in what circumstances.

Behague, D.P. and K.T. Storeng. 2008. "Collapsing the Vertical-Horizontal Divide: An Ethnographic Study of Evidence-based Policymaking in Maternal Health." *American Journal of Public Health* 98(4):644–649.

Abstract

Using the international maternal health field as a case study, we draw on ethnographic research to investigate how public health researchers and policy experts are responding to tensions between vertical and horizontal approaches to health improvement. Despite nominal support for an integrative health system approach, we found that competition for funds and international recognition pushes professionals toward vertical initiatives. We also highlight how research practices contribute to the dominance of vertical strategies and limit the success of evidence-based policy making for strengthening health systems. Rather than support disease- and subfield-specific advocacy, the public health community urgently needs to engage in open dialogue regarding the international, academic, and donor-driven forces that drive professionals toward an exclusive interest in vertical programs.

Brinkerhoff, D.W. and T.J. Bossert. 2008. *Health Governance: Concepts, Experience, and Programming Options*. Washington, DC: U.S. Agency for International Development; Health Systems 20/20, Policy Brief.

Abstract

This policy brief produced by USAID provides an overview of governance in health systems. This refers to developing and putting in place effective rules for policies, programmes, and activities related to fulfilling public health functions. The paper identifies health governance issues and challenges, and reviews some experience with interventions to improve health governance. Interventions aimed to improve the policy process in the health sector by promoting more effective stakeholder engagement; enhancing participation at a variety of levels to promote more effective governance of health programmes; improving accountability and transparency; and reducing corruption in the health sector.

The paper concludes that good health governance emerges from the actions and linkages among the state, providers of health services, and citizens. Health governance improvements—through their impacts on rules, roles, responsibilities, and institutions—affect the availability, quality, distribution, and utilization of health services. Efforts to increase the quality of health governance constitute worthwhile and effective undertakings for improving health systems functioning and increasing the provision and utilization of health services.

Burris, H., J. Parkhurst, Y. Adu-Sarkodie, and P. Mayaud. 2009. "Getting Research into Policy—Herpes Simplex Virus Type-2 (HSV-2) Treatment and HIV Infection: International Guidelines Formulation and the Case of Ghana." *Health Research Policy and Systems* 9(Suppl 1): S5

Abstract

Background: Observational epidemiological and biological data indicate clear synergies between herpes simplex virus type 2 (HSV-2) and HIV, whereby HSV-2 enhances the potential for HIV acquisition or transmission. In 2001, the World Health Organization (WHO) launched a call for research into the possibilities of disrupting this cofactor effect through the use of antiherpetic therapy. A WHO Expert Meeting was convened in 2008 to review the research results. The results of the trials mostly were inconclusive or showed no impact. However, the WHO syndromic management treatment guidelines were modified to include acyclovir as first-line therapy to treat genital ulcer disease on the basis of the high prevalence of HSV-2 in most settings, the impact and cost-benefit of treatment on ulcer healing, and quality of life among patients.

Methods: This paper examines the process through which the evidence related to HIV–HSV-2

interactions influenced policy at the international level and then the mechanism of international to national policy transfer, with Ghana as a case study. To better understand the context within which national policy change occurs, special attention was paid to the relationships between researchers and policymakers as integral to the process of getting evidence into policy. Data from this study were then collected through interviews conducted with researchers, program managers, and policymakers working in sexual health/sexually transmitted infections (STIs) at the 2008 WHO Expert Meeting in Montreux, Switzerland, and Accra, Ghana.

Results: The major findings of this study indicate that investigations into HSV-2 as a cofactor of HIV generated the political will necessary to reform HSV-2 treatment policy. Playing a pivotal role at both the international level and within the Ghanaian policy context were "policy networks," formed either formally (WHO) or informally (Ghana) around an issue area. These networks of professionals serve as the primary conduit of information between researchers and policymakers. Donor influence was cited as the single strongest impetus for and impediment to policy change nationally.

Conclusions: Policy networks may serve as the primary driving force of change in both the international context and the case of Ghana. Communication among researchers and policymakers is critical for uptake of evidence, and opportunities may exist to formalize policy networks and engage donors in a productive and ethical way.

Erasmus, E. and L. Gilson, L. 2008. "How to Start Thinking about Investigating Power in the Organizational Settings of Policy Implementation." *Health Policy and Planning* 23(5): 361–368.

Abstract

Power, a concept at the heart of the health policy process, surprisingly is rarely considered explicitly in the health policy implementation literature for low- and middle-income countries. In an attempt to support empirical research on power, this paper outlines some of the key insights on power from implementation theory. It then describes examples of power that might be seen in health policy implementation settings, such as hospitals, clinics, and the local bureaucracies in which these are embedded, and concludes with suggestions for ways of investigating power and ensuring that sound judgments are made about its existence and influence over policy implementation.

Exworthy, M. and M. Powell. 2004. "Big Windows and Little Windows: Implementation in the 'Congested State'." *Public Administration* 82(2): 263–281.

Abstract

This paper argues for the need to reassess models of policy implementation in the "congested state." This reappraisal focuses on two main directions. The first involves locating implementation in the context of wider models of the policy process. We fuse three models—those of Kingdon, Wolman, and Challis et al.—to form a new "policy streams" approach. The second examines implementation in multi-level governance. In the UK and elsewhere, much of the focus of traditional implementation studies has been on the link between one central government department and a local agency. However, this vertical (central-local) dimension fails to give sufficient stress to the other horizontal dimensions of "central-central" and "local-local." Paraphrasing Kingdon's terms, implementation models also need to incorporate the "little windows" at the local level as well as the "big" windows at the national level. Using evidence relating to the implementation of UK policy towards health inequalities, this paper argues that successful implementation is more likely when the three policy streams are linked across the three dimensions. The model is thought to be applicable to other areas of the public sectors and the complex issues facing all governments.

Hosman, C.H.M. 2000. "Prevention and Health Promotion on the International Scene: The Need for a More Effective and Comprehensive Approach." *Addictive Behaviors* 25, 943–954.

Abstract

The last decade has seen a boom in international networks and projects in health promotion and prevention. The growth of international collaboration is considered to be of crucial importance for the future development of the field. In this paper, the author discusses several arguments in support of a further expansion of collaboration across countries and regions. Hosman criticizes the current lack of effectiveness in international collaboration in health promotion and prevention, and identifies the main barriers to effective collaboration. To make significant progress in research, evidence-based programs and policies, and their implementation worldwide, the creation of a comprehensive system of functional and effective linkages is needed across the core task areas, across disciplines, across system levels, and across countries and cultures. The quality of prevention and health promotion research, as well as its impact on the health of communities, depends on the degree to which research institutes and other stakeholders are embedded in an effective network of interorganizational and international relationships capable of performing a broad range of essential and functionally related tasks. It is critical that the dynamics of effective international collaboration become a legitimate subject of prevention and health promotion science.

Jain, A., ed. 1998. *Do Population Policies Matter? Fertility and Politics in Egypt, India, Kenya, and Mexico*. New York: Population Council.

Summary of Book (self-written)

The implementation of effective population policy is central to the promotion of public health, particularly in developing countries. International organizations have long sought to influence public discourse and political action surrounding population policy, to varying effect.

The case studies of four countries with large populations and successful population policies—Egypt, India, Kenya, and Mexico—serve to illustrate the main issues surrounding the implementation of population policy. These issues include the processes and actors involved in implementing policy, as well as the relationship between local and international entities. Each case study was developed by one or more local investigators with deep personal knowledge of the country.

Khresheh, R. and L. Barclay. 2007. "Practice-Research Engagement (PRE): Jordanian Experience in Three Ministry of Health Hospitals." *Action Research* 5(2):123–138.

Abstract

This article describes the practice-research engagement (PRE) that occurred during an action research project conducted in three hospitals in Jordan. The project aimed to develop and test the feasibility of an improved clinical record-keeping system. This article focuses on how relationships with national and local leaders and practitioners were built and evolved over time to facilitate the study, and how this led to a process of health system improvement. The article draws on outcomes and analyses from data collected in field notes, recorded interviews, and focus groups. Results showed that the PRE approach assisted people to change as they undertook a process of clinical improvement and health systems development.

Klein, K.J. and A.P. Knight. 2005. "Innovation Implementation: Overcoming the Challenge." *Current Directions in Psychological Science* 14(5): 243–246.

Abstract

In changing work environments, innovation is imperative. Yet, many teams and organizations fail to realize the expected benefits of the innovations they adopt. A key reason is not innovation failure but implementation failure—the failure to gain targeted employees' skilled, consistent, and committed use of

the innovation in question. In this article, we review research on the implementation process, outlining the reasons why implementation is so challenging for many teams and organizations. We then describe the organizational characteristics that together enhance the likelihood of successful implementation, including a strong, positive climate for implementation; management support for innovation implementation; financial resource availability; and a learning orientation.

Lee, K., L. Lush, G. Walt, and J. Cleland. 1998. "Family Planning Policies and Programmes in Eight Low-Income Countries: A Comparative Policy Analysis." *Social Science and Medicine* 47(7): 949–959.

Abstract

The extent to which family planning programmes are successful in reducing fertility remains a major debate among population scholars. A comparative policy analysis of four pairs of low-income countries (Bangladesh/Pakistan, Thailand/Philippines, Tunisia/Algeria, and Zimbabwe/Zambia) was done to understand why some countries develop appropriate and effective programmes, whereas others do not. The study found that the formation of coalitions among policy elites, the spread of policy risk, and institutional and financial stability were factors that supported or inhibited the adoption of strong population policies and family planning programmes.

Lehmann, U. and L. Gilson. 2012. "Actor Interfaces and Practices of Power in a Community Health Worker Programme: A South African Study of Unintended Policy Outcomes." *Health Policy and Planning* 1–9.

Abstract

This paper makes a contribution to a much-neglected aspect of policy analysis: the practice of power in implementation. Practices of power are at the heart of every policy process and yet are rarely explicitly explored in the health policy literature. This paper provides a detailed study of micro-practices of power by those at the front line of service delivery in the implementation of a national community health worker policy in one rural South African sub-district. The paper is based on a small-scale qualitative study that collected data through observations, interviews, and focus group discussions with health services and facility managers, community health workers, and community members. Practices of power were analysed using VeneKlasen and Miller's categorization of multiple dimensions of power, as power over, power with, power to, and power within. Furthermore, the concept of "actor interface analysis" allowed exploration of different actors' experiences, interests, and their specific location in the landscape of local health system governance. The study revealed that almost all policy actors exercised some form of power—from authoritative power, derived from hierarchy and budget control, to the discretionary power of those working at lower levels to withhold labour or organize in-service training. Each of these practices of power had their rationale in different actors' efforts to make the intervention "fit" their understandings of local reality. Whereas each had a limited impact on policy outcomes, their cumulative effect produced a significant thinning down of the policy's intent. However, discretionary power was not always used to undermine policy. One manager's use of discretionary power in fact led to a partial reconstruction of the original policy intent. The paper concludes that understanding and being responsive to the complexity of local realities, interests, and contexts, and the multi-layered practices of power may allow managers to adopt more appropriate management strategies.

Lipsky, M. 2010. *Street-level Bureaucracy: The Dilemmas of the Individual in Public Services, 30th Anniversary Expanded Edition.* New York: Russell Sage Foundation.

Summary of Book (self-written)

In this 30th-anniversary edition of *Street-level Bureaucracy,* Michael Lipsky expands upon the role of street-level bureaucrats in policy development in today's world. He defines street-level bureaucrats as those public service workers—such as police officers, social workers, and teachers—who work on the

front lines of public policy and directly affect the success or failure of policy implementation. Although many consider these public servants to be a barrier between government objectives and public outcomes, Lipsky posits that these workers can be useful and positive forces in policy implementation. They are expected to handle difficult situations on a case-by-case basis with little guidance and few resources, Lipsky argues. As a result, many must skimp on quality and individualized attention to account for quantity, leaving clients unsatisfied and policies implemented incorrectly. Lipsky concludes with examples of successful management of street-level bureaucrats and an optimistic argument for the possibility of successful policy implementation despite these obstacles.

Matland, R. 1995. "Synthesizing the Implementation Literature: The Ambiguity-Conflict Model of Policy Implementation." *Journal of Public Administration Research and Theory: J-PART* 5(2): 145–174.

Abstract

A review of the policy implementation literature finds the field split into two major schools—top-down and bottom-up. This paper describes previous attempts to reconcile these models, followed by an alternative model. This model reconciles these approaches by concentrating on the theoretical significance of ambiguity and conflict for policy implementation. The paper identifies a number of factors crucial to the implementation process as varyingly dependent on a policy''s ambiguity and conflict level. It then identifies four policy implementation paradigms, and discusses the relevance of the existing literature to these conditions. The four paradigms are low conflict-low ambiguity (administrative implementation), high conflict-low ambiguity (political implementation), high conflict-high ambiguity (symbolic implementation), and low conflict-high ambiguity (experimental implementation).

McIntyre, D. and B. Klugman. 2003. "The Human Face of Decentralisation and Integration of Health Services: Experience from South Africa." *Reproductive Health Matters* 11(21): 108–119.

Abstract

This paper explores the processes of policy making, budgeting, and service implementation in three provinces of South Africa, drawing on interviews with health managers at different levels of government. It illustrates how the process of decentralisation creates disjunctures between the policy-making authority of higher levels of government and the implementation capacity of service provision levels. It also explores the complex dynamics between those responsible for specific policies, such as reproductive health policies, and those responsible for managing the integrated delivery of all policies, with their resultant contestations over authority and resources. The pace of change in South Africa, and the enormous capacity it requires—both in relation to financial management and the technical skills needed for specific programmes—has created a sense of frustration and demoralisation. Whilst shortage of financial resources, particularly as reflected in shortage of staff, is frequently assumed to be the biggest constraint in this context, most managers identified other issues, particularly staff morale, as greater barriers to the delivery of high-quality health services. The paper concludes that it is the complexity of experience and feelings described by health managers that may determine the extent and quality of service delivery. For this reason, both practice and research need to give greater attention to issues of power relations and personal experience of change.

O'Toole, L. 2007. "Interorganizational Relations and Policy Implementation." In *Handbook of Public Administration: Concise Paperback Edition.* Thousand Oaks, CA: SAGE Publications.

Summary of Chapter (self-written)

Policy implementation is most difficult when attempted on an interorganizational front. In this chapter of *Handbook of Public Administration*, O'Toole describes the policy implementation process from the

interorganizational standpoint and examines how institutional relationships affect policy implementation. He emphasizes that those in charge of managing the policy process must learn to thrive in the unavoidable interorganizational setting and provides practical recommendations for doing so.

Reichenbach, L. and M.J. Roseman. 2009. *Reproductive Health and Human Rights: The Way Forward.* Philadelphia, PA: University of Pennsylvania Press.

Summary of Book (self-written)

This book critically reflects on the past 15 years of international efforts aimed at improving health, alleviating poverty, diminishing gender inequality, and promoting human rights. It includes essays by leading scholars and practitioners, centered on the 1994 United Nations International Conference on Population and Development (ICPD) and its resulting Programme of Action. ICPD, an agreement among 179 governments, UN agencies, and NGOs, was intended to shape population and development policy—reinterpreted and redefined as "reproductive health." More than a decade after the enthusiasm that accompanied ICPD, there is growing concern about its effectiveness in the context of global health and development. *Reproductive Health and Human Rights* addresses that concern.

The book grapples with fundamental questions about the relationships among population, fertility decline, reproductive health, human rights, poverty alleviation, and development, and assesses the various arguments—demographic, public health, human rights-based, and economic—for and against ICPD today.

A number of the chapters address institutional challenges to ICPD and consider how the changing political, religious, academic, and disciplinary contexts matter. Other chapters engage operational and conceptual issues, and whether ICPD has been able to move the reproductive health agenda forward on topics such as maternal mortality, abortion, HIV/AIDS, adolescents, reproductive technologies, and demography. Finally, several chapters examine how ICPD has been sidelined by emerging health and development agendas, and what could be done in response. Unlike any book yet published, *Reproductive Health and Human Rights: The Way Forward* examines the state of the arguments for reproductive health and rights from a multidisciplinary perspective that provides policymakers, scholars, and activists with a better understanding of how reproductive health and rights have developed, their place in the global policy agenda, and how they might evolve most effectively in the future.

Sabatier, Paul A. 1986. "Top-down and Bottom-up Approaches to Implementation Research: A Critical Analysis and Suggested Synthesis." *Journal of Public Policy* 6: 21–48. doi:10.1017/S0143814X00003846.

Abstract

This paper first reviews the implementation literature of the past 15 years, with particular emphasis on the relative strengths and weaknesses of the "top-down" and "bottom-up" approaches. It also argues that the four- to six-year timeframe used in most implementation research misses many critical features of public policy making. It then outlines a conceptual framework for examining policy change over a 10- to 20-year period that combines the best features of the "top-down" and "bottom-up" approaches with insights from other literatures.

Say, L. and D. Chou. 2011. *Universal Access to Reproductive Health. Accelerated Actions to Enhance Progress on Millennium Development Goal 5 Through Advancing Target 5B.* Geneva, Switzerland: World Health Organization.

Summary of Report (self-written)

This 36-page report contains case studies from seven countries, illustrating the application of a variety of strategies to improve access to sexual and reproductive health, including lessons learnt during

implementation and results achieved. The addition of Target 5B—"Achieve, by 2015, universal access to reproductive health"—to MDG 5, with indicators to track global progress, followed the recognition by world leaders that increased attention to sexual and reproductive health is a prerequisite for achieving MDG 5 on improving maternal health. In response, the WHO Department of Reproductive Health and Research convened a technical consultation involving stakeholders from countries, regions, and partner agencies to review strategies applied within countries for advancing universal access to sexual and reproductive health, with a view to identifying strategic approaches to accelerate progress. This report was published following that meeting.

According to the report, a holistic approach to sexual and reproductive health is necessary to achieve MDG 5, so programmes and initiatives will need to expand beyond focusing only on maternal health to also address family planning, sexual health, and prevention of unsafe abortion. A key aspect of universal access to sexual health is ensuring that services are available every day, reliably, which is possible by ensuring commodity availability. Education and training specifically focused on healthcare workers at the primary-healthcare level are crucial for expanding access to sexual and reproductive health services.

Based on case studies from seven countries, the paper suggests actions at the financing, policy, human resources, and service-delivery levels for improved access to reproductive health.

Sheikh, K. and J. Porter. 2010. "Discursive Gaps in the Implementation of Public Health Policy Guidelines in India: The Case of HIV Testing." *Social Science & Medicine* 71: 2005e2013.

Abstract

The implementation of standardized policy guidelines for the care of diseases of public health importance has emerged as a subject of concern in low- and middle-income countries (LMICs) globally. We conducted an empirical research study, using the interpretive policy analysis approach, to diagnose reasons for gaps in the implementation of national guidelines for HIV testing in Indian hospitals. Forty-six in-depth interviews were conducted with actors involved in policy implementation processes in five states of India, including practitioners, health administrators, policy planners, and donors. We found that actors' divergences from their putative roles in implementation were underpinned by their inhabitation of discrete "systems of meaning"—frameworks for perceiving policy problems and acting and making decisions.

Key gaps in policy implementation included conflicts between different actors' ideals of performance of core tasks and conformance with policy, and problems in communicating policy ideas across systems of meaning. These "discursive" gaps were compounded by the lack of avenues for intellectual intercourse and unaccounted interrelationships of power between implementing actors. Our findings demonstrate the importance of thinking beyond shortsighted ideals of aligning front-line practices with global policymakers' intentions. Recognising the deliberative nature of implementation and strengthening discourse and communications between involved actors may be critical to the success of public health policies in Indian and comparable LMIC settings. Effective policy implementation in the long term also necessitates enhancing practitioners' contributions to the policy process and equipping country public health functionaries to actualize their policy leadership roles.

Simwaka, L.K. 2008. "How Power Relations Affect the Implementation of Policy on Equity in Access to Anti-Retroviral Therapy: The Case of Rural Health Centres in Malawi." *EQUINET Discussion Paper 69*. Harare: Malawi Interfaith AIDS Association EQUINET.

Abstract

The national antiretroviral therapy (ART) scale-up plan contains several measures to promote equity while also considering that there are insufficient resources to cover everyone who is eligible. This study

focused on four facilities covering ART enrolment on an open "first-come, first-served" basis; it targeted gender-sensitive health promotion of ART, measures to overcome specific geographical barriers to access for remote populations, and prioritisation of people already on ART and pregnant women and young children. Using a case study approach, the study analysed the power relations that influenced outcomes on these policy measures at four health facilities in Malawi. The findings indicate that health workers commonly exercise power in relation to patients, and that patients acquiesce with health worker behaviours. In poorly performing facilities, implementation of policy measures is negatively affected by managerial practices that discourage teamwork and de-motivate health workers, whereas in the two better-performing facilities, management practices had a more positive role in supporting positive health worker practices. The study findings highlight that the implementation of equity policies needs to include measures to orient and involve staff, and address power and resource imbalances that can undermine access.

Sine, J., M.E. Clyde, and Z. Baser. 2004. "A Political Economy Perspective on Achieving Contraceptive Self-Reliance in Turkey." *POLICY Working Paper Series No. 13.* Washington, DC: The Futures Group, POLICY Project.

Abstract

In 1994, after three decades of donor support to Turkey's national family program, USAID announced its intention to phase out assistance. On the eve of donor phase-out, Turkey's public sector program was serving nearly 60 percent of the market for modern FP methods, including many non-poor clients. During the transition period, the Ministry of Health (MOH) was challenged not only to obtain new resources to replace donated contraceptive commodities but also to assume new technical responsibilities for the program. The story of how the ministry succeeded often is told in technical terms (e.g., number of procurements, budget trends, pilot project design, etc.). An equally important part of the story is the political and institutional context within which success was achieved. Examining how the MCH-FP Directorate overcame challenges to put in place a sustainable strategy for the public sector FP program reveals the political dimensions of the process. Using a political economy framework, this paper examines the processes that led to implementation of two central components of Turkey's national self-reliance strategy: obtaining annual budget allocations for contraceptives and targeting free services to the poor. The framework used here to analyze the process of formulating and adopting Turkey's contraceptive self-reliance strategy has five components: stakeholders' characteristics, institutional characteristics, contextual conditions, process characteristics, and reform characteristics.

Walker, L. and L. Gilson. 2004. "'We Are Bitter but We Are Satisfied'": Nurses as Street-level Bureaucrats in South Africa." *Social Science & Medicine* 59: 1251–1261.

Abstract

This study investigates how a group of nurses based in busy urban primary care health clinics experienced the implementation of the free care (removal of fees) and other South African national health policies introduced after 1996. The study aimed to capture the perceptions and perspectives of front-line providers ("street-level bureaucrats") concerning the process of policy implementation. Using qualitative and quantitative research methods, the study paid particular attention to the personal and professional consequences of the free care policy, the factors that influence nurses' responses to policy changes, such as free care, and what they perceive to be barriers to effective policy implementation. The research first reveals that nurses' views and values inform their implementation of health policy; second, that nurses feel excluded from the process of policy change; and finally, that social, financial, and human resources are insufficiently incorporated into the policy implementation process. The study recommends that the practice of policy change be viewed through the lens of the street-level bureaucrat and highlights three sets of related managerial actions.

Capacity

Baser, H., P. Morgan, J. Bolger, D. Brinkerhoff, A. Land, et al. 2008. *Capacity, Change and Performance*. Maastricht: European Centre for Development Policy Management (ECDPM).

Excerpt

This new study targeted a particular niche: to understand better the processes of capacity development and provide good practice to guide international development agency (IDA) programming, particularly at the operational level. The study was subsequently included in the workplan of the Network on Governance and Capacity Development (Govnet) of the Organisation for Economic Co-operation and Development's (OECD's) Development Assistance Committee (DAC). The agreed purposes of the study were the following:

- To enhance understanding of the interrelationships among capacity, change, and performance across a wide range of development experiences

To provide general recommendations and frameworks to support the effectiveness of external interventions aimed at improving capacity and performance

The study was thus intended to provide some new perspectives on capacity issues. First, it planned to use an endogenous perspective of capacity—how capacity develops from within—rather than looking only at what outsiders, usually international agencies, can do to induce it. This implied considering external contributions as only an influence, rather than the entry point of the research. Second, the study intended to bring in ideas from the capacity literature beyond that produced by the international development community. Third, the study aimed to provide evidence of good practice in developing capacity.

ECDPM. 2008. *Capacity Change and Performance: Insights and Implications for Development Cooperation. Policy Management Brief 21.* Maastricht: ECDPM.

Summary of Report (self-written)

ECDPM recently published the final report on a five-year research programme on capacity, change, and performance.

This research provides fresh perspectives on the topic of capacity and its development. It does so by highlighting endogenous perspectives: how capacity develops from within, rather than focusing on what outsiders do to induce it. The research also embraces ideas on capacity development drawn from literature outside the context of development cooperation.

Although the research draws implications for international development cooperation, it does not specifically examine donor agency experiences in capacity development or related issues of aid management and effectiveness.

The final report, on which this brief is based, provides a comprehensive analysis of the findings and conclusions of the research programme.

In total, 16 case studies were prepared, embracing a wide spectrum of capacity situations covering different sectors, objectives, geographic locations, and organisational histories, from churches in Papua New Guinea to a tax office in Rwanda to nationwide networks in Brazil. The case studies are complemented by seven thematic papers and five workshop reports.

The final report is written for people interested and involved in capacity development work. It offers insights as much for the managers and staff of public sector and civil society organisations as it does for external agencies, either those providing capacity development services to local organisations or donors

that finance capacity development work.

This brief highlights key findings and conclusions of the final report, and presents implications for external agencies engaged in capacity development in the context of international development cooperation.

Fukuyama, F. 2013. *What Is Governance? Working Paper 314.* Washington, DC: Center for Global Development.

Abstract

This paper points to the poor state of empirical measures of the quality of states—that is, of executive branches and their bureaucracies. Much of the problem is conceptual, since there is very little agreement on what constitutes high-quality government. The paper suggests four approaches: (1) procedural measures, such as the Weberian criteria of bureaucratic modernity; (2) capacity measures, which include both resources and degree of professionalization; (3) output measures; and (4) measures of bureaucratic autonomy. The paper rejects output measures and suggests a two-dimensional framework of using capacity and autonomy as a measure of executive branch quality. This framework explains the conundrum of why low-income countries are advised to reduce bureaucratic autonomy while high-income ones seek to increase it.

Gilson, L. and N. Raphaely. 2008. "The Terrain of Health Policy Analysis in Low and Middle Income Countries: A Review of Published Literature 1994–2007." *Health Policy and Planning* 23(5): 294–307.

Abstract

This article provides the first ever review of literature analysing the health policy processes of LMICs. Based on a systematic search of published literature using two leading international databases, the article maps the terrain of work published between 1994 and 2007 regarding policy topics, lines of inquiry, and geographical base, as well as critically evaluating its strengths and weaknesses. The overall objective of the review is to provide a platform for the further development of this field of work.

From an initial set of several thousand articles, only 391 were identified as relevant to the focus of inquiry. Of these, 164 were selected for detailed review because they present empirical analyses of health policy change processes within LMIC settings. Examination of these articles clearly shows that LMIC health policy analysis is still in its infancy. There are only small numbers of such analyses, whilst the diversity of policy areas, topics, and analytical issues that have been addressed across a large number of country settings results in a limited depth of coverage within this body of work. In addition, the majority of articles are largely descriptive in nature, limiting understanding of policy change processes within or across countries. Nonetheless, the broad features of experience that can be identified from these articles clearly confirm the importance of integrating concern for politics, process, and power into the study of health policy. By generating understanding of the factors influencing the experience and results of policy change, such analysis can inform action to strengthen future policy development and implementation. Finally, this article outlines five key actions needed to strengthen the field of health policy analysis within LMICs, including capacity development and efforts to generate systematic and coherent bodies of work underpinned by both the intent to undertake rigorous analytical work and concern to support policy change.

Gleeson, D.H., D.G. Legge, and D. O'Neill. 2009. "Evaluating Health Policy Capacity: Learning from International and Australian Experience." *Australia and New Zealand Health Policy* 6: 3.

Abstract

Background: The health sector in Australia faces major challenges, including an ageing population,

spiraling healthcare costs, continuing poor Aboriginal health, and emerging threats to public health. At the same time, the environment for policy making is becoming increasingly complex. In this context, strong policy capacity—broadly understood as the capacity of government to make "intelligent choices" between policy options—is essential if governments and societies are to address such continuing and emerging problems effectively.

Results: This paper explores the question: "What are the factors that contribute to policy capacity in the health sector?" In the absence of health sector-specific research on this topic, a review of Australian and international public sector policy capacity research was undertaken. Studies from the United Kingdom, Canada, New Zealand, and Australia were analysed to identify common themes in the research findings. This paper discusses these policy capacity studies in relation to context, models, and methods for policy capacity research, elements of policy capacity, and recommendations for building capacity.

Conclusion: Based on this analysis, the paper discusses the organisational and individual factors likely to contribute to health policy capacity, highlights the need for further research in the health sector, and points to some of the conceptual and methodological issues that need to be considered in such research.

Grindle, M. 2006. "Modernising Town Hall: Capacity Building with a Political Twist." *Public Administration and Development* 26: 55–69.

Abstract

Capacity building is a frequent tonic prescribed for local governments in poor performance health. Such initiatives purport to get to the heart of governance with technical approaches free of partisanship and political controversy. Data from municipal governments newly affected by decentralisation and democratisation indicate that, contrary to expectations, the destiny of capacity-building initiatives is dependent upon politics. In the first instance, capacity-building initiatives are dependent on the orientation of elected and appointed leaders who choose to invest in or ignore them. Second, such initiatives are significantly affected by electoral cycles that create moments when significant new capacity initiatives can be introduced and abandoned. Third, they are dependent on the formal and informal institutions that determine how much scope public officials have for introducing change. Thus, while part of the popularity of capacity-building programs and projects is their apparent distance from politics, those who wish to see improvements in government performance need to be sensitive to how it is affected—in positive and negative ways—by political preferences, calendars, and institutions. Data on 57 capacity-building initiatives carried out in 30 medium-sized municipalities in Mexico suggest the ways in which such factors shape the destinies of these initiatives.

Grindle, M. and M. Hilderbrand. 1995. "Building Sustainable Capacity in the Public Sector: What Can Be Done?" *Public Administration and Development* 15: 441–463.

Abstract

Effective government performance is central to the creation of market-oriented economies, secure and productive populations, and democratic political systems in developing countries. Capacity building to improve public sector performance is thus an important focus of development initiatives. Several implicit assumptions underlie most such efforts: that organizations or training activities are the logical site for capacity-building interventions; that administrative structures and monetary rewards determine organizational and individual performance; that organizations work well when structures and control mechanisms are in place; and that individual performance improves as a result of skill and technology transfer through training activities. Each of these assumptions is called into question by the findings of research carried out in six developing countries and reported in this article. Our studies indicate designing interventions that most constructively address sources of poor performance must follow from an assessment of a relatively broad set of variables, including the action environment in which all such activities take place. We also found that effective public sector performance is more often driven by

strong organizational cultures, good management practices, and effective communication networks than it is by rules and regulations, or procedures and pay scales. Our case studies further indicate that individual performance is more affected by opportunities for meaningful work, shared professional norms, teamwork, and promotion based on performance rather than by training in specific skills. In this article, we describe a framework or conceptual map emphasizing that training activities, organizational performance, and administrative structures are embedded within complex environments that significantly constrain their success and often account for training or organizational failure. When applied in the six case study countries, the framework proved useful in identifying capacity gaps and providing a tool for the strategic design of interventions sensitive to the roots of performance deficits. This finding allows us to conclude that the assumptions underlying many capacity-building initiatives may focus attention on interventions that do not generate the highest payoffs in improved performance.

Lafond, A., L. Brown, and K. Macintyre. 2002. "Mapping Capacity in the Health Sector: AConceptual Framework." *International Journal of Health Planning and Management* 17: 3–22.

Abstract

Capacity improvement has become central to strategies used to develop health systems in low-income countries. Experience suggests that achieving better health outcomes requires both increased investment (i.e., financial resources) and adequate local capacity to use resources effectively. International donors and nongovernmental agencies, as well as ministries of health, thus rely increasingly on capacity building to enhance overall performance in the health sector. Despite the growing interest in capacity improvement, there has been little consensus among practitioners and academics on definitions of "capacity building" and how to evaluate it. This paper aims to review current knowledge and experiences from ongoing efforts to monitor and evaluate capacity-building interventions in the health sector in developing countries. It draws on a wide range of sources to develop (1) a definition of capacity building and (2) a conceptual framework for mapping capacity and measuring the effects of capacity-building interventions. Mapping is the initial step in the design of these interventions and provides a framework for monitoring and evaluating their effectiveness. Capacity mapping is useful to planners because it makes explicit the assumptions underlying the relationship between capacity and health system performance, and provides a framework for testing those assumptions.

Morrow, M., Q. Nguyen, S. Caruana, B. Biggs, N. Doan, et al. 2009. "Pathways to Malaria Persistence in Remote Central Vietnam: A Mixed-method Study of Health Care and the Community." *BMC Public Health* 9:85.

Abstract

Background: There is increasing interest in underlying sociocultural, economic, environmental, and health system influences on the persistence of malaria. Vietnam is a Mekong regional "success story" after dramatic declines in malaria incidence following introduction of a national control program providing free bed nets, diagnosis, and treatment. Malaria has largely retreated to pockets near international borders in central Vietnam, where it remains a burden, particularly among impoverished ethnic minorities. In these areas, commune and village health workers are lynchpins of the program. This study in the central province of Quang Tri aimed to contribute to more effective malaria control in Vietnam by documenting the non-biological pathways to malaria persistence in two districts.

Methods: Multiple and mixed (qualitative and quantitative) methods were used. The formative stage comprised community meetings; observation of bed net use; and focus group discussions and semi-structured interviews with health managers, providers, and communities. Formative results were used to guide development of tools for the assessment stage, which included a provider quiz, structured surveys with 160 community members and 16 village health workers, and quality checks of microscopy facilities and health records at the district and commune levels. Descriptive statistics and chi-square analysis were

used for quantitative data.

Results: The study's key findings were the inadequacy of bed nets (only 45% of households were fully covered) and sub-optimal diagnosis and treatment at local levels. Bed net insufficiencies were exacerbated by customary sleeping patterns and population mobility. Whereas care at the district level seemed good, about a third of patients reportedly self-discharged early and many were lost to follow-up. Commune and village data suggested that approximately half of febrile patients were treated presumptively, and 10 village health workers did not carry artesunate to treat the potentially deadly and common P. falciparum malaria. Some staff lacked diagnostic skills, time for duties, and quality microscopy equipment. A few gaps were found in community knowledge and reported behaviours.

Conclusion: Malaria control cannot be achieved through community education alone in this region. Whilst appropriate awareness raising is needed, it is most urgent to address weaknesses at the systems level, including bed net distribution, health provider staffing and skills, and equipment and supplies.

National Academy of Sciences (NAS). 1974. *In Search of Population Policy. Views from the Developing World.* Washington, DC: National Academy of Sciences.

Summary of Book (self-written)

In Search of Population Policy summarizes the opinions of participants from five seminars held in 1973 about population policy. Each participant was a public health worker from a developing country, and each answered questions about the following four topics: (1) population problems, (2) population policies or responses and their effects, (3) policy administration (actors and constituent groups), and (4) policy options. Their responses provided the starting point for discussion, each of which is summarized in this book.

Organisation for Economic Co-operation and Development (OECD). 2006. *The Challenge of Capacity Development: Working Towards Good Practice*. Paris: OECD.

Abstract

This report draws on four decades of documented experience provided by both bilateral and multilateral donors, as well as academic specialists, to help policymakers and practitioners think through effective approaches to capacity development and what challenges remain in the drive to boost country capacity. The analysis is underpinned by a conceptual framework that guides practitioners to view capacity development at three interrelated levels: individual, organizational, and the enabling environment. It provides insights into what capacity development is, why it matters and, more important, what can be done to support it.

Organisation for Economic Co-Operation and Development (OECD/DAC). 2011. *Sector Capacity Development, DAC Perspectives Note*. Paris: OECD.

Excerpt

This perspectives note discusses opportunities for and the challenges of capacity development in a sector context. Departing from the aid effectiveness agenda and recommendations for action contained in the Paris Declaration and Accra Agenda for Action, it considers the progress that has been made by partner countries and donors to integrate capacity development at the sector level.

In focusing on sectors, the note deliberately attempts to examine the challenges of capacity development in sectors from an endogenous vantage point. Sectors are thus regarded first and foremost as frameworks for organizing the design and implementation of domestic development policies, rather than as instruments for structuring the delivery of aid. The note is not then primarily a discussion of programme-based approaches or related aid modalities, such as sector budget support. However, the endogenous perspective is used to consider how external support for capacity development at the sector level can be

effectively provided, as an adjunct to locally driven processes.

Potter, C. and R. Brough. 2004. "Systemic Capacity Building: A Hierarchy of Needs." *Health Policy and Planning* 19: 336–345.

Abstract

"Capacity building" is the objective of many development programmes and a component of most others. However, satisfactory definitions continue to elude us, and it is widely suspected of being too broad a concept to be useful. Too often it becomes merely a euphemism, referring to little more than training. This paper argues that it is more important to address systemic capacity building; it identifies a pyramid of nine separate but interdependent components. These form a four-tier hierarchy of capacity-building needs: (1) structures, systems, and roles; (2) staff and facilities; (3) skills; and (4) tools. Emphasizing systemic capacity building would improve diagnosis of sectoral shortcomings in specific locations, improve project/programme design and monitoring, and lead to more effective use of resources. Based on extensive action research in 25 states, the paper presents experiences from India to illustrate how the concept of the capacity-building pyramid has been put to practical use.

Pritchett, L., M. Woolcock, and M. Andrews, M. 2010. "Capability Traps? The Mechanisms of Persistent Implementation Failure." *Working Paper 234.* Washington, DC: Center for Global Development.

Abstract

Many countries remain stuck in conditions of low productivity that many call "poverty traps." Economic growth is only one aspect of development; another key dimension is the expansion of the administrative capability of the state—the capability of governments to affect the course of events by implementing policies and programs. We use a variety of empirical indicators of administrative capability to show that many countries remain in "state capability traps," in which the implementation capability of the state is both severely limited and improving (if at all) only very slowly. At their current pace of progress, countries like Haiti, Afghanistan, or Liberia would take hundreds (if not thousands) of years to reach the capability of a country like Singapore, and decades to reach even a moderate-capability country like India. In this paper, we explore how this can be the case. That is, we do not attempt to explain why countries remain in capability traps; that would require a historical, political, and social analysis uniquely applied to each country. Rather, we focus on how countries manage to engage in the domestic and international logics of "development" and yet consistently fail to acquire capability. What are the techniques of failure? Two of these stand out. First, "big development" encourages progress through importing standard responses to predetermined problems. This, in turn, encourages isomorphic mimicry as a technique of failure: the adoption of the forms of other functional states and organizations, camouflaging a persistent lack of function. Second, an inadequate theory of developmental change reinforces a fundamental mismatch between expectations and the actual capacity of prevailing administrative systems to implement even the most routine administrative tasks. This then leads to premature load bearing, in which wishful thinking about the pace of progress and unrealistic expectations about the level and rate of improvement of capability lead to stresses and demands on systems that cause capability to weaken, if not collapse. We conclude by noting some suggestive directions for sabotaging these techniques of failure.

Richter, L. 2010. "Riding the Pendulum Between Clocks and Clouds: The History of OD and its Relation to CD." Pp. 101–115 in *Capacity Development in Practice,* edited by J. Ubels, N. Acquaye-Baddoo, and A. Fowler. London: Earthscan.

Abstract

Although the field of organizational development (OD) is often considered unique, Ingrid Richter explains OD in relation to the well-known field of capacity development (CD). CD finds its roots within

OD, leading to similarities between the two fields in both methods and outcomes—particularly long-term outcomes. Richter provides an overview of the origins and development of OD as a practice, and then explains the convergence between CD and OD, along with practical implications for CD practitioners.

Watsierah, C.A., R. Onyango, J. Ombaka, B. Abong'o, and C. Ouma. 2012. "Provider Knowledge of Treatment Policy and Dosing Regimen with Artemether-lumefantrine and Quinine in Malaria-endemic Areas of Western Kenya." *Malaria Journal* 11.

Abstract

Background: Due to widespread anti-malarial drug resistance in many countries, Kenya included, artemisinin-based combination therapy (ACT) has been adopted as the most effective treatment option for treating malaria. Artemether-lumefantrine (AL) is the first-line ACT for treatment of uncomplicated malaria in Kenya, whereas quinine is preferred for complicated and severe malaria. Information on providers' knowledge and practices before or during AL and quinine implementation is scanty. The current study evaluated providers' knowledge and practices of treatment policy and dosing regimens with AL and quinine in the public, private, and not-for-profit drug outlets.

Methods: One of the authors conducted a cross-sectional survey using a three-stage sampling of 288 (126 public, 96 private, and 66 not-for-profits) providers in drug outlets in western Kenya in two Plasmodium falciparum-endemic regions with varying malarial risk. The author collected information on provider in-service training, knowledge (qualification, treatment policy, dosing regimen, recently banned anti-malarials), and practices (request for written prescription, prescription of AL, selling partial packs, and advice given to patients after prescription).

Results: Only 15.6 percent of providers in private outlets had received any in-service training on AL use. All (100%) in public and a majority (98.4%) in not-for-profit outlets mentioned AL as a first line-treatment drug. Quinine was mentioned as a second-line drug by 47.9 percent in private outlets. A total of 92.0 percent in public, 57.3 percent in private, and 78.8 percent in not-for-profit outlets stated the correct AL dose for adults. A total of 85.7 percent of providers in public, 30.2 percent in private, and 41.0 percent in not-for-profit outlets were aware that sulfadoxine/pyrimethamine (SP) recommendations changed from treatment for mild malaria to intermittent preventive treatment of pregnant women (IPTp) in high-risk areas. In-service training influenced treatment regimen for uncomplicated malaria ($P = 0.039$ and $P = 0.039$) and severe malaria ($P < 0.0001$ and $P = 0.002$) in children and adults, respectively. Most (82.3%) private outlets sell partial packs of AL, whereas 72.4 percent do not request a written prescription for AL. In-service training influenced requests for written prescriptions ($P = 0.001$), AL prescriptions ($P < 0.0001$), and selling of partial packs ($P < 0.0001$).

Conclusion: Public sector providers have greater knowledge of treatment policies and dosing regimens for recommended anti-malarials. Changes in treatment guidelines should be accompanied by subsequent implementation activities involving all sector players in unbiased strategies.

Financing

Awoonor-Williams, J.K., E.K. Sory, F.K. Nyonator, J. Phillips, C. Wang, et al. 2013. "Lessons Learned from Scaling Up a Community-based Health Program in the Upper East Region of Northern Ghana." *Global Health: Science and Practice* 11:117–133.

Abstract

Ghana's Community-Based Health Planning and Service (CHPS) initiative is envisioned as a national program to relocate primary healthcare services from sub-district health centers to convenient community locations. The initiative was launched in four phases. First, it was piloted in three villages to develop appropriate strategies. Second, the approach was tested in a factorial trial, which showed that community-

based care could reduce childhood mortality by half in only three years. A replication experiment then was launched to clarify appropriate activities for implementing the fourth and final phase—national scale-up. This paper discusses CHPS progress in the Upper East Region (UER) of Ghana, where the pace of scale-up has been much more rapid than in the other nine regions of the country, despite exceedingly challenging economic, ecological, and social circumstances. The UER employed five strategies that facilitated scale-up: (1) nurses' recruitment from their home districts to improve worker morale and cultural grounding, balanced with some social distance from the village community to ensure client confidentiality, particularly regarding FP use; (2) prioritization of CHPS planning and continuous review in management meetings to make necessary modifications to the initiative's approach; (3) community engagement and advocacy directed to local politicians to mobilize resources for financing start-up costs; (4) a shared and consistent vision about CHPS among health administration leaders to ensure appropriate resources and commitment to the initiative; and (5) knowledge exchange visits between new and advanced CHPS implementers to facilitate learning and scale-up within and between districts.

Balabanova, D., L. Conteh, and M. McKee. 2011. "The Contribution of Health Systems to Good Health." Chapter 9 in *'Good Health at Low Cost' 25 Years On. What Makes a Successful Health System*?, edited by D. Balabanova, M. McKee, and A. Mills. London: London School of Hygiene and Tropical Medicine.

Summary of Chapter (self-written)

This book describes success stories of health and development in Bangladesh, Ethiopia, Kyrgyzstan, India, and Thailand. The chapter investigates how the health system of each case study location helped to promote health—particularly maternal and child health.

The investigation included the identification of three key aspects of a health system: (1) specific programs and interventions that have improved health; (2) elements of the health system that have facilitated these programs and interventions; and (3) factors in the local social, cultural, and political environment that have given rise to these elements.

The investigation yielded the following key components of a health system that contribute to improved health outcomes at low cost:

- Good governance
- Effective institutions and bureaucracies
- Scaling up the health workforce
- Efforts toward fair and sustainable financing
- Financial protection
- Innovative ways of securing health system inputs

Building resilience in the health system

Brugha, R., M. Donoghue, M. Starling, P. Ndubani, F. Ssengooba, et al. 2004. "The Global Fund: Managing Great Expectations." *The Lancet* 364(9428): 95–100.

Abstract

The Global Fund to fight AIDS, Tuberculosis, and Malaria was created to increase funds to combat these three devastating diseases. Here we report interim findings, based on interviews with 137 national-level respondents that track early implementation processes in four African countries. Country coordinating mechanisms (CCMs) are country-level partnerships which were formed quickly to develop and submit grant proposals to the Global Fund. CCM members were often ineffective at representing their constituencies and encountered obstacles in participating in CCM processes. Delay in the dissemination of guidelines from the Global Fund led to uncertainty among members about the function of these new partnerships. Respondents expressed most concern about the limited capacity of fund recipients—

government and nongovernment—to meet Global Fund conditions for performance-based disbursement. Delays in payment of funds to implementing agencies have frustrated rapid financing of disease control interventions. The Global Fund is one of several new global initiatives superimposed on existing country systems to finance the control of HIV/AIDS. New and existing donors need to coordinate assistance to developing countries by bringing together funding, planning, management, and reporting systems if global goals for disease control are to be achieved.

Burjari, P. and E. McGinn. 2013. *Influencing Government Health Budgets in Tanzania: A Guide for Civil Society*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 5.

Excerpt

The purpose of this booklet is to inform civil society organisations (CSOs) on how the health budget is developed in Tanzania and to suggest entry points at which advocates can seek to influence change, especially around increasing the allocation of resources to health and ensuring more efficient use of such resources. Section 1 provides information on the context of health as a right in Tanzania and current government allocations to health. It provides a brief overview of the roles of CSOs in the development of government budgets and the rationale for engaging in health sector budget advocacy. Section 2 reviews some basic concepts and important steps in the advocacy process, and mentions a few tactics and strategies recommended for Tanzanian CSOs. Section 3 provides information on the health system in Tanzania and key structures to be aware of when wishing to influence change, particularly as they relate to budget allocations or monitoring. It also provides information on how the government health budget is structured and developed, and highlights entry points and timing at both the national and local government levels for successful health budget advocacy. Section 4 provides three CSO case studies on government budget advocacy: two at the national level and one at the district level. These case studies provide information on how the advocacy agenda was framed, which advocacy strategies/approaches were used, and the results.

Chen, L.C. 2011. "Good Health at Low Cost: From Slogan to Wicked Problem." *The Lancet 379(9815): 509–510.*

Summary of Article (self-written)

In this book review, Lincoln Chen criticizes *'Good Health at Low Cost' 25 Years On: What Makes a Successful Health System?* for its failure to establish a concrete relationship between good health and successful health systems. Chen argues that the phenomenon of good health at low cost could result either from unusually successful health outcomes or from poor economic standing on the part of case study countries, without any linkage between the two. This connection is important to establish from a health policy standpoint because health policy development depends on a strong understanding of the health system environment and because health policy implementation seeks to improve health outcomes.

FP Ouagadougou Partnership. n.d. "Family Planning: Francophone West Africa on the Move: A Call to Action." Available at: http://www.prb.org/pdf12/ouagadougou-partnership_en.pdf.

Summary of Report (self-written)

Although FP use is increasing in the majority of developing countries, West Africa is lagging behind. Fertility rates among the French-speaking countries of the region remain high, with an average of 5.5 births per woman, and 28 percent of women of reproductive age have an unmet need for family planning—one of the highest rates of any region globally.

This recently released report is a call to action, compiled by members of the Ouagadougou Partnership and other experts in family planning from West Africa. It presents targeted areas of investment in family

planning to spur progress in the region and provides recommendations for strengthening services, mobilizing political commitment and resources, and coordinating actions. The report is also designed to serve as an advocacy tool for high-level policymakers, government officials, parliamentarians, civil society, community leaders, and other potential partners.

Ghana National Population Council, Health Policy Project, and UK Department for International Development. 2012. *Estimating the Resources Required to Achieve Family Planning Targets in Ghana.* Accra, Ghana: Health Policy Project, Futures Group.

Abstract

For a country to successfully achieve its FP goals and targets, stakeholders must fully understand the investment needed to attain them. The Health Policy Project, in collaboration with Ghana's National Population Council, recently reviewed data on demographic patterns, FP costs, and projected funding to inform an application of the GAP (Gather, Analyze, and Plan) Tool. The tool is designed to project the contraceptive, service provision, and program support funding gaps in a country to ultimately help policymakers, decisionmakers, and development partners understand the costs involved in reaching national FP goals and addressing challenges to progress. This presentation and brief summarize the current policy environment in Ghana for family planning, the targets set by the National Population Policy, and the gap in the current and estimated resources needed. These evidence-based advocacy materials aim to bolster financial and political support for the FP program in Ghana.

Gilson, L., D. Kalyalya, F. Kuchler, S. Lake, H. Oranga, et al. 2001. "Strategies for Promoting Equity: Experience with Community Financing in Three African Countries." *Health Policy* 58: 37–67.

Abstract

Although the need for a pro-poor health reform agenda in low- and middle-income countries is increasingly clear, implementing such policy change is always difficult. This paper seeks to contribute to thinking about how to take forward such an agenda by reflecting on the community financing activities of the UNICEF/WHO Bamako Initiative. It presents findings from a three-country study in Benin, Kenya, and Zambia, undertaken in 1994/95, which was initiated to better understand the nature of the equity impact of community financing activities and the factors underlying this impact. The sustained relative affordability gains achieved in Benin emphasise the importance of ensuring that financing change is used as a policy lever for strengthening health service management in support of quality-of-care improvements. All countries, however, failed in protecting the poorest from the burden of payment, benefiting them preferentially, and ensuring that their views were heard in decision making. Tackling these problems requires, amongst other things, an appropriate balance between central- and local-level decision making, as well as the creation of local decision-making structures which have representation from civil society.

Health Policy Project. 2011. *The GAP Tool and Applications in Ethiopia and Nigeria.* Washington, DC: The Futures Group, Health Policy Project.

Abstract

The GAP Tool (Gather, Analyze, and Plan) is a simple Excel-based tool designed to help policymakers, ministry officials, health officials, and advocates understand and plan for the costs associated with expanding family planning to achieve their country's contraceptive prevalence or fertility goals. This brief provides a brief overview of the benefits of and major steps for applying the GAP Tool, and includes highlights from its pilot application in Ethiopia and Nigeria.

King, G., E. Gakidou, K. Imai, R.T. Moore, C. Nail, et al. 2009. "Public Policy for the Poor? A Randomised Assessment of the Mexican Universal Health Insurance Programme." *The Lancet* 373(9673): 1447–1454.

Abstract

Background: We assessed aspects of *Seguro Popular*, a programme aimed at delivering health insurance, regular and preventive medical care, medicines, and health facilities to 50 million uninsured Mexicans.

Methods: We randomly assigned treatment within 74 matched pairs of health clusters—i.e., health facility catchment areas—representing 118,569 households in seven Mexican states, and measured outcomes in a 2005 baseline survey (August 2005 to September 2005) and a follow-up survey 10 months later (July 2006 to August 2006) in 50 pairs (n=32,515). The treatment consisted of encouragement to enroll in a health insurance programme and upgraded medical facilities. Participant states also received funds to improve health facilities and provide medications for services in treated clusters. We estimated intention to treat and complier average causal effects non-parametrically.

Findings: Intention-to-treat estimates indicated a 23 percent reduction from baseline in catastrophic expenditures (1.9 percentage points; 95% CI 0.14–3.66). The effect in poor households was 3.0 percentage points (0.46–5.54), whereas in experimental compliers it was 6.5 percentage points (1.65–11.28)—30 percent and 59 percent reductions, respectively. The intention-to-treat effect on health spending in poor households was 426 pesos (39–812), and the complier average causal effect was 915 pesos (147–1684). Contrary to expectations and previous observational research, we found no effects on medication spending, health outcomes, or utilisation.

Interpretation: Programme resources reached the poor. However, the programme did not show some other effects, possibly due to the short duration of treatment (10 months). Although *Seguro Popular* seems to be successful at this early stage, further experiments and follow-up studies, with longer assessment periods, are needed to ascertain the long-term effects of the programme.

Ndavi, P.M., S. Ogola, P.M. Kizito, and K. Johnson. 2009. *Decentralizing Kenya's Health Management System: An Evaluation. Kenya Working Papers*. Nairobi: USAID, PEPFAR and UNICEF.

Excerpt

Kenya's MOH commitment to address the inherent constraints in the health sector has included deliberate decentralization efforts aimed at strengthening the effective implementation of activities at the district level and fostering closer coordination and collaboration amongst the line ministries, donors, organizations, and other stakeholders. Among these efforts, local District Health Management Boards (DHMBs) and District Health Management Teams (DHMTs) gradually assumed responsibilities for the operation of the facilities under their jurisdiction through a single-line grant, annual work plans, and procurement plans. To assess the current effectiveness of the district health management systems in meeting their responsibilities, we analyzed data from a special District Health Management module of the 2004 Kenya Service Provision Assessment Survey to discern the degree to which the DHMTs and DHMBs meet norms and standards in the areas of governance and management, human resource development and management, commodity management, infrastructure development, healthcare financing, budgeting and management, and performance monitoring. The results of this descriptive analysis indicate that, although most of the DHMTs hold meetings frequently, the unavailability of the guidelines on the functioning of the DHMTs made it difficult to determine their compliance with any existing norms and standards. Lack of funds and transport were the most cited reasons for failure by DHMTs to meet their supervision targets, despite the near universal existence of documented supervision plans. Regarding support of human resources, continuing professional development is an accepted norm

in the districts, but there is an urgent need to strengthen and expand the scope of updates to serving staff through the establishment of district health training committees and regular monitoring of their activities. Regarding financing issues, despite existence of both recurrent and development funds, funding for medicines, equipment, and maintaining buildings was inadequate in most districts.

Oronje, R.N., J. Crichton, S. Theobald, N.O. Lithur, and L. Ibisomi. 2011. "Operationalising Sexual and Reproductive Health and Rights in sub-Saharan Africa: Constraints, Dilemmas and Strategies." *BMC International Health and Human Rights* 11: 1–11.

Abstract

Background: The continued poor sexual and reproductive health (SRH) outcomes in sub-Saharan Africa highlight the difficulties in reforming policies and laws, and implementing effective programmes. This paper uses one international and two national case studies to reflect on the challenges, dilemmas, and strategies used in operationalising sexual and reproductive health and rights (SRHR) in different African contexts.

Methods: The international case study focuses on the progress made by African countries in implementing the African Union's Maputo Plan of Action (for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights) and the experiences of state and non-state stakeholders in this process. The case was developed from an evaluation report of the progress made by nine African countries in implementing the Plan of Action, qualitative interviews exploring stakeholders' experiences and perceptions of the operationalisation of the plan (carried out as part of the evaluation) in Botswana and Nigeria, and the authors' reflections. The first national case study explores the processes involved in influencing Ghana's Domestic Violence Act, passed in 2007; this study was developed from a review of scientific papers and organisational publications on the processes involved in influencing the act, a qualitative interview data, and authors' reflections. The second national case study examines the experiences with introducing the 2006 Sexual Offences Act in Kenya; it was developed from organisational publications on the processes of enacting the act and a review of media reports on the debates and passing of the act.

Results: Based on these three cases, we argue that prohibitive laws and governments' reluctance to institute and implement comprehensive rights approaches to SRH, lack of political leadership and commitment to funding SRHR policies and programmes, and dominant negative cultural framing of women's issues present the major obstacles to operationalising SRHR. Our analysis of successes points to the strategies for tackling these challenges, which include forming and working through strategic coalitions, employing strategic framing of SRHR issues to counter opposition and gain support, collaborating with government, and employing strategic opportunism.

Conclusion: The strategies identified show future pathways through which challenges to the realisation of SRHR in Africa can be tackled.

USAID/Health Policy Initiative, Task Order 1, and the USAID | DELIVER PROJECT, Task Order 1. 2010. *Assessing Policies and Practices that Affect Contraceptive Financing and Procurement: A Review Guide*. Washington, DC: USAID | Health Policy Initiative, Task Order 1, Futures Group and Arlington, VA: USAID | DELIVER PROJECT, Task Order 1.

Excerpt

This guide will provide governments, donors, and other relevant stakeholders with a framework to assess the policy environment for procuring and financing contraceptives. The guide examines policies and practices to identify whether they are supporting or hindering the performance of such financing and procurement. A country's finance and procurement systems determine whether supplies are financed, procured, and delivered in a timely manner. Supportive and functioning policies related to procuring and

financing contraceptives provide an enabling environment and, when implemented effectively and efficiently, serve as the foundation for the effectiveness of those systems. Although tools and approaches have been developed to address challenges related to other aspects of contraceptive security, few address in detail the necessary policies and practices. Analyzing the policy environment related to procuring and financing contraceptives can help determine the root causes of a health system's poor performance and identify opportunities for improvement. This guide can be used as a diagnostic and monitoring tool to accomplish the following:

- Understand the policy environment related to procuring and financing contraceptives in a country
- Identify existing policy barriers that may be hindering contraceptive security
- Improve procurement policies and practices that affect contraceptive financing and procurement
- Plan a smooth transition from donor-procured commodity support to government-financed or basket-funded commodity procurement by government agencies
- Improve implementation of policies when the practice does not match the policy
- Develop evidence to support advocacy for increased financing of contraceptives or more efficient financing and procurement mechanisms

Monitor how financing and procurement policies are implemented

More important, this guide is about both policies and practice, and their implementation. Although countries may have well-designed policies, they may not be implemented appropriately (strictly, correctly, fully) or efficiently. This guide thus examines the prescribed procurement, the financing policies and procedures, or both, to determine where bottlenecks exist and which specific operational aspects should be addressed to improve the situation. Alternatively, if countries lack clear policies or guidelines, it is important to determine

a. How decisions are made nonetheless
b. Which key actors are involved in the decision-making process
c. Whether additional or modified policies are needed to address operational shortcomings

By examining the rules, regulations, guidelines, and practices that governments use to translate laws and policies into program implementation, one can gain a better understanding and appreciation for the challenges or barriers to financing and procuring a country's contraceptive needs.

Strategic Planning and Policy Barriers Analysis

Ahmed, H.M., M. Mitchell, and B. Hedt. 2010. "National Implementation of Integrated Management of Childhood Illness (IMCI): Policy Constraints and Strategies." *Health Policy* 96: 128–133.

Abstract

Integrated management of childhood illness (IMCI) is a pediatric care management strategy that has been shown to improve healthcare service quality and increase healthcare cost savings in multicountry evaluations. However, many countries have faced significant training, health system, political, and financial constraints to national implementation and, as a result, have not been able to observe the sustained benefits of IMCI. This article reviews the literature for evidence of IMCI health impacts, common implementation constraints, and policy strategies for health system strengthening and successful implementation.

Blaauw, D., E. Erasmus, N. Pagaiya, V. Tangcharoensathein, K. Mullei, et al. 2010. "Policy Interventions that Attract Nurses to Rural Areas: A Multicountry Discrete Choice Experiment." *Bulletin of the World Health Organization* 88: 350–356.

Abstract

Objective: To evaluate the relative effectiveness of different policies in attracting nurses to rural areas in Kenya, South Africa, and Thailand, using data from a discrete choice experiment (DCE).

Methods: A labelled DCE was designed to model the relative effectiveness of both financial and non-financial strategies developed to attract nurses to rural areas. Data were collected from more than 300 graduating nursing students in each country. Mixed logit models were used for analysis and to predict the uptake of rural posts under different incentive combinations.

Findings: Nurses' preferences for different human resource policy interventions varied significantly between the three countries. In Kenya and South Africa, better educational opportunities or rural allowances would be most effective in increasing the uptake of rural posts, whereas in Thailand, better health insurance coverage would have the greatest impact.

Conclusion: DCEs can be designed to help policymakers choose more effective interventions to address staff shortages in rural areas. Intervention packages tailored to local conditions are more likely to be effective than standardized global approaches.

Brinkerhoff, D. 1996. *Implementing Policy Change: A Summary of Lessons Learned.* Washington, DC: USAID.

Excerpt

From 1990 through 1995, the Implementing Policy Change Project (IPC) provided technical assistance and undertook studies that concentrated on the implementation and management side of policy reform in more than 30 developing countries. A second phase of the project (IPC 2) began in late 1995 and will continue technical assistance for capacity building and applied research for an additional five years. The unifying theme of IPC technical assistance has been the application of a strategic management process approach to policy reforms. The approach consists of a cycle of five steps:

1. Agreeing on a strategic process for developing a policy implementation strategy
2. Mapping the policy situation, including analysis of political and operating environments, policy content, and stakeholder expectations and resources
3. Identifying key strategic issues

4. Designing an implementation strategy
5. Designing and applying a process to monitor progress and make ongoing adjustments

Associated with this approach is a set of related analytic and management tools. Linked directly to strategic management are the following: stakeholder analysis, force field analysis, political mapping, institutional mapping, SWOT analysis (strengths, weaknesses, opportunities, and threats), priority setting, mission clarification, advocacy/lobbying, constituency mobilization, and values clarification. Drawn from program and project management are the following: objectives specification, activity planning and scheduling, and management information systems.

IPC's first phase of technical cooperation and applied research activities, mostly undertaken in Africa and, to a lesser extent, in Latin America and Asia, has yielded a set of valuable lessons relating to (1) the difficult nature of policy reforms, (2) the applicability of strategic management process approaches, and (3) the use of donor resources to support policy change. This research note summarizes the lessons learned from the first five years of IPC activities.

Brinkerhoff, D. 1996. "Process Perspectives on Policy Change: Highlighting Implementation." *World Development* 24(9): 1395–1401.

Abstract

At the midpoint of the 1990s, many developing countries found themselves confronting a second generation of economic and sectoral policy reforms, characterized by incremental, long-haul adjustments rather than the dramatic, stroke-of-the pen measures taken during the first generation to deal with economic crisis and/or democratic transition (Haggard and Kaufman, 1994). Policymakers and public managers face the challenge of sustaining reforms beyond the launch phase so that those policy changes, whose benefits rarely appear in the short term, can bear fruit. The complexities of these policy changes are a quantum leap beyond those of the earlier ones, where, in many cases, policies were designed and put in place by an elite team of technocrats who concentrated on the technical aspects of policy prescription, insulated from politics as usual and standard bureaucratic procedures. Long-haul reforms, however, extend beyond the narrowly economic and technical to include social, political, cultural, and organizational dimensions, which interact in complex and often unforeseen ways. Public officials charged with responsibility for implementing policy reforms face changes in their roles, severe institutional constraints, new interaction patterns with other public agencies and civil society, and pressures for showing results. In the democratizing political environment of many developing and transitioning countries, governments have limited ability to impose reforms without paying attention to building credibility, consensus, and support. The broad demand for transparency and accountability can act as a brake on tendencies to revert to autocratic and closed-circle decision making. Often, however, the citizens of these nations, encouraged by the initial steps taken toward democracy and expecting greater participation, are frustrated by the inability or (in some cases) unwillingness of public sector agencies to move quickly to include them in decision making or respond to their concerns and needs. Without the ability to make good on policy promises, these nascent democracies risk losing the support of their electorates and dashing the hopes of their constituencies. Regimes that fail to produce results acceptable to the general population or important constituencies provide few incentives to play by the rules, manage conflict creatively, or voluntarily support the regime and its policies. Continued failure to implement policy effectively wastes increasingly scarce resources, undermines prospects for sustainable development, and eventually threatens the legitimacy of the regime itself.

Buse, K. 2008. "Addressing the Theoretical, Practical and Ethical Challenges Inherent in Prospective Policy Analysis." *Health Policy and Planning* 23(5): 351–360.

Abstract

As a function of the inherently political nature of health policy, there long have been calls for, as well as guidance on, analysis of its political dimensions to inform practice. Yet there are few accounts in the literature of systematic attention to real-time documentation and analysis of political/economic factors and feedback to engender reform. The dearth of such prospective policy analysis is perhaps understandable, given the many intrinsic difficulties in such an enterprise. This paper provides an outline approach of how researchers might work together with advocacy coalitions (or other political actors) to document and analyse the efforts of such coalitions to use policy analysis to influence the policy processes—agenda setting, policy formulation, and policy implementation—in which they engage. In so doing, it identifies challenges based on reviews of the theoretical, methodological, and empirical literature as well as the experience of the author. The aim of this paper is to generate debate to assist in resolving the myriad challenges inherent in prospective policy analysis. It responds to appeals for political research that addresses the problems confronting political actors so as to guide future action/research for evidence-informed, pro-poor health policy.

Buse, K., N. Lalji, S.H. Mayhew, M. Imran, and S.J. Hawkes. 2010. "Political Feasibility of Scaling-up Five Evidence-informed HIV Interventions in Pakistan: A Policy Analysis." *Sexually Transmitted Infections* 85(Suppl II): ii37–ii42.

Abstract

Background: Drawing on policy theories, an assessment was made of the perceived political feasibility of scaling up five evidence-based interventions to curb Pakistan's HIV epidemic: needle and syringe exchange programmes; targeted behaviour change communication; sexual healthcare for male and transgender sex workers; sexual and reproductive healthcare for female sex workers; and promoting and protecting the rights of those at greatest risk.

Methods: A questionnaire was emailed to 40 stakeholders and completed by 22 of them. They expressed their level of agreement with 15 statements for each intervention related to variables associated with policy success. Semi-structured interviews were conducted with 12 respondents.

Results: The interventions represent considerable change from the status quo but are perceived to respond to widely acknowledged problems. These perceptions, held by the HIV policy elite, need to be set in the context of the prevailing view that the AIDS response is not warranted, given the small and concentrated nature of the epidemic and that the interventions do not resonate closely with the values held by society. The interventions were perceived to be evidence based, supported by at least one donor, and subject to little resistance from front-line staff, as they will be implemented by contracted nongovernment organisations. The results were mixed as to other factors determining political feasibility, including the extent to which interventions are easy to explain, exhibit simple technical features, require few additional funds, and are supported and not opposed by powerful stakeholders.

Conclusion: The interventions stand a good chance of being implemented, although they depend on donor support. The prospects for scaling them up would be improved by ongoing policy analysis and strengthening of domestic constituencies among the target groups.

Cross, H., K. Hardee, and N. Jewell. 2001. *Reforming Operational Policies: A Pathway to Improving Reproductive Health Programs*. Washington, DC: Futures Group, POLICY Project.

Excerpt

Many countries around the world have made great progress in improving RH programs that now reflect

the principles of the 1994 ICPD Programme of Action. Governments and donors have pursued two main routes to improving reproductive health. First, they have enacted national policies and laws aimed at expanding services and raising the quality of available services. Second, they have implemented a wide range of service projects and demonstrations to show how services can be enhanced and client education improved. Too often, however, national policies and laws are not translated into system-wide programs and improved RH services, especially for the poor. Because these doctrines are necessarily broad and encompassing, they neglect the structures and systems that serve as a bridge between national policies and local programs. Projects and demonstrations often are not replicable because they are not financially sustainable in the long run. More important, they generally do not systematically address the underlying policy constraints in the structures and systems that affect the service delivery environment. This paper focuses on the vast arena stretching between national policies and the point of service delivery—the domain of operational policies.

Operational policies are the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services. Whereas national policies provide necessary leadership and guidance, operational policies are the means for implementing those policies. In many cases, program deficiencies, such as a lack of trained service providers and other resources, can be traced to inadequate, inappropriate, or outdated operational policies. Poor operational policies result in the wastage and inefficiency that pervades every clinic, health post, and hospital, and adversely affects health personnel and every client. When drafted or modified appropriately, operational policies can help enhance the quality of RH programs by making more efficient use of existing resources. This paper discusses the nature of operational policies, stresses the important role they play in the continuum from national decrees to local services, and provides a framework for operational policy reform.

Date, A.A., M. Vitoria, R. Granich, M. Banda, M.Y. Fox, et al. 2010. "Implementation of Co-trimoxazole Prophylaxis and Isoniazid Preventive Therapy for People Living with HIV." *Bulletin of the World Health Organization* 88:253–259.

Abstract

Objective: To measure progress in implementing CPT (trimethoprim plus sulfamethoxazole) and IPT policy recommendations, identify barriers to the development of national policies, and pinpoint challenges to implementation.

Methods: In 2007, we conducted a cross-sectional email survey of WHO HIV/AIDS programme officers in 69 selected countries having a high burden of infection with HIV or HIV-associated TB. The specially designed, self-administered questionnaire contained items covering national policies for CPT and IPT in people living with HIV, the current level of implementation, and barriers to developing or implementing these policies.

Findings: The 41 (59%) respondent countries, representing all WHO regions, comprised 85 percent of the global burden of HIV-associated TB and 82 percent of the global burden of HIV infection. Thirty-eight countries (93%) had an established national policy for CPT, but only 66 percent of them (25/38) had achieved nationwide implementation. For IPT, 21 of 41 countries (51%) had a national policy but only 28 percent of them (6/21) had achieved nationwide implementation. Despite significant progress in the development of CPT policy, the limited availability of cotrimoxazole for this indication and inadequate systems to manage drug supply impeded nationwide implementation. Inadequate intensified TB case-finding and concerns regarding isoniazid resistance were cited as challenges to the development and implementation of national IPT policies.

Conclusion: Despite progress in implementing WHO-recommended CPT and IPT policies, these interventions remain underused. Urgent steps are required to facilitate the development and

implementation of these policies.

Dodani, S. and R.A. Chotani. 2012. "A Tale of Devolution, Abolition, and Performance." *The Lancet* 379: 9814.

Summary of Report (self-written)

In this correspondence piece, the authors question whether the problems with Pakistan's healthcare system could be resolved by abolishing the country's Health Ministry. They begin by pointing out that Pakistan has never included its health sector in its long-term plans or policies. They acknowledge that Pakistan's poor health outcomes can be partly attributed to poverty, poor water and sanitation infrastructure, and low education, but argue that the health system's inadequate resources and spending are a major cause of poor health. Finally, they attribute the health system's shortcomings to governmental corruption and the appointment of health workers ill-suited to their work, but argue that the demolition of the Health Ministry is unlikely to help the situation.

Duc, T.T., D. Stephens, K. Spratt, N. Kapadia-Kundu, and H.T.T. Tran. n.d. *Contrasting the Process of OVC Policy Development and Policy Implementation in Vietnam: Results from a Study on Barriers to Policy Implementation.* Poster. Washington, DC: USAID | Health Policy Initiative, Task Order 1.

Abstract

Issues: Policy implementation lags behind the process of policy development. Little systematic research exists on the process of policy implementation in resource-poor settings such as Vietnam. Vietnam has an estimated 283,000 HIV-affected children and about 8,500 children living with HIV. Decision 65 is the National Plan of Action on "community based care for children in especially difficult circumstances in the period 2005–2010." Decision 65 was approved in March 2005 and followed by another decree that outlined a detailed implementation plan with necessary budgetary allocations.

Description: The objective of this qualitative study was to develop an understanding of the process of policy implementation and its barriers. A total of 31 in-depth interviews were conducted with policymakers and policy implementers. The data indicate that, although a detailed 10-step process of policy development exists in Vietnam, similar clarity is missing in the context of policy implementation.

Lessons learned: The study indicates that the development of implementation guidelines does not necessarily mean that policies will translate into programs. The crucial missing step is that of strengthened provincial-level planning and micro-planning mechanisms. The barriers to policy implementation identified in the study can be divided into three areas:

1. Provincial level
2. Community level
3. Institutional mechanisms for review and monitoring

The focus of policy development is at the national level; that of policy implementation is at the district and commune levels. Policy development requires careful drafting—it is about going to scale.

Next steps: Capacity building to develop detailed district and commune-level plans for implementing policies. Higher motivation levels must be built and sustained at the province, district, and commune levels. Information channels must be established to ensure the flow of new policies. Also needed is the creation of a "Policy Implementation Task Force" at the national, provincial, and district levels.

Feranil, I., and M. Borda. 2008. *Achieving Uttar Pradesh's Population Policy Goals through Demand-based Family Planning Programs: Taking Stock at the Mid-point.* Washington, DC: Health Policy Initiative, Task Order 1, Futures Group International.

Excerpt

This study assessed progress in achieving the goals of the Uttar Pradesh (UP) Population Policy adopted in 2000, the implications of alternative fertility and mortality trends during the next decade, and strategies and program initiatives recommended by national and state policymakers and other experts. To assess progress in implementing the UP Population Policy and show how fertility trends would affect maternal and child health and socioeconomic development, the USAID | Health Policy Initiative, Task Order 1, analyzed data from the National Family Health Survey (NFHS-3) conducted in 2005–2006. The project conducted the analysis using the FamPlan, DemProj, and RAPID models within Spectrum, a modeling system that uses computer software to generate projections and estimates showing the results of policy alternatives.

The project presented the results of the analysis at two roundtable meetings held in India in December 2007. At the Lucknow meeting, participants generated recommendations for new initiatives in UP's Reproductive and Child Health Program to help move the state closer to the goal of population stabilization. The major recommendations were as follows:

- Make communication strategies more focused and strategic
- Strengthen community participation
- Stimulate private sector involvement and public-private collaboration
- Make postpartum family planning a standard service
- Ensure contraceptive security

Produce higher-quality data and analysis

During the second meeting in New Delhi, senior policymakers from the Ministry of Health and Family Welfare further discussed meeting unmet need through repositioning family planning within the overall package of reproductive and child health interventions in UP. Mr. G.C. Chaturvedi, mission director, National Rural Health Mission, facilitated the roundtable discussion. Participants deliberated on the state-specific interventions identified during the Lucknow roundtable and then generated targeted actions to ensure contraceptive security, strengthen communication strategies, and increase community involvement in decision making. These actions include the following:

- Increase the availability of maternal health, reproductive health, and child health services by having round-the-clock services in a minimum of 10 percent of primary health centers, as is being done in other states
- Conduct a study on the acceptability of the multi-load copper intrauterine device
- Expand the choice of FP methods available

Improve access to high-quality services by having fixed days for sterilization instead of periodic sterilization days

Friedland, G., A. Harries, and D. Coetzee. 2007. "Implementation Issues in Tuberculosis/HIV Program Collaboration and Integration: 3 Case Studies." *The Journal of Infectious Diseases* 196:S114–23.

Abstract

The many interactions between TB and HIV infection influence the design and implementation of

programs to address the needs of patients living with or at risk for both diseases. Collaboration between national TB and HIV programs and some degree of integration of services at a local level have been advocated by WHO and other international bodies, and are recognized as essential in those areas where the two diseases are prevalent. However, in most settings, strategies to accomplish this goal are only beginning to reach the field, where their impact will be made and the expectation of improving the outcome of both diseases realized. In this article, three such strategies, offering varying degrees of collaboration and integration, are described, one at a national level in Malawi and two at local sites in South Africa. These geographically and programmatically distinct experiences in TB/HIV service integration are instructive, illustrate common themes, and show that the strategy can be successful; they also show that programmatic, medical, staffing, resource, and scale-up challenges remain. In addition, they indicate that, although broad program principles of TB/HIV service integration are essential, program designs and components may vary by country, and even within countries, as a result of differing TB and HIV disease prevalences, resources, levels of expertise, and differences in program settings (urban vs. rural and/or primary vs. district vs. specialty site). Large national programs can successfully provide rapid, uniform, and widespread change and implementation but also must negotiate the subtleties and intricacies of TB/HIV interactions, which confound a uniform "one-size-fits-all" public health approach. Conversely, smaller demonstration projects, even with successful outcomes, must grapple with issues related to generalization of findings, wider implementation, and scale up to benefit larger populations of those in need.

Getahun, H. and H. Eshete. 2003. *Macro-level Operational Barriers to Family Planning Services in Ethiopia: Taxation and Importation of Contraceptives and the Role of NGOs.* Washington, DC: Futures Group, POLICY Project.

Abstract

The POLICY Project conducted this study in 2002 to identify operational policy barriers to taxation, importation, and clearance of contraceptive commodities in Ethiopia, and identify the barriers to provision of effective FP services by NGOs and the private sector. Key informants—including high-level officials and program managers in the government and nongovernment sectors, international organizations, and selected private practitioners—were interviewed using a semi-structured questionnaire. In addition to these interviews, the authors conducted an extensive document review to capture additional information and insight that might not be provided by informants.

Glassman, A., M. Reich, K. Laserson, and F. Rojas. 1999. *Political Analysis of Health Reform in the Dominican Republic. Health Policy Planning* 14(2):115–126.

Abstract

This article examines the major political challenges associated with the adoption of health reform proposals through the experience of one country, the Dominican Republic. The article briefly presents the problems of the health sector in the Dominican Republic and the health reform efforts initiated in 1995. The article describes the PolicyMaker method of applied political analysis and presents the results of its application in the Dominican Republic, including analysis of the policy content of the health reform and assessment of five key groups of players (public sector, private sector, unions, political parties, and other nongovernmental organizations). The PolicyMaker exercise was conducted in collaboration with the national Office of Technical Coordination (OCT) for health reform and produced a set of 11 political strategies to promote the health reform effort in the Dominican Republic. These strategies were partially implemented by the OCT but were insufficient to overcome political obstacles to the reform as of late 1997. The conclusion presents six factors that affect the pace and political feasibility of health reform proposals, with examples from the case of the Dominican Republic.

Green, A., N. Gerein, T. Mirzoev, P. Bird, S. Pearson, et al. 2011. "Health Policy Processes in Maternal Health: A Comparison of Vietnam, India and China." *Health Policy* 100(2): 167–173.

Abstract

This article reports on a comparative analysis to assess and explain the strengths and weaknesses of policy processes based on nine case studies of maternal health in Vietnam, India, and China. Policy processes are often slow, inadequately coordinated, and opaque to outsiders. Use of evidence is variable; in particular, it could be used more actively to assess different policy options. Whilst an increasing range of actors are involved, there is scope for a further opening up of the policy processes. This is likely if appropriately managed with due regard to issues, such as the accountability of advocacy organisations, to lead to stronger policy development and greater subsequent ownership; it may, however, be a more messy process to coordinate. Coordination is critical when policy issues span conventional sectoral boundaries but is also essential to ensure that the development of policy considers critical health system and resource issues. This coordination and other features related to the nature of a specific policy issue suggests the need both to adapt processes for each particular policy issue and monitor the progress of the policy processes themselves. The article concludes with specific questions to be considered by actors keen to enhance policy processes.

Health Policy Initiative and DELIVER Project. 2008. *Analysis of the Operational Policy Barriers to Financing and Procuring Contraceptives in Malawi.* Washington, DC: Health Policy Initiative, Constella Futures, and Arlington, VA: DELIVER Project, John Snow, Inc.

Summary of Report (self-written)

Contraceptive security exists when every person can choose, obtain, and use high-quality contraceptives whenever they need them. Two of the most important factors in achieving contraceptive security are adequate financing and efficient contraceptive procurement mechanisms. The USAID | Health Policy Initiative and USAID | DELIVER Project worked together to develop a methodology for identifying operational policy barriers in the financing and procurement of FP products. The goal is to help national governments, donors, and other key stakeholders improve the policy environment for contraceptive security. This report presents the findings from a pilot study of the two projects conducted in Malawi to test this methodology.

Hunsmann, M. 2012. "Limits to Evidence-based Health Policymaking: Policy Hurdles to Structural HIV Prevention in Tanzania." *Social Science & Medicine* 74(10): 1477–1485.

Abstract

Despite the well-documented role of highly co-endemic biological cofactors in facilitating HIV transmission and the availability of comparatively inexpensive tools to control them, cofactor-related interventions are included only hesitantly in African HIV prevention strategies. Against this background, this study analyzes political obstacles to policy uptake of evidence concerning structural HIV prevention. The data used were gathered during fieldwork conducted in Tanzania between 2007 and 2009. They include 92 in-depth interviews with key AIDS policymakers and observations of eight national-level policy meetings. Adopting a political economy perspective, the study shows that (1) assuming cost aversion as a spontaneous reflex of policymakers is empirically wrong and analytically misleading, (2) political constituencies induce a path dependence of allocative decisions inconducive to structural prevention, (3) interventions' political attractiveness depends on the nature of their outputs and the expected temporality of political returns, (4) policy fragmentation entailed by vertical disease control disfavours the consideration of broader causalities, and (5) cofactor-based measures are hampered by policymakers' perceptions of structural prevention as being excessively complex and ultimately tantamount to poverty eradication.

Confronting the policy players' reading of the Tanzanian situation with recent and classical literature on evidence-based decision making and the politics of public health, this paper shows that, far from being strictly evidence-driven, HIV prevention policies result from a politically negotiated aggregation of competing, frequently non-optimizing rationalities. A realistic appraisal of policy processes suggests that the failure to consider the invariably political nature of HIV-related policy making hampers the formulation of effective, politically informed strategies for positive change. Consequently, developing policy practitioners' understanding of how to engage effectively in evidence-influenced political struggles over priorities might be more instrumental in improving HIV prevention strategies than attempts to sidestep these ineradicably antagonistic controversies through technical decision tools meant to optimize health outcomes via the formulation of "rational consensus."

Islam, M. (ed.). 2007. "Health Systems Assessment Approach: A How-To Manual." ***Submitted to the U.S. Agency for International Development in Collaboration with Health Systems 20/20, Partners for Health Reformplus, Quality Assurance Project, and Rational Pharmaceutical Management Plus, Arlington, VA: Management Sciences for Health.***

Excerpt

The USAID Office of Health, Infectious Diseases and Nutrition (HIDN) requested the development of a health systems assessment approach as part of its global Mainstreaming Health Systems Strengthening Initiative. The approach is meant to serve the following purposes:

- To enable USAID missions to assess a country's health system, possibly during early phases of program development or sector planning; this assessment would diagnose the relative strengths and weaknesses of the health system, prioritize key weakness areas, and identify potential solutions or recommendations for interventions
- To inform population, health, and nutrition (PHN) officers and USAID mission health teams about the basic elements and functions of health systems
- To improve the capacity of bilateral projects to achieve USAID's health impact objectives through increased use of health systems interventions
- To aid health systems officials at USAID to conceptualize key issues, increase the use of health systems interventions in technical program design and implementation, and improve the role of the Health Systems Division
- To inform ministries of health and other stakeholders of the relative strengths and weaknesses of the health system, priority issues, and potential solutions or recommendations for interventions and programs

National Institute for Health and Clinical Excellence. 2007. ***How to Change Practice: Understand, Identify and Overcome Barriers to Change.*** **London: NICE. Available at: http://www.nice.org.uk/Media/Default/About/what-we-do/Into-practice/Support-for-service-improvement-and-audit/How-to-change-practice-barriers-to-change.pdf.**

Excerpt

This guide aims to improve patient care by giving practical advice on how to encourage healthcare professionals and managers to change their practice in line with the latest guidance. It is focused on the healthcare setting, but the general principles of change may be applicable elsewhere.

Certain factors may help to foster an environment conducive to change. An organisation in which there is strong leadership and everyone is focused on improving patient care is likely to develop motivated staff with a desire for continuous improvement. However, barriers to changing established practice may prevent or impede progress in all organisations, whatever the culture. In this guide, we focus on barriers

that operate at an individual rather than an organisational level.

Ngabaza, S. and T. Shefer. 2013. "Policy Commitments vs. Lived Realities of Young Pregnant Women and Mothers in School, Western Cape, South Africa." *Reproductive Health Matters* 21:106–113.

Abstract

Reproductive rights in South Africa continue to be undermined for young women who fall pregnant and mothers while still at school. Before 1994, exclusionary practices were common, and the majority of those who fell pregnant failed to resume their education. With the adoption of new policies in 2007, young pregnant women and mothers are supposed to be supported in completing school successfully. Notwithstanding these new policies, incongruities continue to exist between policy implementation and young women's lived experience in school. This paper explores the experiences of pregnancy and parenting among a group of 15 young women who fell pregnant and mothers while attending three high schools in Khayelitsha township, a working-class community in the Western Cape of South Africa. Qualitative, in-depth interviews, conducted between 2007 and 2008, highlighted two key areas of concern: continuing exclusionary practices on the part of schools, based on conservative interpretations of policy, and negative and moralistic responses from teachers and peers. Such practices resulted in secrecy and shame about being pregnant, affecting the young women's emotional and physical well-being and their decisions about whether to remain in school during pregnancy and return after having the baby. Further attention is required to ensure appropriate implementation of policies aimed at supporting pregnant and parenting young women in completing their education successfully.

Okundi, B., C. Aloo-Obunga, R. Sanders, C. Shepherd, and C. Green. 2008. *Rapid Assessment on Policy and Operational Barriers to the Integration of FP/RH/HIV Services in Kenya*. Washington, DC: Health Policy Initiative, Task Order 1, Futures Group International.

Excerpt

As part of an overall effort to improve access to family planning and reproductive health in selected countries, the USAID | Health Policy Initiative, Task Order 1 conducted a literature review and rapid assessment to identify policy and operational barriers to the integration of family planning and reproductive health and HIV in Kenya. The project is continuing to support work to eliminate these barriers by facilitating an ongoing and participatory process to develop an integration strategy and operational policy guidelines. The strategy and guidelines will provide a framework for coordination among the agencies and organizations offering integrated services, and will cover topics such as the procurement of commodities and supplies, training, supervision, and financing.

The Health Policy Initiative research team worked closely with the Integration Technical Working Group (ITWG), which includes representatives of key Kenyan government agencies, service providers, and international agencies. In collaboration with policymakers, program implementers, service providers, and other key stakeholders, the research team completed the following tasks:

- Reviewed the research literature on FP/RH/HIV integration
- Conducted a rapid assessment of stakeholder views on FP/RH/HIV integration
- Disseminated research findings to the ITWG, government officials, and key stakeholders
- Met with key stakeholders to build consensus on the need for operational policy guidelines

Established a task force to draft a strategy and operational policy guidelines

The research team conducted the rapid assessment during April–June 2007 in four provinces (Central,

Coast, Nairobi, and Western). These provinces were selected because they have been implementing FP/RH/HIV integrated services. The key informants were chosen based on their involvement in integration activities and role in formulating and implementing policies that affect the provision of health services. The 99 respondents included 15 national-level policymakers from the public and private sectors; 33 program managers at the national, provincial, and district levels in all four provinces; and 51 service providers in 31 public and private health facilities.

Peters, D.H., L. Paina, and S. Bennett. 2012. "Expecting the Unexpected: Applying the Develop-Distort Dilemma to Maximize Positive Market Impacts in Health." *Health Policy and Planning* 27(Suppl iv): iv44–iv53.

Abstract

Although health interventions start with good intentions to develop services for disadvantaged populations, they often distort the health market, making the delivery or financing of services difficult once the intervention is over—a condition called the "Develop-Distort Dilemma" (DDD). In this paper, we describe how to examine whether a proposed intervention may develop or distort the health market. Our goal is to produce a tool that facilitates meaningful and systematic dialogue for practitioners and researchers to ensure that well-intentioned health interventions lead to productive health systems while reducing the undesirable distortions of such efforts. We apply the DDD tool to plan for development rather than distortions in health markets, using intervention research being conducted under the Future Health Systems consortium in Bangladesh, China, and Uganda. Through a review of research proposals and interviews with principal investigators, we use the DDD tool to systematically understand how a project fits within the broader health market system and identify gaps in planning for sustainability. We found that although current stakeholders and funding sources for activities were easily identified, future ones were not. The implication is that the projects could raise community expectations that future services will be available and paid for, despite this actually being uncertain. Each project addressed the "rules" of the health market system differently. The China research assesses changes in the formal financing rules, whereas Bangladesh and Uganda's projects involve influencing community-level providers, for whom informal rules are more important. In each case, we recognize the importance of building trust between providers, communities, and government officials. Each project could both develop and distort local health markets. Anyone intervening in the health market must recognize the main market perturbations, whether positive or negative, and manage them so as to maximize the benefits to the health system and population health.

Policy Project. 2005. *Core Package Final Report: Determining the Feasibility and Potential Scope of Integrating Reproductive Health (FP/MCH/STI/HIV/AIDS) Services in Jamaica*. Washington, DC: Futures Group, POLICY Project.

Abstract

The POLICY Project funded a core package to assess the feasibility of integrating FP/maternal and child health (MCH) and STI/HIV services in two areas of Jamaica: the parish of Portland and the St. Ann's Bay Health District. Activities included the following: (1) mapping existing healthcare clinics and staff in Portland and St. Ann's Bay; (2) identifying potential integration interventions; (3) identifying operational policy barriers to integration; (4) conducting a feasibility study to determine whether the interventions could be implemented; (5) estimating the associated implementation costs; and (6) conducting a cost-effectiveness study regarding various alternatives for diagnosing and treating STIs. The core package's main results included the identification of priority interventions to facilitate integration and the development of a cost-effectiveness model for STI diagnosis and treatment.

This report documents the POLICY Project's research activities and findings, including the context and organization of health services; activities undertaken to determine the feasibility and cost-effectiveness of integration interventions; key research findings; and the key results, challenges, lessons learned, and

potential impact of the research conducted under this core package.

Rechel, B. 2010. "HIV/AIDS in the Countries of the Former Soviet Union: Societal and Attitudinal Challenges." *Central European Journal of Public Health* 18:110–115.

Abstract

For several years, some of the countries of the former Soviet Union have experienced the fastest-growing HIV epidemic in the world, with the vast majority of reported infections contracted through injecting drug use. However, most governments of the region have been slow to recognize the severity of the problem. The scope and coverage of governmental HIV/AIDS programmes have remained very limited. Harm reduction programmes are mainly financed by external donors, and substitution treatment remains illegal in Russia and unavailable in some other countries of the region. Based on a review of published and grey literature, this paper explores attitudinal and societal barriers to scaling up HIV programmes in the countries of the former Soviet Union. A major challenge in many countries is negative public attitudes towards people living with HIV, as well as towards those most at risk of contracting the disease: people who inject drugs (PWID), sex workers, and men who have sex with men (MSM). This challenge extends to the actions of state authorities, which often pursue a punitive approach to PWID, with high rates of incarceration for minor drug offences. Although many of the findings reported here relate to the Russian Federation, there is reason to believe that similar challenges exist in many other countries of the former Soviet Union. More needs to be done to document challenges to HIV prevention and treatment programmes across the region so that policy interventions can be more effective.

Reproductive Health Supplies Coalition (RHSC). 2012. *Family Planning Access for All: Policy Change for Action and Accountability. A Catalyst for Discussion.* Brussels, Belgium: RHSC, Resources Mobilization and Awareness (RMA) Working Group.

Excerpt

The Family Planning Summit's goal is to give access to lifesaving FP information, services, and supplies to an additional 120 million women in the poorest countries by 2020. By striving to do so, it firmly places improved access to family planning at the core of the global development agenda and gives the global FP community a unique opportunity to build on successes to date and accelerate actions that will contribute to transforming the quality of life of women, men, and young people.

A range of political, social, behavioral, programmatic, and funding factors must be addressed to achieve access for all. This document focuses on commitment to change policy and practice, as this is an area in which countries and civil society have great contributions to make. The Family Planning Summit lays the groundwork for policy commitment and change at the highest level in countries, which will greatly contribute to improving the operating environment for FP services. As a contribution to the Family Planning Summit, the RMA Working Group (WG) tapped into the collective experience of more than 150 partners from 26 of the world's poorest countries and asked them to identify those policy changes that stand to make a substantial contribution to meeting the unmet need for family planning. These partners also provided insights regarding the concomitant actions that must be either changed or scaled up in countries and helped to outline the role civil society can play.

Rubin, D.S. and B. Herstad. 2009. *Integrating Gender in Policy Implementation Barriers Analysis: A Methodology.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Excerpt

This report outlines a methodology for integrating gender into the Policy Implementation Barriers Analysis (PIBA) activity. The pilot methodology focused on integrating attention to gender inequalities into the survey and analysis process; identifying gender-based obstacles affecting the achievement of

targets under the President's Emergency Plan for AIDS Relief (PEPFAR); and determining whether the root sources of the obstacles resulted from the impact of the policies, the way access is structured in implementation, and/or other issues related to training, supply, or institutional collaboration. Specifically, this report describes the main activities to be undertaken by a team of gender experts: a desk review and analysis of the relevant policies; drafting a briefing note; conducting gender training; and assistance with the preparation and implementation of the PIBA survey. The report also presents examples of how each activity was developed and/or used in several of the country PIBA surveys.

Sanders D. and A. Haines. 2006. "Implementation Research Is Needed to Achieve International Health Goals." *PLoS Med* 3(6): e186.

Summary of Report (self-written)

The next step in health systems research must be the investigation of the "knowledge-implementation gap": the gap between the knowledge of health problems and solutions, and the implementation of health promotion programs in developing countries. This article describes the concepts of the health system and health systems research, analyzes the barriers to reducing the gap, and provides recommendations for conducting health systems research with the knowledge-implementation gap in mind.

Sonneveldt, E., T. Shaver, and A. Bhuyan. 2008. *Understanding Operational Barriers to Family Planning Services in Conflict-affected Countries: Experiences from Sierra Leone.* USAID. Washington, DC: Constella Futures, Health Policy Initiative.

Summary of Report (self-written)

Recognizing the importance of a sound policy environment and the operational guidelines necessary for putting policies into practice, a study was commissioned in Sierra Leone in 2007 to explore refugee/ internally displaced person (IDP) FP needs before, during, and after conflict, in addition to determining the root causes of the barriers to high-quality accessible services. Other objectives include building the capacity of local groups to analyze operational barriers to services and devising policy actions and recommendations for overcoming barriers that are applicable both in country and in other conflict-affected countries.

Spratt, K. 2009. *Policy Implementation Barriers Analysis: Conceptual Framework and Pilot Test in Three Countries.* Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Excerpt

In recent decades, the world has been severely affected by the AIDS pandemic. In bringing attention to the pandemic, international agencies, AIDS activists, and national health experts have helped spur national governments to respond by creating and approving policies and programs intended to address HIV/AIDS-related challenges. However, not all of these policies or program directives are being implemented at the country level. Recognizing this, the United States Office of the Global AIDS Coordinator (OGAC) has acknowledged the importance of identifying and addressing policy barriers related to implementation. In the HIV/AIDS FY2008 PEPFAR Country Operating Plan Guidance, specific instructions are included for the first time for operating units to describe policy barriers they need to overcome to ensure a program area's success.

The USAID | Health Policy Initiative, Task Order 1 is well positioned to examine such policy barriers, as the project's mandate includes contributing to a better understanding of fundamental barriers to policy implementation by developing systematic approaches to assess and reduce these barriers. This paper describes the project's effort to develop such an approach through conducting a Policy Implementation Barriers Analysis. In this pilot phase, the Health Policy Initiative focused on three Asian countries (China, Indonesia, and Vietnam) representing a range of political systems in which the HIV epidemic has become

prominent in particular populations. The experience in Asia has yielded many country-specific lessons and insights on policy development and implementation (as described in this document), as well as a validation of several global lessons that can be applied more broadly.

Thomas, J.W. and M.S. Grindle. 1990. "After the Decision: Implementing Policy Reforms in Developing Countries." *World Development* 18(8): 1163–1181.

Summary of Report (self-written)

Implicit in many reform proposals is a model of the policy process that is roughly linear: a proposed reform gets on the agenda for government action, a decision is made on the proposal, and the new policy or institutional arrangement is implemented, either successfully or unsuccessfully. This article presents an alternative, interactive model of implementation that focuses on the conflict and reactions that are evoked by efforts to bring about changed policy or institutional contexts for development and the resources policymakers and managers are likely to require in sustaining a reform in the face of such reactions. Central to the analysis is the assertion that characteristics of the reform being implemented will largely determine the kind of conflict it engenders, where such reaction is likely to become manifest, and what resources are needed for sustainability. The analysis suggests a framework for the strategic management of reform initiatives.

Walt, G. and L. Gilson. 1994. "Reforming the Health Sector in Developing Countries: The Central Role of Policy Analysis." *Health Policy and Planning* 9(4): 353–370.

Abstract

Policy analysis is an established discipline in the industrialized world, yet its application to developing countries has been limited. In particular, the health sector appears to have been neglected. This is surprising, because there is a well-recognized crisis in health systems, and prescriptions abound as to *what* health policy reforms countries should introduce. However, little attention has been paid to *how* countries should carry out reforms, much less *who* is likely to favour or resist such policies.

This paper argues that much health policy wrongly focuses attention on the *content* of reform and neglects the actors involved in policy reform (at international, national, and subnational levels), the processes *contingent* on developing and implementing change, and the context within which policy is developed. Focus on policy content diverts attention from understanding the processes, which explains why desired policy outcomes fail to emerge. The paper is organized in four sections. The first sets the scene, demonstrating how the shift from consensus to conflict in health policy established the need for a greater emphasis on policy analysis. The second section explores what is meant by policy analysis. The third investigates what researchers in other disciplines have written that helps to develop a framework of analysis. The final section suggests how policy analysis can be used not only to analyze the policy process, but also to plan.

Monitoring and Accountability

Bhuiya, A., S.M.A. Hanifi, and S.S. Mahmood. 2008. "Action Monitoring for Equity and Gender in Health." *Journal of Health, Population, and Nutrition 26(3): 378.*

Abstract

Equity and gender, despite being universal concerns for all health programmes in Bangladesh, are often missing in many health agendas. These health programmes fail to address these important dimensions unless they are specifically included in the planning stage of a programme and continually monitored for progress. This paper presents the situation of equity in health in Bangladesh, innovations in monitoring equity in the use of health services in general and the poor in particular, and the impact of targeted non-health interventions on the health outcomes of the poor. This paper argues that an equitable use of health services might also result in enhanced overall coverage of the services. The findings show that government services at the upazila level are used by the poor proportionately more than in the community, whereas at private facilities, the situation is the reverse. Commonly used monitoring tools are not very useful at times in informing the programme managers how well they are doing in reaching the poor. Use of a benefit-incidence ratio may provide quick feedback to health facility managers about the extent to which they serve the poor. Similarly, lot quality assurance sampling can be an easy-to-use tool for monitoring coverage at the community level, in that it requires a very small sample size. Although health problems are biomedical phenomena, their solutions may include actions beyond the biomedical framework. Studies have shown that non-health interventions targeted towards the poor improve the use of health services and reduce mortality among children in poor households. This study on equity and health deals with various interlocking issues; the examples and views it presents are intended to introduce their importance in designing and managing health and development programmes.

Brinkerhoff, D. 2004. "Accountability and Health Systems: Toward Conceptual Clarity and Policy Relevance." *Health Policy and Planning* 19(6): 371–379.

Abstract

Improved accountability is often called for as an element in improving health system performance. At first glance, the notion of better accountability seems straightforward, but it contains a high degree of complexity. If accountability is to be more than an empty buzzword, conceptual and analytical clarity is required. This article elaborates a definition of accountability as to answerability and sanctions, and distinguishes three types of accountability: financial, performance, and political/democratic. It proposes an analytic framework for mapping accountability that identifies linkages among health sector actors and assesses capacity to demand and supply information, and exercise oversight and sanctions. The article describes three accountability purposes: reducing abuse, ensuring compliance with procedures and standards, and improving performance/learning. Using an accountability lens can (1) help to generate a system-wide perspective on health sector reform, (2) identify connections among individual improvement interventions, and (3) reveal gaps requiring policy attention. These results can enhance a system.

Chambers, V. 2012. *Improving Maternal Health when Resources Are Limited: Safe Motherhood in Rural Rwanda.* London: Africa Power and Politics Programme.

Summary of Report (self-written)

Over the past decade, Rwanda has managed to overcome many critical bottlenecks to make impressive progress on maternal health. It has done so despite the fact that health spending per capita in the country remains below the sub-Saharan African average.

Africa Power and Politics (APPP) carried out 11 months of fieldwork during 2009–2011 in the rural Rwandan districts of Nyamagabe and Musanze. This work indicates that substantial gains can be made, even in the absence of adequate material resources.

Dennis, S. 2009. *Making Aid Effectiveness Work for Family Planning and Reproductive Health*. Washington, DC: Population Action International.

Excerpt

This Population Action International working paper analyzes the five principles of aid effectiveness—country ownership, alignment, harmonization, managing for results, and mutual accountability—from FP and RH perspectives. It also describes how the Paris Declaration has changed the ways of managing and delivering aid; highlights entry points and obstacles for champions working to improve funding and policies; and makes recommendations for civil society organizations, governments, and donors.

While acknowledging challenges that aid effectiveness presents, this paper recognizes the need for champions to adjust to evolving circumstances and take advantage of emerging opportunities. Entry points for civil society champions working within the new aid architecture include pressuring governments and donors to prioritize family planning and reproductive health within national and sectoral budgets as well as poverty reduction strategies and other national and sectoral development plans. Ensuring that these documents include funding and indicators to monitor progress toward FP and RH goals increases the likelihood that programs will be implemented. Civil society organizations can also monitor budget expenditures and implementation of government and donor policies and commitments, and follow up with advocacy for improvements.

Health Systems 2020. 2012. *Health Systems 20/20 and Measuring and Monitoring Health System Performance*. Washington, DC: USAID and Health Systems 2020.

Excerpt

For data to be useful to country stakeholders and absorbed into policies, they must be timely and relevant to their specific needs. Health Systems 20/20 provides and maximizes the use of a set of established and innovative tools that allow countries to rapidly create specific yet standardized measurements that are comparable internationally and over time. The project works with country counterparts to implement the following:

- *Health System Assessments (HSAs)*: This methodology tracks indicators from WHO's six building blocks to identify the relative strengths and weaknesses of the health system, priority issues, and recommendations to improve health outcomes. HSA findings are used for a wide variety of activities, including defining interventions, developing funding requests, and informing country strategic planning initiatives.
- *Geographic Information Systems (GIS)*: GIS technology enables policymakers to identify and visually present trends that inform program planning and decision making, and correlate service delivery with health outcomes.

Health System Database: This web-based tool allows users to analyze and compile standardized country data from internationally comparable sources, such as WHO, the World Bank, and country Demographic and Health Surveys. The database provides stakeholders with a broader understanding of their country's health system and helps them benchmark performance against other countries or regions and monitor progress toward achieving goals.

Judice, N.R, J. Lane, E. Hunger, N. Wallace, R. MacInnis, et al. 2012. *Monitoring HIV Policy Interventions in PEPFAR Partnership Frameworks.* Washington, DC: Health Policy Project, PEPFAR, CDC, University of Washington.

Abstract

As part of a joint activity, the Health Policy Project, the University of Washington, USAID, and the Centers for Disease Control and Prevention (CDC) conducted a *global* analysis of planned policy interventions across the 22 publicly accessible PEPFAR Partnership Frameworks, with the purpose of

understanding how the interventions are related to PEPFAR and country or regional priorities. In addition to the desk review, the team conducted multicountry and multistakeholder capacity-building workshops for monitoring the policy process within PEPFAR-supported countries. This poster, produced by HPP, provides an analysis of the data collected as well as conclusions about the need to strengthen policy monitoring.

Judice, N.R. and O. Zaglada. 2012. *Assessment of HIV Policy Development and Implementation in Ukraine.* Conference Poster.

Abstract

Ukraine has one of the fastest-growing HIV epidemics in the world; the number of HIV cases diagnosed in the country has doubled since 2001. Ukraine's epidemic remains concentrated among most-at-risk populations (MARPs)—with more than 80 percent of reported HIV cases occurring in these groups. In this context, the Health Policy Project evaluated the degree to which an enabling policy framework for HIV exists in Ukraine, with a focus on HIV prevention among MARPs. The project interviewed 72 key informants regarding the policy environment and policy dissemination and implementation at national and subnational levels. The assessment findings indicate a strong enabling environment, but one that has gaps and barriers, such as lack of operational guidelines to support the implementation of HIV laws and regulations. Building on the joint U.S. and Ukraine governments' Partnership Framework, the findings reveal new possibilities for developing effective mechanisms to support the implementation and enforcement of HIV-related regulations in Ukraine.

Kickbush, I. 2000. "The Development of International Health Policies—Accountability Intact?" *Social Science & Medicine* 51; 979–989.

Abstract

International health governance as it exists today is facing major structural challenges in view of globalization, the increased transfer of international health risks, and the mounting challenge of health inequalities worldwide. As a consequence, the capacity of nation states to ensure population health and address major health determinants has been weakened. This paper explores health as an exemplary field to illustrate that we have entered a new era of public policy, defined by increasing overlaps between domestic and foreign policy, multilateral and bilateral strategies, and national and international interests. Cross-border spillovers and the externalities of national actions need to move into the core of public policy at the national and global levels within a new rules-based system. Further, a new perspective on global health governance is needed due to the increased number of players in the global health arena. The emerging organizational form is based on networks and is characterized by shifting alliances and blurred lines of responsibility. The paper explores the emerging paradox of state sovereignty and makes a set of proposals to pool state sovereignty on health and structure the myriad of networks. Particular attention is given to the role of WHO within this process of change and adjustment. Using a framework from international relations analysis, the paper explores how nation states are socialized into accepting new norms, values, and perceptions of interest with regard to national and international health, and what challenges emerge for WHO in "inventing" global health policy.

Maluka, S. 2001. "Strengthening Fairness, Transparency and Accountability in Health Care Priority Setting at District Level in Tanzania." *Global Health Action* 4: 10.

Abstract

Healthcare systems are faced with the challenge of resource scarcity and have insufficient resources to respond to all health problems and target groups simultaneously. Hence, priority setting is an inevitable aspect of every health system. However, priority setting is complex and difficult because the process is influenced by political, institutional, and managerial factors not considered by conventional priority-setting tools. In a five-year EU-supported project, which started in 2006, ways of strengthening fairness

and accountability in priority setting in district health management were studied. This review is based on a Ph.D. thesis that aimed to analyse healthcare organisation and management systems, and explore the potential and challenges of implementing an Accountability for Reasonableness (A4R) approach to priority setting in Tanzania. A qualitative case study in Mbarali district formed the basis of exploring the sociopolitical and institutional contexts within which healthcare decision making takes place. The study also explored how the A4R intervention was shaped, enabled, and constrained by the contexts. Key informant interviews were conducted. Relevant documents were also gathered and group priority-setting processes in the district were observed. The study revealed that, despite the obvious national rhetoric on decentralisation, actual practice in the district involved little community participation. The assumption that devolution to local government promotes transparency, accountability, and community participation is far from the reality. The study also found that, whereas the A4R approach was perceived to be helpful in strengthening transparency, accountability, and stakeholder engagement, integrating the innovations into the district health system was challenging. This study underscores the idea that greater involvement and accountability among local actors may increase the legitimacy and fairness of priority-setting decisions. A broader and more detailed analysis of health system elements and sociocultural context is imperative in fostering sustainability. Additionally, the study stresses the need to deal with power asymmetries among various actors in priority-setting contexts.

McGee, R. and J. Gaventa. 2010. *Review of Impact and Effectiveness of Accountability and Transparency Initiatives: Synthesis Report*. London: Department for International Development.

Summary of Report (self-written)

Transparency and accountability have emerged over the past decade as key ways to address both developmental failures and democratic deficits. In the development context, the argument is that through greater accountability, the "leaky pipes" of corruption and inefficiency will be repaired, aid will be channelled more effectively and, in turn, development initiatives will produce greater and more visible results.

For scholars and practitioners of democracy, a parallel argument holds that, following the 20th century wave of democratisation, democracy now has to "deliver the goods," especially in material outcomes, and new forms of democratic accountability can help it to do so. Whereas traditional forms of state-led accountability are increasingly found to be inadequate, thousands of multistakeholder and citizen-led approaches have come to the fore to supplement or supplant them.

Despite their rapid growth, and the growing donor support they receive, little attention has been paid to the impact and effectiveness of these new transparency and accountability initiatives. Responding to this gap, this report, based on a review of literature and experience across the field, with special focus on five sectors of transparency and accountability work, aims to improve understanding among policymakers and practitioners of the available evidence, and identify gaps in knowledge to inform a longer-term research agenda.

Merino, L. 2010. "Keeping Watch: Accountability for FP/RH Laws in Guatemala." Presentation at the USAID | Health Policy Initiative Task Order 1 End of Project Meeting, Washington, DC.

Abstract

Reproductive Health Observatories Networks (OSARs) are multisectoral bodies that monitor implementation of FP and RH laws and policies in Guatemala. This approach, initiated at the national level, has been replicated in various departments. Indigenous women's networks have played a key role in decentralizing the approach and monitoring FP, RH, and maternal health programs in communities.

Ogden, J., K. Morrison, and K. Hardee. 2014. "Social Capital to Strengthen Health Policy and Health Systems." ***Health Policy and Planning*** **29(8):1075–1085.**

Abstract

This article recounts the development of a model for social capital building developed over the course of interventions focused on HIV-related stigma and discrimination, safe motherhood, and reproductive health. Through further engagement with the relevant literature, it explores the nature of social capital and suggests why undertaking such a process can enhance health policy and programmes, advocacy, and governance for improved health systems strengthening (HSS) outcomes. The proposed social capital process facilitates the systematic and effective inclusion of community voices in the health policy process—strengthening programme effectiveness as well as health system accountability and governance. Because social capital building facilitates communication and the uptake of new ideas, norms, and standards within and between professional communities of practice, it can provide an important mechanism for integration both within and between sectors—a process long considered a "wicked problem" for health policymakers. The article argues that the systematic application of social capital building, from bonding through bridging into linking social capital, can greatly enhance the ability of governments and their partners to achieve their HSS goals.

POLICY Project. 2000. ***Health Reform, Decentralization and Participation in Latin America: Protecting Sexual and Reproductive Health.*** **Washington, DC: Futures Group.**

Excerpt

Much of the work undertaken by the USAID-supported POLICY Project in Latin America and the Caribbean (LAC) has been based on the premise that improving partnerships between governments and civil society, and strengthening participatory processes in the region can help improve the decentralization of the health sector. Working in Bolivia, Peru, Mexico, and Guatemala, the project has helped governments and civil society clarify their roles and strengthen decision making at central, state, and municipal levels. The project has used its limited funds to intervene strategically to motivate citizens and build the capacity of civil society organizations to participate as partners with governments in policy making and governance, and convince government officials that sharing power and collaborating with civil society serves the interests of the country and its government.

The POLICY Project's overall goal in the LAC region has been to strengthen participatory processes as a means of creating a policy environment favorable to sexual and reproductive health. This book represents the voices of project staff and local counterparts alike in telling the story of progress made in Latin America in forging national and local partnerships to promote sexual and reproductive health in the context of decentralization.

World Health Organization (WHO). 2012. "Every Woman, Every Child: From Commitments to Action." ***The First Report of the independent Expert Review Group (iERG) on Information and Accountability for Women's and Children's Health.*** **Geneva: WHO, iERG. Available at: http://www.who.int/woman_child_accountability/ierg/reports/2012/IERG_report_low_resolution.pdf.**

Excerpt

The UN secretary-general's Global Strategy for Women's and Children's Health, Every Woman, Every Child, was launched in September 2010. Its goal is "scaling up and prioritising a package of high-impact interventions, strengthening health systems, and integrating efforts across diseases and sectors such as health, education, water, sanitation, and nutrition. It also means promoting human rights, gender equality, and poverty reduction." With the target date of the MDGs now in sight, Every Woman, Every Child represents the global community's commitment to accelerate progress towards MDGs 4 (child survival) and 5 (maternal and reproductive health).

A critical part of this strategy was the creation of a global oversight mechanism to ensure that commitments to women's and children's health were being delivered on time and with impact. The Commission on Information and Accountability for Women's and Children's Health reported in 2011. One of its 10 recommendations was the creation of an independent Expert Review Group (iERG) to report regularly to the UN secretary-general on the results and resources related to the Global Strategy, and on progress in implementing the commission's recommendations. This is the first of four annual reports up to and including 2015.

The focus of the iERG is on 75 countries where 98 percent of maternal, newborn, and child deaths take place. The accountability framework used has its origins in human rights bodies—namely, monitoring (based on a small number of health status and coverage indicators), transparent and participatory review, and remedy and action.

United Nations (UN) Integrated Implementation Framework. 2013. "UN Integrated Implementation Framework." New York: UN. Available at: http://iif.un.org/content/integrated-implementation-framework-achieving-mdgs-through-mutual-accountability.

Summary of Report (self-written)

The Integrated Implementation Framework (IIF) keeps track of the financial and policy-related promises toward the MDGs made by UN member states and other bodies. Commitments toward the MDGs have been made during General Assembly resolutions, G8 and G20 summits, special initiatives, and high-level task forces. The IIF seeks to decrease the commitment-progress gap—the difference between the pledges made and the policies implemented by members—by increasing the accountability of members.

USAID. 2000. *Monitoring the Policy Reform Process. Recent Practices in Monitoring and Evaluation TIPS (English)*. Washington, DC: USAID Center for Development Information and Evaluation. Number 14.

Summary of Report (self-written)

The policy reform process is often complex. It can involve many stakeholders with a range of perspectives and desires, as well as implementers who bring their individual styles and approaches to each reform effort. Measuring performance is equally challenging, as the policy reform process—as a whole—is not typically easily quantified, tracked, or monitored. Not only are reform processes difficult to capture, but the evolving environment in which they are carried out makes the reforms themselves more elusive. The sociocultural, political, and economic context of individual countries makes it difficult to take "snapshots" of a reform at particular points in time.

The discussions and examples in this paper are organized around the issues and challenges that USAID's development professionals and their clients/partners face when designing and implementing systems to monitor the policy reform process.

3. SOCIAL PARTICIPATION

The policy development process requires community engagement to be successful. This engagement includes participation by civil society, key stakeholders, and poor and marginalized populations. This section includes examples of the positive effects of social participation on policy, training methods for social advocacy, and guidelines for holding governments and organizations socially accountable. These effects can be achieved by increasing the ability of citizens to voice their needs and concerns regarding health issues. In addition, civil society organizations and the general public should be engaged in increasing accountability among policymakers.

Author and title	Year of publication	Type of reference	Country of Focus
Bhavna, S. *Voice, Accountability and Civic Engagement: A Review*	2008	Report	Global
Brinkerhoff, D.W. and B.L. Crosby. *Managing Policy Reform: Concepts and Tools for Decision-makers in Developing and Transitioning Countries*	2002	Book	Global
Goetz, A.M. and J. Gaventa. *Bringing Citizen Voice and Client Focus into Service Delivery*	2001	Report	Global
Jieshuang, X., V. Noortje, S. Pearson, and Q. Xu. "Engaging Civil Society Organizations in Adolescent Reproductive Health Policy Process in Mainland of China"	2013	Journal article	China
London, L. and H. Schneider. "Globalisation and Health Inequalities: Can a Human Rights Paradigm Create Space for Civil Society Action?"	2012	Journal article	Global
Malena, C., R. Forster, and J. Singh. *Social Accountability: An Introduction to the Concept and Emerging Practice*	2004	Report	Global
Policy Project. *Networking for Policy Change: An Advocacy Training Manual*	1999	Report	Global
Health Policy Initiative. *Promoting Accountability for Safe Motherhood: The White Ribbon Alliance's Social Watch Approach*	2010	Report	Global
Tembo, F. *Citizen Voice and State Accountability: Towards Theories of Change that Embrace Contextual Dynamics*	2012	Report	Global
World Bank Social Accountability Tools and Methods		Tool	Global

Bhavna, Sharma. 2008. *Voice, Accountability and Civic Engagement: A Review.* Overseas Development Institute.

Abstract

The United Nations Development Programme's (UNDP's) 2008–2011 Strategic Plan made a renewed commitment to strengthen civic engagement at all levels, specifically by bringing the voices of poor and marginalized groups into policy processes.

This discussion paper provides an overview of current thinking on voice, accountability, and the role of civic engagement in promoting more responsive democratic governance and sustainable development. It reviews recent reports, studies, and evaluations of key donors and institutions, and lays out lessons learnt in promoting voice and accountability mechanisms and strengthening civic engagement. These lessons include the importance of political relationships in the functioning of state institutions; the recognition

that the creation of voice can be a messy, conflictual, and difficult process; and the need for development practitioners to focus on both "voice" and "accountability" simultaneously.

The paper concludes with key recommendations for policy and programme considerations in promoting voice and accountability mechanisms by UNDP.

Brinkerhoff, D.W. and B.L. Crosby. 2002. *Managing Policy Reform: Concepts and Tools for Decision-makers in Developing and Transitioning Countries*. Bloomfield, CT: Kumarian Press.

Summary of Book (self-written)

This textbook serves as a tool for civil society and government workers to develop and change public policy. It draws upon lessons learned from more than 40 countries to teach policy workers about effective and comprehensive policy reform. These lessons come from government, the private sector, and civil society at both the local and national levels, and apply to policy change in all sectors and levels.

Goetz, A.M. and J. Gaventa. 2001. *Bringing Citizen Voice and Client Focus into Service Delivery*. IDS Working Paper 138. Brighton, UK: Institute of Development Studies.

Abstract

This is a study of efforts to improve the responsiveness of public service providers to the needs of service users, particularly the poorest ones. This paper examines more than 60 case studies of both public sector reforms to foster stronger client focus in service delivery and civil society initiatives to demand improved services. This work focused on identifying the means of amplifying citizen "voice," such that engagement with the state moves beyond consultative processes to more direct forms of influence over policy and spending decisions. The case studies upon which this research is based were drawn from around the world from both developing and developed countries. They are organised into 14 different types of "voice" or "responsiveness" mechanisms, and are available at: www.ids.ac.uk/ids/govern/citizenvoice/annexcs.html.

Across different types of public service, the potential for citizen voice and varying degrees of public sector responsiveness can be surmised from features of service design and delivery, such as the complexity of the technology involved in the service; the remoteness and geographical, social, and educational attributes of providers; the extent to which the service is a shared good or an individually consumable product; or the social and environmental consequences of dramatic service breakdown. Variations in voice and client focus are also explained by client characteristics: the social status of clients, their geographic concentration, and whether they have a sustained or one-off relationship with providers. The study concludes with policy-relevant findings on ways of enhancing citizen voice in decision making, planning, and monitoring of public services. For citizen engagement with public service providers to move beyond consultation to real influence, citizens must enjoy rights to a more meaningful form of participation. This would include formal recognition for citizens' groups, their right to information about government decision making and spending patterns, and rights to seek redress for poor-quality service delivery. Public sector providers, for their part, need assurances regarding the mandate and internal accountability of such groups. This study was commissioned by the UK's Department for International Development (DFID).

Jieshuang, X., V. Noortje, S. Pearson, and Q. Xu. 2013. "Engaging Civil Society Organizations in Adolescent Reproductive Health Policy Process in Mainland of China." *Chinese Studies* 2(3):121–127.

Abstract

This paper explores how Chinese CSOs have been involved in an adolescent RH policy process and its implications for other developing countries with similar political and social contexts. The case study was

the sixth cycle of the country program on adolescent reproductive health (January 2006–December 2010). It was a multiphased, retrospective qualitative study in Guangxi Autonomous Region. Six categories of policy actors were interviewed, including politicians, CSOs, policymakers, health managers, development partners, and researchers; 34 documents were reviewed; and one participatory stakeholder workshop was held between June 2007 and April 2008. We focused on different CSOs that had been involved in different stages of the policy process, what strategies they had used to interact with the policy process, and how they influenced the content and implementation of the policy. Our results showed that new forms of CSOs in China were emerging, with different mechanisms being used to express their voice and influence the policy process. The involvement of CSOs in the adolescent RH policy process also showed how new opportunities were arising in a rapidly changing Chinese political context, but various factors might affect their involvement in policy process. Critical amongst these were the characteristics of the CSOs, the wider political context of the country, and the nature of the policy itself.

London, L. and H. Schneider. 2012. "Globalisation and Health Inequalities: Can a Human Rights Paradigm Create Space for Civil Society Action?" *Social Science & Medicine* 74:1: 6–13.

Abstract

While neoliberal globalisation is associated with increasing inequalities, global integration simultaneously has strengthened the dissemination of human rights discourse around the world. This paper explores the seeming contradiction that globalisation is conceived as disempowering nations states' ability to act in their population's interests at the same time that implementation of human rights obligations requires effective states to deliver socioeconomic entitlements, such as health. Central to the actions required of the state to build a health system based on a human rights approach is the notion of accountability. Two case studies were used to explore the constraints on states meeting their human rights obligations regarding health, the first drawing on data from interviews with parliamentarians responsible for health in East and Southern Africa, and the second reflecting on the response to the HIV/AIDS epidemic in South Africa. The case studies illustrate the importance of a human rights paradigm in strengthening parliamentary oversight over the executive in ways that prioritise pro-poor protections and increase leverage for resources for the health sector within parliamentary processes. Further, a rights framework creates the space for civil society action to engage with the legislature so as to hold public officials accountable and confirms the importance of rights as enabling civil society mobilization, thus reinforcing community agency to advance health rights for poor communities. In this context, critical assessment of state incapacity to meet claims to health rights raises questions as to the diffusion of accountability rife under modern international aid systems. Such diffusion of accountability opens the door for "cunning" states to deflect the rights claims of their populations. We argue that human rights, as both a normative framework for legal challenges and a means to create room for active civil society engagement, provide a way to contest both the real and purported constraints imposed by globalisation.

Malena, C., R. Forster, and J. Singh. 2004. "Social Accountability: An Introduction to the Concept and Emerging Practice." Paper No. 76, *Social Development Papers*. Washington, DC: The World Bank.

Summary of Report (self-written)

This paper highlights the World Bank's growing interest and involvement in social accountability initiatives, which derive from its core goals of promoting poverty reduction and effective and sustainable development. It addresses five fundamental questions: (1) What is social accountability?; (2) Why is it important?; (3) What are its core features?; (4) What are its key applications?; and (5) What are the factors that underpin its success? The paper also explores the linkages between this concept and other key issues, such as governance, gender, participation, empowerment, and rights. Social accountability is defined as an approach toward building accountability that relies on civic engagement; that is, in which ordinary citizens and/or civil society organizations participate directly or indirectly in exacting

accountability. In a public sector context, social accountability refers to a broad range of actions and mechanisms that citizens, communities, independent media, and civil society organizations can use to hold public officials and public servants accountable. These include, among others, participatory budgeting, public expenditure tracking, monitoring of public service delivery, investigative journalism, and public commissions and citizen advisory boards. These citizen-driven accountability measures complement and reinforce conventional mechanisms of accountability, such as political checks and balances, accounting and auditing systems, administrative rules, and legal procedures. Evidence suggests that social accountability mechanisms can contribute to improved governance, increased development effectiveness through better service delivery, and empowerment. Although the range of social accountability mechanisms is wide and diverse, key common building blocks include obtaining, analyzing, and disseminating information; mobilizing public support; and advocating and negotiating change. Critical factors of success include access to and effective use of information, civil society and state capacities, and synergy between the two. Ultimately, the effectiveness and sustainability of social accountability mechanisms are improved when they are institutionalized and the state's own internal mechanisms of accountability are rendered more transparent and open to civic engagement. To be effective in the long run, social accountability mechanisms need to be institutionalized and linked to existing governance structures and service delivery systems.

Policy Project. 1999. *Networking for Policy Change: An Advocacy Training Manual.* Washington, DC: Policy Project.

Excerpt

It is through advocacy—a set of targeted actions in support of a specific cause—that a supportive and self-sustaining environment for FP and RH goals can be created. This training manual was prepared to help representatives of NGOs and other formal groups of civil society form and maintain advocacy networks and develop effective FP/RH advocacy skills. The manual's tools and approaches can be used to affect FP/RH policy decisions at the international, national, regional, and local levels.

The manual is based on the principle that advocacy strategies and methods can be learned. The building blocks of advocacy are the formation of networks, the identification of political opportunities, and the organization of campaigns. The manual includes a section on each of these building blocks, with specific subjects presented in individual units. Units within each section contain background notes, learning objectives, and handouts. While the manual can be used in its entirety, it is designed for use in sections, depending on the particular needs of the network. The manual promises to be a useful and practical tool for NGOs and other organizations committed to improving the quality of FP and RH programs.

Health Policy Initiative. *Promoting Accountability for Safe Motherhood: The White Ribbon Alliance's Social Watch Approach.* 2010. Washington, DC: Health Policy Initiative, Task Order 1.

Abstract

This brief outlines social watch techniques that civil society groups can use to hold governments accountable to their commitments. It also provides examples of how the White Ribbon Alliance for Safe Motherhood (WRA) has used these techniques in India and Tanzania.

Tembo, Fletcher. 2012. "Citizen Voice and State Accountability: Towards Theories of Change that Embrace Contextual Dynamics." *ODI Working Paper 343.* London: Overseas Development Institute.

Summary of Report (self-written)

The development industry is increasingly pushing practitioners to achieve results and do better in demonstrating what works, what does not, and explaining why. There is a growing interest in going

beyond the measurement of results to being able to understand the basis for success or failure. Consequently, the development of explicit theories of change (ToCs) is beginning to be viewed as central to this process, as a key part of what constitutes "rigour" in impact evaluations.

Citizen voice and accountability (CV&A) project interventions produce and reproduce diverse outcomes not amenable to linear models of ToCs. This paper uses a critical analysis of CV&A cases from the Mwananchi Governance and Transparency Fund (GTF) programme to examine how citizen voice and accountability occurs in different governance contexts.

The analytical framework used in this paper draws on the well-known tools of outcome mapping (OM) and political economy analysis (PEA).

Key points include the following:

- Enabling citizens to influence government accountability is a complex process, involving political dynamics at citizens' interface with state institutions
- Developing explicit ToCs from the start of programme planning helps planners delve into complex citizen-state dynamics

Fusing political economy analysis and outcome mapping tools can help develop a deeper understanding of these dynamics to generate more effective ways to achieve outcomes

World Bank. "World Bank Social Accountability Tools and Methods." Washington, DC: World Bank. Available at: http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALDEVELOPMENT/EXTPCENG/0,,contentMDK:20509421~menuPK:1278132~pagePK:148956~piPK:216618~theSitePK:410306,00.html.

Summary of Tool (self-written)

Social accountability mechanisms have applications in varied contexts. Such mechanisms build citizen voice and create spaces for more proactive engagement of citizens/civil society with the state. These mechanisms include right-to-information movements, citizen advisory boards and vigilance committees, public interest litigations, public hearings, citizens' charters, and more.

However, social accountability mechanisms geared toward public expenditure management processes—mechanisms that seek to involve ordinary citizens directly in the processes of allocating, disbursing, monitoring, and evaluating the use of public resources—have proved very effective, since it is this resource flow that puts policy into action.

Several methods and tools exist to measure social accountability. Here, the World Bank provides four: Participatory Budgeting, Independent Budget Analysis, Participatory Expenditure Tracking, and Participatory Performance Monitoring.

4. MEASURING HEALTH SYSTEMS STRENGTHENING

Effective policies pave the way for highly functioning health systems, including service coverage and quality, financial coverage, and population coverage and equity, thus resulting in improved health outcomes. In turn, well-run health systems facilitate the successful implementation of health policies. This section provides guidance on measuring health system indicators and scaling up health systems, and covers the use of models and existing evidence for successful health systems strengthening.

Author and title	Year of publication	Type of reference	Country of Focus
Bongaarts, J., J. Cleland, J. Townsend, J. Bertrand, and M. Das Gupta. *Family Planning Programs for the 21st Century: Rationale and Design*	2012	Report	Global
Gay, J., K. Hardee, N. Judice, K. Argarwal, K. Flemming, et al. *What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions, Safe Motherhood Module 1*	2003	Report	Global
Hardee, K., K. Agarwal, N. Luke, E. Wilson, M. Pendzich, et al. "Reproductive Health Policies and Programs in Eight Countries: Progress Since Cairo"	1999	Journal article	Bangladesh, India, Nepal, Jordan, Ghana, Senegal, Jamaica, Peru
Mangham, L.J. and K. Hanson. "Scaling Up in International Health: What Are the Key Issues?"	2010	Journal article	Global
Miller, R. *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook*	1997	Report	Global
WHO. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies*	2010	Report	Global
Nutley, T. and H. Reynolds. "Improving the Use of Health Data for Health Systems Strengthening"	2013	Journal article	Global
Shiffman, J. and S. Smith. "Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality"	2007	Journal article	Global
Siddiqi, S., I. Tayyeb, T. Masud, S. Nishtan, D.H. Peters, et al. "Framework for Assessing Governance of the Health System in Developing Countries: Gateway to Good Governance"	2009	Journal article	Global
Spicer, N. and A. Walsh. "10 Best Resources on … The Current Effects of Global Health Initiatives on Country Health Systems"	2012	Journal article	Global
Subramanian, S., J. Naimoli, T. Matsubayashi, and D. Peters. "Do We Have the Right Models for Scaling Up Health Services to Achieve the Millennium Development Goals?"	2011	Journal article	Global
Waddington, C. *Scaling Up Health Services: Challenges and Choices*	2012	Report	Global
Wamai, R. "The Kenya Health System—Analysis of the Situation and Enduring Challenges"	2009	Journal article	Kenya

Author and title	Year of publication	Type of reference	Country of Focus
Weir, S. *Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men Who Have Sex with Men, and Transgender People (Volume 1: National and Sub-National Levels)*	2012	Report	Global

Bongaarts, J., J. Cleland, J. Townsend, J. Bertrand, and M. Das Gupta. 2012. *Family Planning Programs for the 21st Century: Rationale and Design*. New York: Population Council.

Abstract

This publication provides a roadmap to help policymakers and donors in priority countries implement high-quality FP programs. The book explains the rationale for increased funding and support for voluntary family planning, and outlines how reinvigorated programs should be structured to operate most effectively. Chapter One, explaining the neglect of FP programs since the mid-1990s, argues for a reinvestment in publicly funded FP programs and presents new evidence on fertility decline and its economic and health benefits. Chapter Two, on the impact of voluntary FP programs on fertility, provides proof that voluntary FP programs reduce fertility and can lower the trajectory of future population growth. The second half explains how reinvigorated voluntary FP programs can be structured to operate more effectively: Chapter Three, FP services and the strengthening of health systems, illustrates how family planning can be integrated into national health systems and proposes innovative strategies for reaching the most vulnerable individuals; Chapter Four, FP communication programs, discusses the importance of behavior change communication campaigns to educate the general population and motivate potential users to adopt family planning.

Gay, J., K. Hardee, N. Judice, K. Argarwal, K. Flemming, et al. 2003. *What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions, Safe Motherhood Module 1*. Washington, DC: Policy Project.

Abstract

Worldwide, about 500,000 women and girls die of complications related to pregnancy and childbirth each year, and more than 99 percent of these deaths occur in developing countries. The tragedy—and opportunity—is that most maternal deaths could be prevented with cost-effective healthcare services. Facing a range of competing priorities and limited resources, policymakers and program planners are in need of concise information on programs that are both effective and feasible.

This publication—the first in a series entitled "What Works: A Policy and Program Guide to the Evidence on Family Planning, Safe Motherhood, and STI/HIV/AIDS Interventions"—presents a comprehensive review of the interventions (with supporting evidence) that have been shown to enhance maternal health in developing countries.

Importantly, this document helps public health officials and decisionmakers answer the question "What should we do?" when trying to figure out how to improve maternal health. It is also a tool to help maternal health advocates demonstrate that safe motherhood programs save lives; benefit societies and communities; and are effective and feasible, even in resource-constrained settings.

The Safe Motherhood Module brings together the best available evidence on a range of interventions and packages it in one convenient source, covering topics such as labor and delivery, postnatal care, care during pregnancy, pre-pregnancy care, and policy and program issues. It also provides guidance on programs that have not been shown to work, those that should be avoided, and those for which more

evidence is needed. Additional sections provide a summary of safe motherhood interventions and present resources for program designers.

Hardee, K., K. Agarwal, N. Luke, E. Wilson, M. Pendzich, et al. 1999. "Reproductive Health Policies and Programs in Eight Countries: Progress since Cairo." *International Family Planning Perspectives* 25(Suppl), S2–9.

Abstract

Context: Although many countries adopted the Programme of Action drafted at the 1994 ICPD in Cairo, little is known about countries' experiences since then with revising RH policies and implementing programs.

Methods: In-depth interviews were conducted in 1997 with stakeholders in eight countries—three in Asia (Bangladesh, India, and Nepal); three in the Middle East and Africa (Jordan, Ghana, and Senegal); and two in Latin America and the Caribbean (Jamaica and Peru).

Results: Although all but two of the countries have adopted the ICPD definition of reproductive health and all have initiated policy reforms to reflect a new focus, less has been accomplished in implementing integrated RH programs. Several challenges face all eight countries as they continue to design RH programs: improving knowledge and support among stakeholders, planning for integration and decentralized services, developing human resources, improving quality of care, and maintaining a long-term perspective regarding implementation of the Cairo agenda.

Conclusions: The next critical steps needed for moving from policy formulation to program implementation are to help countries set priorities for establishing integrated RH interventions, increase financing for services, and develop strategies for delivering them.

Mangham, L.J. and K. Hanson. 2010. "Scaling Up in International Health: What Are the Key Issues?" *Health Policy and Planning* 25(2):85–96.

Abstract

The term "scaling up" is now widely used in the international health literature, though it lacks an agreed-upon definition. We review what is meant by scaling up in the context of changes in international health and development over the last decade. We argue that the notion of scaling up is used primarily to describe the ambition or process of expanding the coverage of health interventions, though the term has also referred to increasing the financial, human, and capital resources required to expand coverage.

We discuss four pertinent issues in scaling up the coverage of health interventions: the costs of scaling up coverage, constraints to scaling up, equity and quality concerns, and key service delivery issues when scaling up.

We then review recent progress in scaling up the coverage of health interventions, including a considerable increase in the volume of aid, accompanied by numerous new health initiatives and financing mechanisms. There have also been improvements in health outcomes and some examples of successful large-scale programmes. Finally, we reflect on the importance of obtaining a better understanding of how to deliver priority health interventions at scale, the current emphasis on health system strengthening, and the challenges of sustaining scale-up in the prevailing global economic environment.

Miller, R. 1997. *The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook.* New York: Population Council.

Abstract

Situation analysis is the first systematic data collection tool to enable FP managers to credibly document the quality of client care. The method has four essential objectives: (1) to describe the potential of current policies and program standards to promote the delivery of quality services; (2) to describe and compare the current readiness of service delivery staff and facilities to provide quality services to clients with current policies and program standards; (3) to describe the actual quality of care received by clients; and (4) to evaluate the impact provision of quality services has on client satisfaction, contraceptive use dynamics, fulfillment of reproductive intentions, and fertility. This manual updates situation analysis procedures and materials as they have evolved since 1989, when the first such analysis was performed in Kenya. It is intended as a reference for program managers and planners, policymakers, researchers, and field interviewers. Chapter 1 introduces the research methodology and related conceptual issues; it aims to help decisionmakers understand the values and limitations of the type of data collected, and determine whether to carry out such a study. Chapter 2 provides practical guidelines for implementing field studies, with emphasis on training field workers. Chapter 3 sets forth the core interview schedules, inventory, and observation guide, as well as guidelines for adapting questions to local conditions. Finally, Chapter 4 provides advice on data analysis and preparation of the final report.

World Health Organization. 2010. *Monitoring the Building Blocks of Health Systems: A Handbook of Indicators and their Measurement Strategies*. Geneva, World Health Organization. Available at: http://www.who.int/healthinfo/systems/monitoring/en/index.html.

Summary of Report (self-written)

Strengthening health systems requires a sound monitoring strategy that enables decisionmakers to accurately track health progress and performance, evaluate impact, and ensure accountability at the country and global levels.

This 110-page handbook describes a set of indicators and related measurement strategies, structured around the WHO framework that describes health systems in terms of six core components or "building blocks": (1) service delivery, (2) health workforce, (3) health information systems, (4) access to essential medicines, (5) financing, and (6) leadership/governance.

The process can harmonize donor funding commitments and improve the way in which international agencies, donors, and developing countries work together to develop and implement national health plans.

The handbook is divided into six sections, each of which covers one health system component or building block; each is set out along the following lines:

- Introduction to the component and related indicators
- Description of possible sources of information and available measurement strategies

Proposed "core indicators," supplemented, when necessary, by additional indicators that may be used, depending on the country's health system attributes and needs

Nutley, T. and H. Reynolds. 2013. "Improving the Use of Health Data for Health Systems Strengthening." *Global Health Action* 6: 20001.

Abstract

Background: Good quality, timely data from health information systems are the foundation of all health systems. However, too often data sit in reports, on shelves, or in databases, and are not sufficiently

utilised in policy and program development, improvement, strategic planning, and advocacy. Without specific interventions aimed at improving the use of data produced by information systems, health systems will never fully be able to meet the needs of the populations they serve.

Objective: To employ a logic model to describe a pathway for how specific activities and interventions can strengthen the use of health data in decision making to ultimately strengthen the health system.

Design: A logic model was developed to provide a practical strategy for developing, monitoring, and evaluating interventions to strengthen the use of data in decision making. The model draws on the collective strengths and similarities of previous work, and adds to it by making specific recommendations about those interventions and activities most proximate in affecting the use of data in decision making. The model provides an organizing framework for how interventions and activities work to strengthen the systematic demand, synthesis, review, and use of data.

Results: The logic model and guidance are presented to facilitate its widespread use and enable improved data-informed decision making in program review and planning, advocacy, and policy development. Real-world examples from the literature support the feasible application of the activities outlined in the model.

Conclusions: The logic model provides specific and comprehensive guidance to improve data demand and use. It can be used to design, monitor, and evaluate interventions, and improve demand for and use of data in decision making. As more interventions are implemented to improve use of health data, such efforts need to be evaluated.

Shiffman, J. and S. Smith. 2007. "Generation of Political Priority for Global Health Initiatives: A Framework and Case Study of Maternal Mortality." *The Lancet* 370(9595): 1370–1379.

Abstract

Why do some global health initiatives receive priority from international and national political leaders, whereas others receive little attention? To analyse this question, we propose a framework consisting of four categories: the strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and characteristics of the issue itself. We apply this framework to the case of a global initiative to reduce maternal mortality, which was launched in 1987. We undertook archival research and interviewed people connected with the initiative, using a process-tracing method commonly employed in qualitative research. We report that, despite two decades of effort, the initiative remains in an early phase of development, hampered by difficulties in all of these categories. However, the initiative's 20th year, 2007, presents opportunities to build political momentum. To generate political priority, advocates will need to address several challenges, including the creation of effective institutions to guide the initiative and the development of a public positioning of the issue to convince political leaders to act. We use the framework and case study to suggest areas for future research on the determinants of political priority for GHIs—a subject that has attracted much speculation but little scholarship.

Siddiqi, S., I. Tayyeb, T. Masud, S. Nishtan, D.H. Peters, et al. 2009. "Framework for Assessing Governance of the Health System in Developing Countries: Gateway to Good Governance." *Health Policy* 90: 13–25.

Abstract

Governance is thought to be a key determinant of economic growth, social advancement, and overall development, as well as for the attainment of the MDGs in low- and middle-income countries. Governance of the health system is the least well-understood aspect of health systems. A framework for

assessing health system governance (HSG) at the national and subnational levels is presented, which has been applied in countries of the Eastern Mediterranean.

In developing the HSG frameworks, key issues considered included the roles of the state vs. the market, ministries of health vs. other state ministries, actors in governance, static vs. dynamic health systems, and health reform vs. a human rights-based approach to health. Four existing frameworks were considered: WHO's domains of stewardship, the Pan American Health Organization's essential public health functions, the World Bank's six basic aspects of governance, and UNDP principles of good governance. The proposed HSG assessment framework includes the following 10 principles—strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics.

The framework permits "diagnoses of the ills" in HSG at the policy and operational levels, and points to interventions for its improvement. In the case of Pakistan, where the framework was applied, a positive aspect was the growing participation and consensus orientation among stakeholders, whereas weaknesses were identified in relation to strategic vision, accountability, transparency, effectiveness and efficiency, and rule of law.

In using the HSG framework, it needs to be recognized that the principles are value driven, not normative, and are to be seen in the social and political context; also, the framework relies on a qualitative approach and does not follow a scoring or ranking system. It does not directly address aid effectiveness; rather, it provides insight into the ability to utilize external resources. The framework also includes the effect of global health governance on national HSG as the subject itself becomes better crystallized.

The improved performance of ministries of health and state health departments is at the heart of this framework among policymakers. It also helps raise the level of awareness of the importance of HSG. The road to good governance in health is long and uneven. Assessing HSG is only the first step; the challenge that remains is to carry out effective governance in vastly different institutional contexts.

Spicer, N. and A. Walsh. 2012. "10 Best Resources on…The Current Effects of Global Health Initiatives on Country Health Systems." *Health Policy and Planning* 27: 265–269.

Abstract

This article outlines 10 of the best resources that focus on the current effects of GHIs (Global Fund to Fight AIDS, Tuberculosis and Malaria; PEPFAR; MAP; GAVI Alliance) on country health systems. It lists and describes the usefulness of these 10 resources, which include the following: The Systems-wide Effects of the Global Fund to Fight AIDS, Tuberculosis and Malaria: A Conceptual Framework; Global Health Initiatives and Public Health Policy; Center for Global Development's HIV/AIDS Monitor; Global HIV/AIDS Initiatives Network (GHIN) website; The Effects of Global Health Initiatives on Country Health Systems: A Review of the Evidence from HIV/AIDS Control; What Impact Do Global Health Initiatives Have on Human Resources For Antiretroviral Treatment Roll-out? A Qualitative Policy Analysis of Implementation Processes in Zambia; Interactions Between Global Health Initiatives and Health Systems; An Assessment of Interactions Between Global Health Initiatives and Country Health Systems; The Impact of Collective Efforts on the Reduction of the Disease Burden of AIDS, Tuberculosis and Malaria; and Global Health Partnerships in Practice: Taking Stock of the GAVI Alliance's New Investment in Health Systems Strengthening.

Subramanian, S., J. Naimoli, T. Matsubayashi, and D. Peters. 2011. "Do We Have the Right Models for Scaling Up Health Services to Achieve the Millennium Development Goals?" *BMC Health Services Research* 11 (336).

Abstract

Background: There is widespread agreement on the need for scaling up in the health sector to achieve the MDGs. Many countries are not on track to reach the MDG targets, however. The dominant approach that GHIs use promotes uniform interventions and targets, assuming that specific technical interventions tested in one country can be replicated across countries to expand coverage rapidly. Yet countries scale up health services and progress against the MDGs at very different rates. GHIs need to take advantage of what has been learned about scaling up.

Methods: We conducted a systematic literature review to identify conceptual models for scaling up health in developing countries; the articles were assessed according to the practical concerns of how to scale up, including the planning, monitoring, and implementation approaches.

Results: We identified six conceptual models for scaling up in health, based on experience with expanding pilot projects and diffusion of innovations. They place importance on paying attention to enhancing organizational, functional, and political capabilities through experimentation and adaptation of strategies, in addition to increasing the coverage and range of health services. These scaling-up approaches focus on fostering sustainable institutions and the constructive engagement between end users and the provider and financing organizations.

Conclusions: The current approaches to scaling up health services to reach the MDGs are overly simplistic and not working adequately. Rather than relying on blueprint planning and raising funds—an approach characteristic of current global health efforts—experience with alternative models suggests that more promising pathways involve "learning by doing" in ways that engage key stakeholders, use data to address constraints, and incorporate results from pilot projects. Such approaches should be applied to current strategies to achieve the MDGs.

Waddington, Catriona. 2012. *Scaling Up Health Services: Challenges and Choices.* London: HLSP Institute.

Abstract

While not a new idea, the term "scaling up" has become increasingly popular in global health. This paper clarifies the way the term is used, presents the objectives of different types of scaling up, and highlights lessons from implementation.

It discusses common challenges and choices that have to be made in the context of scaling up: which interventions should be scaled up; who will champion scaling up and deliver the interventions; how to deal with equity concerns; how to finance scale-up; how fast to scale up; sequencing; and how to monitor progress.

The paper concludes that scaling up health services as a means of improving health outcomes is not just about increased spending. A number of health system, financial, institutional, legal, and social challenges need to be addressed, and choices made.

Wamai, R. 2009. "The Kenya Health System—Analysis of the Situation and Enduring Challenges." *Japan Medical Association Journal* 52.

Summary of Report (self-written)

In this situational analysis of Kenya's healthcare system, Richard Wamai addresses the utilization, financing, and distribution of facilities. This article explains how the distribution of power led to the

division of the MOH into the Ministry of Public Health and the Ministry of Medical Services. This division has weakened quality of services, increased costs, and decreased coordination between providers. Wamai proposes a reconsideration of the previously stalled socialization of the National Hospital Insurance Fund. He concludes with the acknowledgment of the effect HIV/AIDS has had on the country's economy and health, and argues that only strengthening the national health system can have a true effect on the situation.

Weir, S. 2012. *Operational Guidelines for Monitoring and Evaluation of HIV Programmes for Sex Workers, Men Who Have Sex with Men, and Transgender People (Volume 1: National and Sub-National Levels)*. MEASURE Evaluation. *Available at: Vol. 1—* http://www.cpc.unc.edu/measure/publications/ms-11-49a.

Excerpt

The primary objective of this document is the scale-up of monitoring and evaluation (M&E) of HIV prevention programmes serving sex workers (SWs), MSM, and transgender (TG) populations. Currently, there is limited information on the implementation of programmes for the prevention and treatment of HIV infection among these populations. Few countries monitor the determinants of transmission, even fewer monitor the quality and adequacy of programmes delivered to meet the needs of these populations, and fewer still rigorously assess whether the programmes actually contribute to the reduction of HIV transmission in key populations. A good M&E system can measure these enabling environments and the availability and quality of services, guide focused programme implementation, and assess effectiveness.

The specific objectives of the guidelines are the following:

- Support M&E systems that are responsive to local HIV epidemics among SWs, MSM, and TG people
- Function as an advocacy tool to lobby for the inclusion of M&E of HIV programmes for SWs, MSM, and TG people in existing M&E systems
- Provide guidance for M&E of prevention programmes at three levels: national, subnational, and service delivery
- Recommend indicators for M&E of HIV prevention programmes at the national, subnational, and service delivery levels
- Describe methods to estimate indicators and generic forms to collect indicator data
- Include methods that facilitate meaningful involvement of MSM, SWs, and TG people in M&E of HIV programmes
- Incorporate experience-based and qualitative evidence as M&E data sources
- Encourage timely sharing of data between the national/subnational and service delivery levels
- Promote the use of programme implementation pathways using input-output-coverage models
- Facilitate use of the guideline through simple checklists, decision trees, and examples
- Provide methods that can be used to identify and prioritize questions for operations and effectiveness research, and provide links to relevant tools and resources

5. METHODOLOGIES TO STUDY POLICY IMPLEMENTATION

There are many approaches to the study of policy implementation. This bibliography highlights five sets of methodologies used in this area: complex adaptive systems, path dependence, implementation science, examples of evaluations, and evaluation designs.

The **Complex Adaptive Systems** section looks at the way large macro-level systems increase stability by managing the complex organization of relatively similar and partially connected micro-structures. These connections allow the macro-system to adapt to changing environments and circumstances. This section further looks at the way policies interact within the various pathways of implementation, and how these systems of interactions affect policy. It includes using innovations that allow for flexibility in programming while remaining focused on priority activities. Ideally, this will also allow for later scaling up of health activities and an increased program capacity.

In **Path Dependence**, the references illustrate how policies and systems are influenced by their predecessors and historical evolutions, and how results cannot often be replicated in different environments due to a variety of unique and context-specific factors.

The section on **Implementation Science** guides readers in the study of policy methods and the theoretical frameworks behind them to promote the use of evidence in future policy, with the objective of ultimately improving population health. Included are comprehensive guides for implementation in policy involving HIV and AIDS and PEPFAR's response.

The **Examples of Evaluations** section provides dozens of country- and program-specific evaluations and lessons learned for use by future policymakers in emulating successful policies. Understanding a country's context is very important in the evaluation of health programs, as culture, income, and public health profiles can have a significant impact on the effectiveness of a health program. Overall, evaluations should measure a program's adequacy, plausibility, and probability of performance and impact.

Evaluation Designs focuses on methods and guidelines for conducting evaluations, offering several examples of actual evaluations having varying objectives. Also included are guidelines on evaluating the results of a public political participation program. In addition, this section includes several overviews of the evaluation process, providing best practices on the planning and design phases of evaluation.

Author and title	Year of publication	Type of reference	Country of Focus
Kruk, M.A. and L.P. Freedman. "Assessing Health System Performance in Developing Countries: A Review of the Literature"	2008	Journal article	Global
Rwashana, A.S., D.W. Williams, and S. Neema. "System Dynamics Approach to Immunization Healthcare Issues in Developing Countries: A Case Study of Uganda"	2009	Journal article	Uganda
Walt, G., J. Shiffman, H. Schneider, S.F. Murray, R. Brugha, et al. "Doing Health Policy Analysis: Methodological and Conceptual Reflections and Challenges"	2008	Journal article	Global
Complex Adaptive Systems			
Atun, R. "Health Systems, Systems Thinking and Innovation"	2012	Journal article	Global
Gericke, C.A., C. Kurowski, M.K. Ranson, and A. Mills. "Intervention Complexity: A Conceptual Framework to Inform Priority-setting in Health"	2005	Journal article	Global
Paina, L. and D.H. Peters. "Understanding Pathways for Scaling Up Health Services Through the Lens of Complex Adaptive Systems"	2011	Journal article	Global
Path Dependence			
Howlett, M. and J. Rayner. "Understanding the Historical Turn in the Policy Sciences: A Critique of Stochastic, Narrative, Path Dependency and Process-sequencing Models over Time"	2006	Journal article	Global
Page, S. "Path Dependence"	2006	Journal article	Global
Torfing, J. "Rethinking Path Dependence in Public Policy Research"	2009	Journal article	Global
Implementation Science			
Gilson, L. *Health Policy and Systems Research: A Methodology Reader*	2012	Report	Global
Padian, N.S., C.B. Holmes, S.I. McCoy, R. Lyerla, P.D. Bouey, et al. "Implementation Science for PEPFAR"	2011	Journal article	Global
Schackman, B. "Implementation Science for the Prevention and Treatment of HIV/AIDS"	2010	Journal article	Global

Author and title	Year of publication	Type of reference	Country of Focus
Evaluations of Policy Implementation			
Abuya, T., R. Njuki, C.E. Warren, J. Okal, F. Obare, et al. "A Policy Analysis of the Implementation of a Reproductive Health Vouchers Program in Kenya"	2012	Journal article	Kenya
Adam, T., J. Hsu, D. de Savigny, J. Lavis, J-A. Rottingen, et al. "Evaluating Health Systems Strengthening Interventions in Low-Income and Middle-Income Countries: Are We Asking the Right Questions?"	2012	Journal article	Global
Amouzou, A., O. Habi, K. Bensaid, and the Niger Countdown Case Study Working Group. "Reduction in Child Mortality in Niger: A Countdown to 2015 Country Case Study"	2012	Journal article	Niger
du Heyns, A., R.J. Benjamin, J.P. Ronel Swanevelder, M.E. Laycock, B.L. Pappalardo, et al. "Prevalence of HIV-1 in Blood Donations Following Implementation of a Structured Blood Safety Policy in South Africa"	2006	Journal article	South Africa
Bärnighausen, T., D. Bloom, and S. Humair. "Health Systems and HIV Treatment in sub-Saharan Africa: Matching Intervention and Programme Evaluation Strategies"	2012	Journal article	Sub-Saharan Africa
Biesma, R.G., R. Brugha, A. Harmer, A. Walsh, N. Spicer, et al. "The Effects of Global Health Initiatives on Country Health Systems: A Review of the Evidence from HIV/AIDS Control"	2009	Journal article	Global
Björkman, M. and J. Svensson. "Power to the People: Evidence from a Randomized Field Experiment on Community-based Monitoring in Uganda"	2009	Journal article	Uganda
Blattman, C. *Impact Evaluation 2.0*	2008	Report	Global
Bryce, J., C. Victora, T. Boema, D. Peters, and R. Black. "Evaluating the Scale-Up for Maternal and Child Survival: A Common Framework"	2011	Journal article	Global
Bryce, J., C.G. Victora, J.P. Habicht, R.E. Black, and R.W. Scherpbier, on behalf of the MCE-IMCI Technical Advisors. "Programmatic Pathways to Child Survival: Results of a Multi-Country Evaluation of Integrated Management of Childhood Illness"	2005	Journal article	Bangladesh, Brazil, Peru, Tanzania, Uganda
Bryce, J., C.G. Victora, and the MCE-IMCI Technical Advisors. "Ten Methodological Lessons from the Multi-Country Evaluation of Integrated Management of Childhood Illness"	2005	Journal article	Global
Centers for Disease Control and Prevention. "Achievements in Public Health, 1990–1999"	1999	Journal article	Global

Author and title	Year of publication	Type of reference	Country of Focus
Chandrasekaran, P., G. Dallabetta, V. Loo, S. Mills, T. Saidel, et al., for the Avahan Evaluation Partners. "Evaluation Design for Large-scale HIV Prevention Programmes: The Case of Avahan, the India AIDS Initiative"	2008	Journal article	India
Chriqui, J.F., J.C. O'Connor, and F.J. Chaloupka. "What Gets Measured, Gets Changed: Evaluating Law and Policy for Maximum Impact"	2011	Journal article	Global
Cailhol, J., I. Craveiro, T. Madede, E. Makoa, T. Mathole, et al. "Analysis of Human Resources for Health Strategies and Policies in 5 countries in Sub-Saharan Africa, in Response to GFATM and PEPFAR-funded HIV-Activities"	2013	Journal article	Angola, Burundi, Lesotho, Mozambique, South Africa
Chopra, M. and N. Rollins. "Infant Feeding in the Time of HIV: Rapid Assessment of Infant Feeding Policy and Programmes in Four African Countries Scaling Up Prevention of Mother to Child Transmission Programmes"	2008	Journal article	Botswana, Kenya, Malawi, Uganda
Cooper, D., D. Morroni, P. Orner, J. Moodley, J. Harries, et al. "Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status"	2004	Journal article	South Africa
de Savigny, D., J. Webster, I.A. Agyepong, A. Mwita, C. Bart-Plange, et al. "Introducing Vouchers for Malaria Prevention in Ghana and Tanzania: Context and Adoption of Innovation in Health Systems"	2012	Journal article	Ghana and Tanzania
Ditlopo, P., D. Blaauw, P. Bidwell, and S. Thomas. "Analyzing Implementation of the Rural Allowance in Hospitals in North West Province, South Africa"	2011	Journal article	South Africa
Doherty, T.M., D. McCoy, and S. Donohue. "Health System Constraints to Optimal Coverage of the Prevention of Mother-to-Child HIV Transmission Programme in South Africa: Lessons from the Implementation of the National Pilot Programme"	2005	Journal article	South Africa
Frenk, J. "Bridging the Divide: Global Lessons from Evidence-based Health Policy in Mexico"	2006	Journal article	Mexico
Habicht, J.P., C.G. Victora, and J.P. Vaughan. "Evaluation Designs for Adequacy, Plausibility, and Probability of Public Health Programme Performance and Impact"	1999	Journal article	Global
Hanson, K. "Advances in Impact Evaluation." In *Health Policy and Systems Research: A Methodology Reader*, edited by L. Gilson	2012	Book chapter	Global
Hardee, K., L. Ashford, E. Rottach, R. Jolivet, and R. Kiesel. *The Policy Dimensions of Scaling Up*	2012	Report	Global
Hesketh, T., L. Lu, and Z.W. Xing. "The Effect of China's One-Child Family Policy after 25 Years"	2005	Journal article	China

Author and title	Year of publication	Type of reference	Country of Focus
Hyder, A., S. Syde, P. Puvanachandra, G. Bloom, S. Sundaram, et al. "Stakeholder Analysis for Health Research: Case Studies from Low- and Middle-Income Countries"	2010	Journal article	Uganda, India, China, Afghanistan, Bangladesh, Nigeria
Khresheh, R. and L. Barclay. "Implementation of a New Birth Record in Three Hospitals in Jordan: A Study of Health System Improvement"	2008	Journal article	Jordan
King, G., E. Gakidou, K. Imai, R.T. Moore, C. Nail, et al. "Public Policy for the Poor? A Randomised Assessment of the Mexican Universal Health Insurance Programme"	2009	Journal article	Mexico
Kruk, M.E. and M.R. Prescott. "The Role of Health Systems and Policies in Promoting Safe Delivery in Low- and Middle-Income Countries: A Multilevel Analysis"	2012	Journal article	Global
Larsson, E.C., A. Thorson, G. Pariyo, P. Conrad, M. Arinaitwe, et al. "Opt-out HIV Testing During Antenatal Care: Experiences of Pregnant Women In Rural Uganda"	2012	Journal article	Uganda
Macinkoa, J., M. de Souza, F. Guanais, and C. da Silva Simoes. "Going to Scale with Community-based Primary Care: An Analysis of the Family Health Program and Infant Mortality in Brazil"	2007	Journal article	Brazil
The Maximizing Positive Synergies Academic Consortium. *Interactions Between Global Health Initiatives and Health Systems: Evidence from Countries*	2009	Report	Global
May, J. *World Population Policies: Their Origin, Evolution, and Impact*	2012	Book	Global
McConnell, A. "Policy Success, Policy Failure and Grey Areas in-Between"	2010	Journal article	Global
Milton, B., M. Moonan, D. Taylor-Robinson, and M. Whitehead (eds.). *How Can the Health Equity Impact of Universal Policies Be Evaluated?: Insights into Approaches and Next Steps*	2010	Report	Global
Palumbo, D., S. Maynard-Moody, and P. Wright. "Measuring Degrees of Successful Implementation: Achieving Policy Versus Statutory Goals"	1984	Journal article	Global
PAHO. *The Essential Public Health Functions as a Strategy for Improving Overall Health Systems Performance: Trends and Challenges since the Public Health in the Americas Initiative, 2000–2007*	2007	Report	Global
Panisset, U., T.P. Koehlmoos, A.H. Alkhatib, T. Pantoja, P. Singh, et al. "Implementation Research Evidence Uptake and Use for Policy-making"	2012.	Journal article	Global
Rahmani, A.M., B. Wade, and W. Riley. "Evaluating the Impact a Proposed Family Planning Model Would Have on Maternal and Infant Mortality in Afghanistan"	2013	Journal article	Afghanistan

Author and title	Year of publication	Type of reference	Country of Focus
Rau, B. *From Isolation to Solidarity: How Community Mobilization Underpins HIV Prevention in the Avahan India AIDS Initiative*	2013	Report	India
Robinson, W.C. and J.A. Ross. *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*	2007	Report	Global
Ross, J. and E. Smith. "Trends in National Family Planning Programs, 1999, 2004 and 2009"	2011	Journal article	Global
Saetren, H. "Facts and Myths About Research on Public Policy Implementation: Out of Fashion, Allegedly Dead, but Still Very Much Alive and Present"	2005	Journal article	Global
Sakyi, K. "A Retrospective Content Analysis of Studies on Factors Constraining the Implementation of Health Sector Reform in Ghana"	2008	Journal article	Ghana
Solon, O., K. Woo, S.A. Quimbo, R. Shimkhada, J. Florentino, et al. "A Novel Method for Measuring Health Care System Performance: Experience from QIDS in the Philippines"	2009	Journal article	Philippines
Spicer, N., J. Aleshkina, R. Biesma, R. Brugha, C. Caceres, et al. "National and Subnational HIV/AIDS Coordination: Are Global Health Initiatives Closing the Gap Between Intent and Practice?"	2010	Journal article	Global
UN, USAID/Africa Bureau, USAID/Population and Reproductive Health, Ethiopia Federal Ministry of Health, Malawi Ministry of Health, and Rwanda Ministry of Health. *Three Successful sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs*	2013	Report	Ethiopia, Rwanda, Malawi
Victora, C.G., R.E. Black, T.J. Boerma, and J. Bryce. "Measuring Impact in the Millennium Development Goal Era and Beyond: A New Approach to Large-scale Effectiveness Evaluations"	2011	Journal article	Global
Evaluation Designs			
WHO and International Health Partnership. *Monitoring, Evaluation and Review of National Health Strategies: A Country-led Platform for Information and Accountability*	2011	Report	Global
Nabatchi, T. *A Manager's Guide to Evaluating Citizen Participation*	2012	Report	Global
Schmeer, K. *Guidelines for Conducting a Stakeholder Analysis*	1999	Report	Global

Author and title	Year of publication	Type of reference	Country of Focus
Sumner, A., J. Crichton, S. Theobald, E. Zulu, and J. Parkhurst. "What Shapes Research Impact on Policy? Understanding Research Uptake in Sexual and Reproductive Health Policy Processes in Resource Poor Contexts"	2011	Journal article	Global
Warburton, D., R. Wilson, and E. Rainbow. *Making a Difference: A Guide to Evaluating Public Participation in Central Government*	2009	Tool	Global
Wholey, J.F., H.P. Hatry, and K.E. Newcomer. *Handbook of Practical Program Evaluation*	2004	Book	Global

Kruk, M.A. and L.P. Freedman. 2008. "Assessing Health System Performance in Developing Countries: A Review of the Literature." *Health Policy* 85: 263–276.

Abstract

With the setting of ambitious international health goals and an influx of additional development assistance for health, there is growing interest in assessing the performance of health systems in developing countries. This paper proposes a framework for the assessment of health system performance and reviews the literature on indicators currently in use to measure performance, using online medical and public health databases, complemented by a review of relevant books and reports in the grey literature. The indicators were organized into three categories: effectiveness, equity, and efficiency. Measures of health system effectiveness were improvement in health status, access to and quality of care and, increasingly, patient satisfaction. Measures of equity included access and quality of care for disadvantaged groups, together with fair financing, risk protection, and accountability. Measures of efficiency were appropriate levels of funding, the cost-effectiveness of interventions, and effective administration. This framework and review of indicators may be helpful to health policymakers interested in assessing the effects of different policies, expenditures, and organizational structures on health outputs and outcomes in developing countries.

Rwashana, A.S., D.W. Williams, and S. Neema. 2009. "System Dynamics Approach to Immunization Healthcare Issues in Developing Countries: A Case Study of Uganda." *Health Informatics Journal* 15(2): 95–107.

Abstract

This article critically examines the challenges associated with demand for immunization, including the interplay of political, social, economic, and technological forces that influence the level of immunization coverage. The article suggests a framework to capture the complex and dynamic nature of the immunization process, and tests its effectiveness using a case study of Ugandan healthcare provision. Field study research methods and qualitative system dynamics, and a feedback and control theory-based modelling approach are used to capture the complexity and dynamic nature of the immunization process to enhance a deeper understanding of the immunization organizational environment. The article also presents a model showing the dynamic influences associated with demand and provision of immunization services, with the aim of facilitating the decision-making process as well as healthcare policy interventions.

Walt, G., J. Shiffman, H. Schneider, S.F. Murray, R. Brugha, et al. 2008. "Doing Health Policy Analysis: Methodological and Conceptual Reflections and Challenges." *Health Policy and Planning* 23(5): 308–317.

Abstract

The case for undertaking policy analysis has been made by a number of scholars and practitioners. However, much less attention has been given to *how* to do policy analysis—what research designs, theories, or methods best inform policy analysis. This paper begins by looking at the health policy environment, and some of the challenges in researching this highly complex phenomenon. It focuses on research in middle- and low-income countries, drawing on some of the frameworks and theories, methodologies, and designs that can be used in health policy analysis, giving examples from recent studies. It explores the implications of case studies and of temporality in research design, and draws attention to the roles of the policy researcher and the importance of reflexivity and researcher positionality in the research process. The final section explores ways of advancing the field of health policy analysis, making recommendations on theory, methodology, and researcher reflexivity.

Complex Adaptive Systems

Atun, R. 2012. "Health Systems, Systems Thinking and Innovation." *Health Policy and Planning* 27: iv4–iv8.

Summary of Article (self-written)

Successful health systems contribute to good health outcomes by using resources effectively, maintaining responsible finances, and meeting citizens' needs. By leading to a healthy population and responding well to health crises, successful health systems also lead to economic achievement. Rifat Atun attributes the following factors to an efficient health system: "the capacity of both individuals and institutions within health systems, continuity of stewardship, ability to seize opportunities, and contextual characteristics, such as path-dependency, sociocultural beliefs, economic set up, and history of the country concerned." These complex factors interplay within health systems and make it difficult to predict which health policies will succeed and which will not. Atun argues that one common reason why policies are not implemented as predicted is that measurement tools are incapable of capturing the complexity of health systems. Atun also explains the creation and interworkings of complex adaptive systems (CAS) and provides examples of how CAS respond to new policies.

Gericke, C.A., C. Kurowski, M.K. Ranson, and A. Mills. 2005. "Intervention Complexity: A Conceptual Framework to Inform Priority-setting in Health." *Bulletin of the World Health Organization* 83(4): 285–293.

Abstract

Health interventions vary substantially in the degree of effort required to implement them. To some extent, this is apparent in their financial cost, but the nature and availability of non-financial resources is often of similar importance. In particular, human resource requirements are frequently a major constraint. We propose a conceptual framework for the analysis of interventions according to their degree of technical complexity; this complements the notion of institutional capacity in considering the feasibility of implementing an intervention. We categorize interventions into four dimensions: characteristics of the basic intervention; characteristics of delivery; requirements for government capacity; and usage characteristics. The analysis of intervention complexity should lead to a better understanding of supply- and demand-side constraints to scaling up, indicate priorities for further research and development, and possibly point to potential areas for improvement of specific aspects of each intervention to close the gap between the complexity of an intervention and the capacity to implement it. The framework is illustrated using the examples of scaling up condom social marketing programmes and the DOTS strategy for tuberculosis control in highly resource-constrained countries. The framework could be used as a tool for policymakers, planners, and programme managers when considering the expansion of existing projects or the introduction of new interventions. Intervention complexity thus complements the considerations of burden of disease, cost-effectiveness, affordability, and political feasibility in health policy decision making. Reducing the technical complexity of interventions will be crucial to meeting the health-related MDGs.

Paina, L. and D.H. Peters. 2011. "Understanding Pathways for Scaling Up Health Services Through the Lens of Complex Adaptive Systems." *Health Policy and Planning*. Published online August 5. doi: 10.1093/heapol/czr054. Available at: http://www.ncbi.nlm.nih.gov/pubmed/21821667.

Abstract

Despite the increased prominence and funding of global health initiatives, efforts to scale up health services in developing countries are falling short of the expectations of the MDGs. Arguing that the dominant assumptions for scaling up are inadequate, we propose that interpreting change in health systems through the lens of CAS provides better models of pathways for scaling up.

Based on an understanding of CAS behaviours, we describe how phenomena such as path dependence, feedback loops, scale-free networks, emergent behaviour, and phase transitions can uncover relevant lessons for the design and implementation of health policy and programmes in the context of scaling up health services. The implications include paying more attention to local context, incentives, and institutions, as well as anticipating certain types of unintended consequences that can undermine scaling up efforts, and developing and implementing programmes that engage key actors through transparent use of data for ongoing problem solving and adaptation.

We propose that future efforts to scale up should adapt and apply the models and methodologies which have been used in other fields that study CAS, yet are underused in public health. This can help policymakers, planners, implementers, and researchers to explore different and innovative approaches for reaching populations in need with effective, equitable, and efficient health services.

The old assumptions have led to disappointed expectations about how to scale up health services and offer little insight on how to scale up effective interventions in the future. The alternative perspectives offered by CAS may better reflect the complex and changing nature of health systems, and create new opportunities for understanding and scaling up health services.

Path Dependence

Howlett, M. and J. Rayner. 2006. "Understanding the Historical Turn in the Policy Sciences: A Critique of Stochastic, Narrative, Path Dependency and Process-sequencing Models over Time." *Policy Sciences* 39(1): 1–18.

Abstract

This article evaluates four general models of historical change processes that have emerged in various fields in the social sciences—stochastic, historical narrative, path dependency, and process sequencing—and their application to the study of public policy making. The article sets out and assesses the merits and evidence for each, both in general social research and the policy sciences. The article suggests that more work needs to be done in examining the assumptions and presuppositions of each model before concluding that any of them represents the general case in policy processes. However, since neither the irreversible linear reality assumed by narrative models, nor the random and chaotic world assumed by stochastic models, nor the contingent turning points and irreversible trajectories required of the path dependency model are found very often in policy making, these models are likely to remain less significant than process-sequencing models in describing the overall general pattern of policy dynamics.

Page, S. 2006. "Path Dependence." *Quarterly Journal of Political Science* 1: 87–115.

Summary of Report (self-written)

This essay offers a primer on the concept of path dependence, distinctions between different kinds of path dependence, and some examples of path dependent processes. Page distinguishes between processes that are "phat dependent" (function of events in a history but not to their ordering) and "path dependent" (function of both events and their order). He describes variations on the Polya process (drawing colored balls from an urn). He attempts to define strong path dependence, but there is no interesting difference between this and regular path dependence. He defines recent path dependence—what he calls a Forgetting Process (semi-Markovian)—which offers nice elaborations on the basic concept.

Torfing, J. 2009. "Rethinking Path Dependence in Public Policy Research." *Critical Policy Studies* 3(1): 70–83.

Abstract

Path dependence arguments are highly relevant for analysing and explaining the resilience and persistence of public policies in the face of intentional reform. However, path dependence arguments were originally

developed to explain the predominance of suboptimal solutions in the private market economy. Furthermore, several unresolved problems crop up when applying path dependence arguments in the study of politics. This article thus aims to rethink the path dependence arguments to customize them for the study of public policy reforms by revisiting the classical argument about self-reinforcing technological paths advanced by P.A. David and W.B. Arthur. After a critical review of the rationalistic critique of the classical argument and a reiteration of the call for a renewed focus on path dependence in political science, the article identifies a series of analytical challenges to the classical path dependence argument that must be addressed to make it relevant to public policy studies. The article concludes with a preliminary sketch of the theoretical responses to the analytical challenges and an empirical illustration of the main arguments, based on the empirical case studies presented in this special issue.

Implementation Science

Gilson, L, ed. 2012. *Health Policy and Systems Research: A Methodology Reader.* Geneva: World Health Organization.

Excerpt

This methodology reader seeks to contribute to the field of health policy and systems research (HPSR) by guiding the research and instruction of health policies and systems, particularly in LMICs. Part 1 of this reader includes a guide to political theories, such as positivism, relativism, and critical realism. Part 2 primarily covers the process of implementation, putting special emphasis on the ability to accurately and thoroughly identify your research question. The last three sections explain effective primary research methods and provide an extensive bibliography of superior publications on health policy and systems. The reader also serves to advance the field of HPSR by promoting the following:

- The use of integrative, interdisciplinary methods that address the complications and difficulties inherent to health policy and systems
- The generation of multisectoral dialogue surrounding health policy and systems

A better understanding of the diversity of methods and disciplines involved in HPSR, including new and relatively unknown approaches

Padian, N.S., C.B. Holmes, S.I. McCoy, R. Lyerla, P.D. Bouey, et al. 2011. "Implementation Science for PEPFAR." *Journal of Acquired Immune Deficiency Syndromes* 56(3): 199–203.

Summary of Article (self-written)

The implementation science (IS) framework seeks to minimize the knowledge-implementation gap—the gap between the understanding and use of information gained from research. IS can be used to improve programmes and projects by improving the evaluations of these activities. The framework includes "monitoring and evaluation, operations research, and impact evaluation (including modeling and cost-effective analyses)." While PEPFAR has had an enormous effect on the HIV/AIDS epidemic, the IS framework will contribute to this impact by identifying and responding to implementation issues in HIV/AIDS programs.

Schackman, B. 2010. "Implementation Science for the Prevention and Treatment of HIV/AIDS." *Journal of Acquired Immune Deficiency Syndromes* 55(Suppl 1): S27–S31.

Abstract

Implementation science is the scientific study of methods to promote the integration of research findings and evidence-based interventions into healthcare policy and practice, and hence to improve the quality and effectiveness of health services and care. Implementation science is distinguished from M&E by its emphasis on the use of the scientific method. The origins of IS include operations research, industrial engineering, and management science. Today, IS encompasses a broader range of methods and skills,

including decision science and operations research, health systems research, health outcomes research, health and behavioral economics, epidemiology, statistics, organization and management science, finance, policy analysis, anthropology, sociology, and ethics. Examples of IS research are presented for HIV prevention (prevention of mother-to-child transmission (PMTCT), male circumcision) and HIV and drug use (syringe distribution, treating drug users with ART and opioid substitution therapy). For IS to become an established field in HIV/AIDS research, there needs to be better coordination between funders of research and program delivery, and greater consensus on scientific research approaches and standards of evidence.

Evaluations of Policy Implementation

Abuya, T., R. Njuki, C.E. Warren, J. Okal, F. Obare, et al. 2012. "A Policy Analysis of the Implementation of a Reproductive Health Vouchers Program in Kenya." *BMC Public Health* 12:540.

Abstract

Background: Innovative financing strategies such as those that integrate supply and demand elements, such as the output-based approach (OBA), have been implemented to reduce financial barriers to maternal health services. The Kenyan government, with support from the German Development Bank (KfW), implemented an OBA voucher program to subsidize priority RH services. Little evidence exists on the experience of implementing such programs in different settings. We describe the implementation process of the Kenyan OBA program and draw implications for scale-up.

Methods: Policy analysis, using document review and qualitative data from 10 in-depth interviews with facility in-charges and 18 with service providers from the contracted facilities; local administration; and health and field managers in Kitui, Kiambu, and Kisumu districts as well as the Korogocho and Viwandani slums in Nairobi.

Results: The OBA implementation process was designed in phases, providing an opportunity for learning and adapting the lessons to local settings. The design consisted of five components: a defined benefit package, contracting, quality assurance, marketing and distribution of vouchers, and claims processing and reimbursement. Key implementation challenges included limited feedback to providers on the outcomes of quality assurance and accreditation and budgetary constraints that limited effective marketing, leading to inadequate information to clients regarding the benefit package. Claims processing and reimbursement were sophisticated but required adherence to time-consuming procedures and, in some cases, private providers complained of low reimbursement rates for services provided.

Conclusions: OBA voucher schemes can be implemented successfully in similar settings. For effective scale-up, strong partnerships will be required between the public and private entities. The government's role is key and should include provision of adequate funding, stewardship, and looking for opportunities to utilize existing platforms to scale up such strategies.

Adam, T., J. Hsu, D. de Savigny, J. Lavis, J-A. Rottingen, et al. 2012. "Evaluating Health Systems Strengthening Interventions in Low-Income and Middle-Income Countries: Are We Asking the Right Questions?" *Health Policy and Planning* 27: iv9–iv19.

Abstract

In recent years, there have been several calls for rigorous health policy and systems research to inform efforts to strengthen health systems (HS) in LMICs, including the use of systems thinking concepts in designing and evaluating HS strengthening interventions. The objectives of this paper are to assess recent evaluations of such interventions to examine the extent to which they ask a broader set of questions and provide an appropriately comprehensive assessment of their effects across the health system. A review of

evaluations conducted in 2009–10 was performed to answer these questions. Out of 106 evaluations, less than half (43%) asked broad research questions to allow for a comprehensive assessment of the intervention's effects across multiple HS building blocks. Only half of the evaluations referred to a conceptual framework to guide their impact assessment. Overall, 24 percent and 9 percent conducted process and context evaluations, respectively, to answer the question of whether the intervention worked as intended and, if so, for whom, and under what circumstances. Almost half of the evaluations considered HS impact on one building block, while most interventions were complex, targeting two or more building blocks. None incorporated evaluation designs that took into account the characteristics of CAS, such as the nonlinearity of effects or interactions between the HS building blocks. Although we do not argue that all evaluations should be comprehensive, there is a need for more comprehensive evaluations of the wider range of the intervention's effects, when appropriate. Our findings suggest that the full range of barriers to more comprehensive evaluations need to be examined and, when appropriate, addressed. Possible barriers may include limited capacity, lack of funding, inadequate timeframes, lack of demand from both researchers and research funders, or difficulties in undertaking this type of evaluation.

Amouzou, A., O. Habi, K. Bensaid, and the Niger Countdown Case Study Working Group. 2012. "Reduction in Child Mortality in Niger: A Countdown to 2015 Country Case Study." *Lancet* 380: 1169–78.

Summary of Report (self-written)

Background: The MDG 4 calls for reducing by two-thirds the mortality rate of children younger than five years between 1990 and 2015. The 2012 Countdown profile shows that Niger has achieved far greater reductions in child mortality and gains in coverage for interventions in child survival than neighbouring countries in West Africa. For this reason, Countdown invited Niger to complete an in-depth analysis of its child survival programme between 1998 and 2009.

Methods: We developed new estimates of child and neonatal mortality for 1998–2009 using a 2010 household survey. We recalculated coverage indicators using eight nationally representative surveys for that period and documented maternal, newborn, and child health programmes and policies since 1995. We used the Lives Saved Tool (LiST) to estimate the child lives saved in 2009.

Findings: The mortality rate in children younger than five years declined significantly, from 226 deaths per 1,000 live births (95% CI 207–246) in 1998 to 128 deaths (117–140) in 2009, an annual rate of decline of 5.1 percent. Stunting prevalence decreased slightly in children ages 24–35 months, and wasting declined by about 50 percent, with the largest decreases occurring in children younger than two years. Coverage increased greatly for most child survival interventions in this period. Results from LiST show that about 59,000 lives of children younger than five years were saved in 2009, attributable to the introduction of insecticide-treated bed nets (25%); improvements in nutritional status (19%); vitamin A supplementation (9%); treatment of diarrhoea with oral rehydration salts and zinc, and care seeking for fever, malaria, or childhood pneumonia (22%); and vaccinations (11%).

Interpretation: Government policies supporting universal access, provision of free healthcare for pregnant women and children, and decentralised nutrition programmes permitted Niger to decrease child mortality at a pace that exceeds that needed to meet the MDG 4.

du P. Heyns, A., R.J. Benjamin, J.P. Ronel Swanevelder, M.E. Laycock, B.L. Pappalardo, et al. 2006. "Prevalence of HIV-1 in Blood Donations Following Implementation of a Structured Blood Safety Policy in South Africa." ***Journal of the American Medical Association*** **295(5): 519–526. Available at: http://jama.ama-assn.org.**

Abstract

Context: The South African National Blood Service collects more than 700 000 units of blood annually from a population in which 11.4 percent are infected with HIV-1. The prevalence of HIV-1 in blood donations increased to 0.26 percent (1:385) in 1998, indicating that a significant number of window-period infective units were entering the blood supply (risk 3.4/100 000).

Objectives: To determine whether the implementation of a new donor selection policy and educational program introduced in 1999 was associated with reductions in the incidence and prevalence of HIV-1 in blood donations and the reduced transmission risk.

Design: We compared the prevalence of HIV-1 in 880,534 blood donations collected from 1999 through 2000 with the 791,639 blood donations collected from 2001 through 2002. We estimated the incidence of HIV-1 in 93,378 (1999–2000) and 67,231 (2001–2002) first-time donations, and the residual risk for all donations in 2001–2002 using the less-sensitive enzyme-linked immunoassay and incidence-window period model.

Setting: All blood donors in the Inland region of the South African National Blood Service were analyzed.

Intervention: Donor clinics in high HIV prevalence areas were closed. Programs targeting repeat donors and youth were initiated and HIV risk behavior education programs were developed. Structured donor interviews and an enhanced donor self-exclusion questionnaire were institutionalized.

Results: The prevalence of HIV-1 in blood donations declined from 0.17 percent in 1999–2000 to 0.08 percent in 2001–2002 after the implementation of the new donor selection and education policy. The number of high-risk donations collected decreased from 2.6 percent to 1.7 percent (P<.001), and the likelihood of these donations being infected decreased from 4.8 percent to 3.25 percent. The likelihood of first-time donors being recently infected with HIV-1 decreased from 18 percent to 14 percent (P = .07) and the respective incidence of high-risk donations collected decreased from 2.6 percent to 1.7 percent. Donations from the majority black population declined from 6.6 percent to 4.2 percent (P<.001). Analysis of HIV-1 incidence in 2001–2002 suggests a residual risk of collecting a window-period infectious unit of 2.6/100,000.

Conclusion: The implementation of enhanced education and selection policies in South Africa was associated with decreased prevalence of HIV-1 in blood donations.

Bärnighausen, T., D. Bloom, and S. Humair. 2012. "Health Systems and HIV Treatment in sub-Saharan Africa: Matching Intervention and Programme Evaluation Strategies." ***Sexually Transmitted Infections*** **88(2): e2.**

Abstract

Objectives: International donors financing the delivery of ART in developing countries recently have emphasised their commitment to rigorous evaluation of ART impact on population health. In the same timeframe, but for different reasons, they have announced that they will shift funding from vertically structured (i.e., disease-specific) interventions to horizontally structured interventions (i.e., staff, systems, and infrastructure that can deliver care for many diseases). The authors analyse the likely effects of the latter shift on the feasibility of impact evaluation.

Methods: The authors examine the effect of the shift in intervention strategy on (1) outcome measurement, (2) cost measurement, (3) study-design options, and the (4) technical and (5) political feasibility of programme evaluation.

Results: As an intervention structure changes from vertical to horizontal, outcome and cost measurements are likely to become more difficult because the number of relevant outcomes and costs increases, and the sources holding data on these measures become more diverse; study-design options become more limited because it often is impossible to identify a rigorously defined counterfactual in horizontal interventions; the technical feasibility of interventions is reduced because lag times between intervention and impact increase in length, and effect-mediating and effect-modifying factors increase in number; and the political feasibility of evaluation is decreased because national policymakers may be reluctant to support the evaluation.

Conclusions: In the choice of intervention strategy, policymakers need to consider the effect of intervention strategy on impact evaluation. Methodological studies are needed to identify the best approaches to evaluate the population health impact of horizontal interventions.

Biesma, R.G., R. Brugha, A. Harmer, A. Walsh, N. Spicer, et al. 2009. "The Effects of Global Health Initiatives on Country Health Systems: A Review of the Evidence from HIV/AIDS Control." *Health Policy and Planning* 24: 239–252.

Abstract

This paper reviews country-level evidence about the impact of GHIs, which have had profound effects on recipient country health systems in middle- and low-income countries. We have selected three initiatives that account for an estimated two-thirds of external funding earmarked for HIV/AIDS control in resource-poor countries: the Global Fund to Fight AIDS, TB and Malaria; the World Bank Multi-country AIDS Program (MAP); and PEPFAR. This paper draws on 31 original country-specific and cross-country articles and reports, based on country-level fieldwork conducted between 2002 and 2007. Positive effects have included a rapid scale-up in HIV/AIDS service delivery, greater stakeholder participation, and channeling of funds to nongovernmental stakeholders, mainly NGOs and faith-based bodies. Negative effects include distortion of recipient countries' national policies, notably through distracting governments from coordinated efforts to strengthen health systems and re-verticalization of planning, management, and M&E systems. Subnational and district studies are needed to assess the degree to which GHIs are learning to align with and build the capacities of countries to respond to HIV/AIDS; whether marginalized populations access and benefit from GHI-funded programmes; and about the cost-effectiveness and long-term sustainability of the HIV and AIDS programmes funded by the GHIs. Three multi-country sets of evaluations, which were to be reported in 2009, would answer some of these questions.

Björkman, M. and J. Svensson. 2009. "Power to the People: Evidence from a Randomized Field Experiment on Community-based Monitoring in Uganda." *The Quarterly Journal of Economics* 124(2): 735–769.

Abstract

This paper presents a randomized field experiment on community-based monitoring of public primary healthcare providers in Uganda. Through two rounds of village meetings, localized nongovernmental organizations encouraged communities to be more involved with the state of health service provision and strengthened their capacity to hold their local health providers to account for performance. A year after the intervention, treatment communities are more involved in monitoring the provider, and the health workers appear to exert greater efforts to serve the community. We document large increases in utilization and improved health outcomes—reduced child mortality and increased child weight—that compare favorably to more successful community-based intervention trials reported in the medical literature.

Blattman, C. 2008. "Impact Evaluation 2.0." Presentation to the Department for International Development (DFID). London, UK. February 14, 2008. Available at: http://www.chrisblattman.com/documents/policy/2008.ImpactEvaluation2.DFID_talk.pdf?9d7bd4.

Excerpt

We tend to associate randomized trials with new drugs for blood cholesterol and baldness, not school textbooks, mosquito bed nets, and police patrols. A growing number of development agencies are beginning to change our minds, however; they are assessing the impact of humanitarian aid and development programs with the randomized control trial.

I am going to assume that this fact is already a familiar one. For convenience, this talk will actually presume a great deal: that you appreciate the case for evidence-based programming; that you understand the nature of a randomized trial; and that you believe the ethical and political concerns with randomization are important but in many cases can be overcome.

My goal is not to make the case for randomized evaluation. Rather, I want to challenge the conventional wisdom. In particular, I want us to be more ambitious, more aware of the needs of implementers, and more forward-thinking in our approach to evaluation. Much of what is being done in evaluation today is very good, but I will argue we can do better. The hard work and ingenuity of researchers and implementers the world round have pushed us to a point where we are ready for a revision of evaluation practice: an impact evaluation 2.0.

Bryce, J., C. Victora, T. Boema, D. Peters, and R. Black. 2011. "Evaluating the Scale-up for Maternal and Child Survival: A Common Framework." *International Health* 3(3): 139–146.

Abstract

Programs to reduce mortality among women and children are the target of new resources and redoubled commitment as the 2015 date for achieving the MDGs approaches. The need for a common evaluation framework to guide the collection, analysis, and synthesis of evidence is increasingly evident. This paper presents such a framework in four parts: (1) a conceptual model for the scale-up to MDGs 4 and 5 for maternal and child survival; (2) recommended indicators for each part of the model that bring together the work of various existing technical groups and prioritize a limited number of indicators for standardization and common use; (3) guidelines for documenting program implementation and contextual factors that may affect program implementation and its effectiveness in reducing maternal and child mortality; and (4) design considerations in evaluating the scale-up. We first present an overview of what is known and/or agreed upon within each of these areas; then, in the discussion, we highlight areas of uncertainty or where gaps need to be addressed.

Bryce, J., C.G. Victora, JP. Habicht, RE. Black, and R.W. Scherpbier, on behalf of the MCE-IMCI Technical Advisors. 2005. "Programmatic Pathways to Child Survival: Results of a Multi-Country Evaluation of Integrated Management of Childhood Illness." *Health Policy and Planning* 20(Issue Suppl 1): i5–i17.

Abstract

Objective: To summarize the expectations held by WHO programme personnel about how the introduction of the IMCI strategy would lead to improvements in child health and nutrition, compare these expectations with what was learned from the Multi-Country Evaluation of IMCI Effectiveness, Cost and Impact (MCE-IMCI), and discuss the implications of these findings for child survival policies and programmes.

Design: The MCE-IMCI study designs were based on an impact model developed in 1999–2000 to define how IMCI would be implemented at the country level and below, and the outcomes and impact it would have on child health and survival. MCE-IMCI studies included feasibility assessments documenting IMCI implementation in 12 countries (1999–2001); in-depth studies using compatible designs in Bangladesh, Brazil, Peru, Tanzania, and Uganda; and cross-site analyses addressing the effectiveness of specific subsets of IMCI activities.

Results: The IMCI strategy was successfully introduced in the great majority of countries with moderate to high levels of child mortality in the period from 1996 to 2001. Seven years of country-based evaluation, however, indicate that some of the basic expectations underlying the development of IMCI were not met. Four of the five countries (the exception is Tanzania) had difficulties in expanding the strategy at the national level while maintaining adequate intervention quality. Technical guidelines on delivering interventions at the family and community levels were slow to appear; in their absence, countries stalled in their efforts to increase population coverage through essential interventions related to care seeking, nutrition, and correct care of the sick child at home. The full weight of health system limitations on IMCI implementation was not appreciated at the outset; only now is it clear that solutions to larger problems in political commitment, human resources, financing, integrated—or at least coordinated—programme management, and effective decentralization are essential underpinnings of successful efforts to reduce child mortality.

Conclusions: This analysis highlights the need for a shift if child survival efforts are to be successful. Delivery systems that rely solely on government health facilities must be expanded to include the full range of potential channels in a setting and strong community-based approaches. The focus on process within child health programmes must change to include greater accountability for intervention coverage at the population level. Global strategies that expect countries to make massive adaptations must be complemented by country-level implementation guidelines that begin with local epidemiology and rely on tools developed for specific epidemiological profiles.

Bryce, J., C.G. Victora, and the MCE-IMCI Technical Advisors. 2005. "Ten Methodological Lessons from the Multi-Country Evaluation of Integrated Management of Childhood Illness." *Health Policy and Planning* 20 (Suppl 1): i94–i105.

Abstract

Objective: To describe key methodological aspects of MCE-IMCI and analyze their implications for other public health impact evaluations.

Design: The MCE-IMCI evaluation designs are based on an impact model that defined expectations in the late 1990s about how IMCI would be implemented at the country level and below, and the outcomes and impact it would have on child health and survival. MCE-IMCI studies include feasibility assessments documenting IMCI implementation in 12 countries, in-depth studies using compatible designs in five countries, and cross-site analyses addressing the effectiveness of specific subsets of IMCI activities. The MCE-IMCI was designed both to evaluate the impact of IMCI and see that the findings from the evaluation were taken up through formal feedback sessions at the national, subnational, and local levels.

Results: Issues that arose early in the MCE-IMCI included the following: (1) defining the scope of the evaluation, (2) selecting study sites and developing research designs, (3) protecting objectivity, and (4) developing an impact model. Issues that arose mid-course included the following: (5) anticipating and addressing problems with external validity, (6) ensuring an appropriate timeframe for the full evaluation cycle, (7) providing feedback on results to policymakers and programme implementers, and (8) modifying site-specific designs in response to early findings about the patterns and pace of programme implementation. Two critical issues best addressed only near the close of the evaluation are (9) factors affecting the uptake of evaluation results by policymakers and programme decisionmakers, and (10) the

costs of the evaluation.

Conclusions: Large-scale effectiveness evaluations present challenges that have not been addressed fully in the methodological literature. Although some of these challenges are context specific, there are important lessons from the MCE that can inform future designs. Most of the issues described here are not addressed explicitly in research reports or evaluation textbooks. Describing and analyzing these experiences is one way to promote improved impact evaluations of new global health strategies.

Centers for Disease Control and Prevention. 1999. "Achievements in Public Health, 1990–1999: Family Planning." *MMWR Weekly* 48: 1073–1080.

Summary of Report (self-written)

During the 20th century, the hallmark of family planning in the United States has been the ability to achieve desired birth spacing and family size. Fertility decreased as couples chose to have fewer children; concurrently, child mortality declined, people moved from farms to cities, and the age at marriage increased. Smaller families and longer birth intervals have contributed to the better health of infants, children, and women, and have improved the social and economic roles of women. Despite high failure rates, traditional methods of fertility control contributed to the decline in family size. Modern contraception and reproductive healthcare systems that became available later in the century further improved couples' ability to plan their families. Publicly supported FP services prevent an estimated 1.3 million unintended pregnancies annually. This report reviews the history of family planning during the past century; summarizes social, legal, and technological developments, and the impact of FP services; and discusses the need to ensure continued technological improvements and access to care.

Chandrasekaran, P., G. Dallabetta, V. Loo, S. Mills, T. Saidel, et al., for the Avahan Evaluation Partners. 2008. "Evaluation Design for Large-scale HIV Prevention Programmes: The Case of Avahan, the India AIDS Initiative." *AIDS* 22: S1–S15.

Abstract

Background: Closing the HIV prevention gap to prevent HIV infections requires rapid, worldwide roll-out of large-scale national programmes. Evaluating such programmes is challenging and complex, requiring clarity of evaluation purpose and evidential approaches substantively different from those employed for pilots and small programmes.

Objectives: This paper describes the evaluation design for the implementation phase of Avahan, the India AIDS initiative, a large HIV prevention programme funded by the Bill and Melinda Gates Foundation. Avahan, which began in December 2003, has a 10-year charter to impact the Indian epidemic and the response to it by implementing an HIV prevention programme targeting core and bridge groups in 83 districts of six Indian states, transferring the programme to the government of India, and disseminating programme learning.

Methods: The foundation commissioned an external process to design Avahan's evaluation framework. An independent advisory group oversees and guides course corrections in the execution of this framework.

Results: Avahan's evaluation framework comprises the following: trend and synthetic analysis of data from core, bridge, and household biobehavioural surveys in a subset of intervention districts, denominator estimates and programme monitoring from all intervention districts, and the government's antenatal surveillance (two sites per district in all districts); bespoke transmission dynamics modelling to estimate

infections averted (subset of districts); and cost-effectiveness studies (subset of districts). In addition, Avahan engages in other knowledge-building and quality-monitoring activities.

Conclusion: Rather than a small set of monofocal outcome measures, scaled programmes require nuanced evaluations that approximate programmatic scale by collecting data with different levels of geographical scope, synthesize multiple data and methods to arrive at a composite picture, and can cope with continuous environmental and programme evolution.

Chriqui, J.F., J.C. O'Connor, and F.J. Chaloupka. 2011. "What Gets Measured, Gets Changed: Evaluating Law and Policy for Maximum Impact." *Journal of Law, Medicine & Ethics* 39(Suppl 1): 21–26.

Summary of Article (self-written)

The global health field has begun to rely more on law and policy to support the generation of long-lasting improved health outcomes. Examples include reduction of smoking and second-hand smoke, underage drinking and driving, and unhealthy eating and dental cavities, and an increase in seatbelt use in areas affected by health policy. This article seeks to support the next step in health policy and law—M&E—by providing guidance for and examples of policy impact research.

Cailhol, J., I. Craveiro, T. Madede, E. Makoa, T. Mathole, et al. 2013. "Analysis of Human Resources for Health Strategies and Policies in 5 Countries in sub-Saharan Africa, in Response to GFATM and PEPFAR-funded HIV-Activities." *Globalization and Health* 9:52.

Abstract

Background: GHIs, aiming at reducing the impact of specific diseases such as HIV, have flourished since 2000. Amongst these, PEPFAR and GFATM have provided a substantial amount of funding to countries affected by HIV, predominantly for delivery of ART and prevention strategies. Since the need for additional HRH was not initially considered by GHIs, to allow ARV scale-up, countries implemented short-term HRH strategies adapted to GHI-funding conditionality. Such strategies differed from one country to another and slowly evolved into long-term HRH policies. The processes and content of HRH policy shifts in five countries in sub-Saharan Africa were examined.

Methods: A multi-country study using a mixed-methods design was conducted from 2007 to 2011 in five countries (Angola, Burundi, Lesotho, Mozambique, and South Africa) to assess the impact of GHIs on the health system. This paper focuses on the impact of GFATM and PEPFAR on HRH policies. Qualitative data consisted of semi-structured interviews undertaken at the national and subnational levels, and analysis of secondary data from national reports. Data were analysed to extract countries' responses to HRH challenges posed by implementation of HIV-related activities. Common themes across the five countries were selected and compared in light of each country context.

Results: In all countries, successful ARV roll-out was observed, despite HRH shortages. This was a result of a mostly short-term emergency response by GHI-funded NGOs and, to a lesser extent, by governments, consisting of using and increasing available HRH for HIV tasks. As the challenges and limits of short-term HRH strategies were revealed and HIV became a chronic disease, the five countries slowly implemented mid- to long-term HRH strategies, such as formalisation of pilot initiatives, an increase in HRH production, and mitigation of internal HRH migration, sometimes in collaboration with GHIs.

Conclusion: Sustainable HRH strengthening is a complex process, depending mostly on HRH production and retention factors, these factors being country specific. GHIs could assist in these strategies, provided they are flexible enough to incorporate country-specific needs for funding, coordinate at the global level, and minimise conditionality for countries.

Chopra, M. and N. Rollins. 2008. "Infant Feeding in the Time of HIV: Rapid Assessment of Infant Feeding Policy and Programmes in Four African Countries Scaling Up Prevention

of Mother to Child Transmission Programmes." ***Archives of Diseases in Children*** **93: 288–291.**

Abstract

Objective: To assess the infant feeding components of prevention of mother-to-child HIV transmission programmes.

Methods: Assessments were performed across Botswana, Kenya, Malawi, and Uganda. A total of 29 districts offering PMTCT were selected by stratified random sampling of rural and urban strata. All health facilities in the selected PMTCT district were assessed. The facility-level manager and the senior nurse in charge of maternal care were interviewed. A total of 334 randomly selected health workers involved in the PMTCT programme completed self-administered questionnaires. A total of 640 PMTCT counselling observations were carried out, and 34 focus groups were conducted amongst men and women.

Results: Most health workers (234/334, 70%) were unable to correctly estimate the transmission risks of breastfeeding, irrespective of exposure to PMTCT training. Infant feeding options were mentioned in 307 of 640 (48%) observations of PMTCT counselling sessions, and in only 35 (5.5%) were infant feeding issues discussed in any depth; of these, 19 of these discussions (54.3%) were rated as poor. Several health workers also reported receiving free samples of infant formula in contravention of the International Code on Breastmilk Substitutes. National HIV managers stated they were unsure about infant feeding policy in the context of HIV. Finally, there was an almost universal belief that an HIV-positive mother who breastfeeds her child will always infect the child, and intentional avoidance of breastfeeding by the mother indicates that she is HIV positive.

Conclusion: These findings underline the need to implement and support systematic infant feeding policies and programme responses in the context of HIV programmes.

Cooper, D., D. Morroni, P. Orner, J. Moodley, J. Harries, et al. 2004. "Ten Years of Democracy in South Africa: Documenting Transformation in Reproductive Health Policy and Status." ***Reproductive Health Matters*** **12(24): 70–85.**

Abstract

The advent of democracy in South Africa in 1994 created a unique opportunity for new laws and policies to be passed. Today, a decade later, South African RH policies and the laws that underwrite them are among the most progressive and comprehensive in the world regarding the recognition they give to human rights, including sexual and reproductive rights. This paper documents the changes in health policy and services that have occurred, focusing particularly on key areas of sexual and reproductive health: contraception, maternal health, termination of pregnancy, cervical and breast cancer, gender-based and sexual violence, HIV/AIDS, and STIs, and infertility. Despite important advances, significant changes in women's RH status are difficult to discern, given the relatively short period of time and the multitude of complex factors that influence health, especially inequalities in socioeconomic and gender status. Gaps remain in the implementation of RH policies and service delivery that need to be addressed to achieve meaningful improvements in women's RH status. Civil society has played a major role in securing these legislative and policy changes, and health activist groups continue to pressure the government to introduce further changes in policy and service delivery, especially in the area of HIV/AIDS.

de Savigny D., J. Webster, I.A. Agyepong, A. Mwita, C. Bart-Plange, et al. 2012. "Introducing Vouchers for Malaria Prevention in Ghana and Tanzania: Context and

Adoption of Innovation in Health Systems." *Health Policy and Planning* 27 Suppl 4: iv32–iv43.

Abstract

Striking similarities in their health systems and other contexts exist between Tanzania and Ghana that are relevant to the scaling up of continuous delivery of insecticide-treated nets (ITNs) for malaria prevention. However, specific contextual factors of relevance to ITN delivery have led implementation down very different pathways in the two countries. Both countries have made major efforts and investments to address this intervention through integrating consumer discount vouchers into the health system. Discount vouchers require arrangements among the public, private, and nongovernmental sectors, and constitute a complex intervention in both health systems and business systems. In Tanzania, vouchers have moved beyond the planning agenda, have had policies and programmes formulated, have been sustained in implementation at the national scale for many years and, as of 2012, have become the main and only publicly supported continuous delivery system for ITNs. In Ghana, national-scale implementation of vouchers has never progressed beyond consideration on its agenda and piloting towards formulation of policy, and this approach was replaced by mass distribution campaigns with less dependency on or integration with the health system. By 2011, Ghana had entered a phase with no publicly supported continuous delivery system for ITNs. To understand the different outcomes, we compared the voucher programme timelines, phases, processes, and contexts in both countries in reference to the main health system building blocks (governance, human resources, financing, informatics, technologies, and service delivery). Contextual factors that provided an enabling environment for the voucher scheme in Tanzania did not do so in Ghana. This scheme was never seen as an appropriate national strategy, other delivery systems were not complementary, and the private sector was underdeveloped. The extensive time devoted to engagement and consensus building among all stakeholders in Tanzania was an important and clearly enabling difference, as was public sector support of the private sector. This contributed to the alignment of partner action behind a single coordinated strategy at the service delivery level, which in turn gave confidence to the business sector and avoided the "interference" of competing delivery systems that occurred in Ghana. Principles of systems thinking for intervention design correctly emphasize the importance of enabling contexts and stakeholder management.

Ditlopo, P., D. Blaauw, P. Bidwell, and S. Thomas. 2011. "Analyzing Implementation of the Rural Allowance in Hospitals in North West Province, South Africa." *Journal of Public Health Policy* 32 Suppl 1: S80–S93.

Abstract

Using a policy analysis framework, we analyzed the implementation and perceived effectiveness of a rural allowance policy and its influence on the motivation and retention of health professionals in rural hospitals in the North West province of South Africa. We conducted 40 in-depth interviews with policymakers, hospital managers, nurses, and doctors at five rural hospitals, and found weaknesses in policy design and implementation. These weaknesses included lack of evidence to guide policy formulation, restricting eligibility for the allowance to doctors and professional nurses, lack of clarity on the definition of rural areas, weak communication, and the absence of an M&E framework. Although the rural allowance was partially effective in the recruitment of health professionals, it has had the unintended negative consequences of perceived divisiveness and staff dissatisfaction. The government should take more account of contextual and process factors in policy formulation and implementation so that policies have the intended impact.

Doherty, T.M., D. McCoy, and S. Donohue. 2005. "Health System Constraints to Optimal Coverage of the Prevention of Mother-to-Child HIV Transmission Programme in South Africa: Lessons from the Implementation of the National Pilot Programme." *African Health Sciences* 5(3): 213–218.

Abstract

Background: It is three years since the government of South Africa began implementing a PMTCT programme. Over this period of time, attempts have been made to scale it up across all provinces under routine health service conditions.

Objectives: To report on the uptake and performance of South Africa's national pilot programme for PMTCT and identify health system constraints to optimal coverage.

Methods: Routine programme data were collected from antenatal records and delivery registers at the pilot sites, and interviews were conducted with health workers on site and with provincial programme managers.

Results: Routine PMTCT programme data were collected from all 18 pilot sites for the period January to December 2002. During this period, of 84,406 women attending the sites for first antenatal visits, 47,267 (56%) agreed to an HIV test. Of those tested, 14,340 (30%) were HIV positive; of these, 7,853 (55%) were dispensed nevirapine. A total of 7,950 (99%) infants born to women identified as being HIV positive received nevirapine syrup. A total of 58 percent (4196/7237) of HIV-positive women expressed an intention to exclusively formula feed, and 42 percent (3041/7237) intended to breastfeed exclusively. Between January and December 2002, 1,907 infants were due for 12-month HIV testing; of these, 949 (50%) infants were tested.

Conclusions: Programme effectiveness was limited by the low rate of HIV test acceptance, poor delivery of nevirapine to mothers, and inability to track mother-infant pairs postnatally for 12-month HIV testing of infants. Infant feeding intentions of mothers suggest inadequate counselling and possible negative effects of the provision of free formula milk. The poor performance of the main components of this programme will seriously reduce its operational effectiveness. There is a need for greater integration of voluntary counselling and testing within antenatal care (ANC), a review of the current policy of providing free formula milk, and an alternative model for mother-infant follow-up.

Frenk, J. 2006. "Bridging the Divide: Global Lessons from Evidence-based Health Policy in Mexico." *The Lancet* 368(9539): 954–961.

Abstract

During the past six years, Mexico has undergone a large-scale transformation of its health system. This paper provides an overview of the main features of the Mexican reform experience. Because of its high degree of social inequality, Mexico is a microcosm of the range of problems that affect countries at all levels of development. Its health system had not kept up with the pressures of the double burden of disease, whereby malnutrition, common infections, and RH problems coexist with noncommunicable disease and injury. With half of its population uninsured, Mexico was facing an unacceptable paradox: whereas health is a key factor in the fight against poverty, a large number of families became impoverished by expenditures for healthcare and drugs. The reform was designed to correct this paradox by introducing a new scheme—Popular Health Insurance (*Seguro Popular*). This innovative initiative is gradually protecting the 50 million Mexicans, most of them poor, who had until its advent been excluded from formal social insurance. This paper reports encouraging results in the achievement of the ultimate objective of the reform: universal access to high-quality services with social protection for all. The Mexican experience provides a wealth of lessons that can be summarised in five elements [agenda, budget, capacity, deliverables, and evidence]. It shows the possibility of bridging one more divide:

between analysis and advocacy.

Habicht, J.P., C.G. Victora, and J.P. Vaughan. 1999. "Evaluation Designs for Adequacy, Plausibility, and Probability of Public Health Programme Performance and Impact." *International Journal of Epidemiology* 28(1): 10–18.

Abstract

The question of *why* to evaluate a programme is seldom discussed in the literature. The present paper argues that the answer to this question is essential for choosing an appropriate evaluation design. The discussion is centered on summative evaluations of large-scale programme effectiveness, drawing upon examples from the fields of health and nutrition, but the findings may be applicable to other subject areas. The main objective of an evaluation is to influence decisions. How complex and precise the evaluation must be depends on who the decisionmaker is and what types of decisions will be taken as a consequence of the findings. Different decisionmakers demand not only different types of information but also vary in their requirements for how informative and precise the findings must be. Both complex and simple evaluations, however, should be equally rigorous in relating the design to the decisions. Based on the types of decisions that may be taken, a framework is proposed for deciding upon appropriate evaluation designs. Its first axis concerns the indicators of interest, whether these refer to provision or utilization of services, coverage, or impact measures. The second axis refers to the type of inference to be made, whether it is a statement of adequacy, plausibility, or probability. In addition to the above framework, other factors affect the choice of an evaluation design, including the efficacy of the intervention, the field of knowledge, timing, and costs. Regarding the latter, decisionmakers should be made aware that evaluation costs increase rapidly with complexity, so a compromise often must be reached. Examples are given of how to use the two classification axes, as well as these additional factors, in helping decisionmakers and evaluators translate the need for evaluation—the why—into the appropriate design—the how.

Hanson, K. "Advances in Impact Evaluation." 2012. In *Health Policy and Systems Research: A Methodology Reader*, edited by L. Gilson. Geneva: World Health Organization.

Summary of Chapter (self-written)

System-level impact evaluations are becoming more common as an understanding of their importance has spread. Donors and organizations have begun to provide more funding, create evaluative bodies, and increase capacity for evaluations so that future development programs may be informed by evidence. A distinct advancement made in the practice of impact studies is the consideration of context: what works in one system at one time may not in another. This chapter of *Health Policy and Systems Research* provides an overview of current study designs and methods in impact evaluation.

Hardee, K., L. Ashford, E. Rottach, R. Jolivet, and R. Kiesel. 2012. *The Policy Dimensions of Scaling Up*. Washington, DC: Futures Group, Health Policy Project.

Excerpt

Adopting new practices in health on a large scale requires systematic approaches to planning, implementation, and follow-up; and often calls for profound and lasting changes in health systems. Any systematic approach must include addressing the policy dimensions of scaling up. Without attention to the policies that underlie health systems and health services, the scaling up of promising pilot projects is not likely to succeed and be sustained.

This paper focuses on efforts to scale up interventions in family planning; reproductive health; and maternal, neonatal, and child health in developing countries. It defines "scale-up" and describes some of the frameworks and approaches to scaling up found in the recent health literature, and how they address

policy. The paper also reviews the experience of selected organizations in scaling up best practices and how they have addressed policy issues.

"Policy" should be understood as more than a national law or health policy that supports a program or intervention. Operational policies are the rules, regulations, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services. The policy process encompasses decisions made at a national or decentralized level (including funding decisions) that affect whether and how services are delivered. Thus, attention must be paid to policies at multiple levels of the health system and over time to ensure sustainable scale-up. A supportive policy environment will facilitate the scale-up of health interventions.

This paper does not replace the valuable guides available for scaling up health innovations. Rather, it focuses on lessons learned related to policy implementation associated with scaling up and outlines key actions to ensure supportive policies, regardless of the scale-up model or approach used.

Hesketh, T., L. Lu, and Z.W. Xing. 2005. "The Effect of China's One-Child Family Policy after 25 Years." *New England Journal of Medicine* 353(11): 1171–1176.

Abstract

China's one-child family policy has had a great effect on the lives of nearly a quarter of the world's population for a quarter of a century. When the policy was introduced in 1979, the Chinese government claimed that it was a short-term measure and that the goal was to move toward a voluntary small-family culture. In this article, we examine to what extent this goal has been achieved and the implications for the future of the policy. First, we explain why the policy was introduced and how it is now implemented. We also examine the consequences of the policy in regard to population growth, the ratio between men and women, and the ratio between adult children and dependent elderly parents. Finally, we examine the relevance of the policy in contemporary China and whether the time has come for the policy to be relaxed.

Hyder A., S. Syde, P. Puvanachandra, G. Bloom, S. Sundaram, et al. 2010. "Stakeholder Analysis for Health Research: Case Studies from Low- and Middle-Income Countries." *Public Health* 124: 159–166.

Abstract

Objectives: Future Health Systems: Innovations for Equity (FHS) is working in six partner countries in Asia and Africa, focusing on strengthening the research-policy interface in relation to specific health system research projects. These projects present an opportunity to study the influence of stakeholders on research and policy processes.

Study Design: Qualitative stakeholder analysis.

Methods: Stakeholder analysis was conducted in each FHS country using a structured approach. A cross-country evaluation was performed, concentrating on six key areas: chosen research topic; type of intervention considered; inclusion/exclusion of stakeholder groups; general stakeholder considerations; power level, power type, and agreement level of stakeholders; and classification of and approaches to identified stakeholders.

Results: All six countries identified a range of stakeholders but each country had a different focus. Four of the six countries identified stakeholders in addition to the guidelines, whereas some of the stakeholder categories were not identified by countries. The mean power level of identified stakeholders was between 3.4 and 4.5 (1 = very low; 5 = very high). The percentage of classified stakeholders that were either drivers or supporters ranged from 60 percent to 91 percent.

Conclusion: Three important common areas emerge when examining the execution of the FHS country stakeholder analyses: clarity as to the purpose of the analyses; value of internal vs. external analysts; and the role of primary vs. secondary analyses. This paper adds to the global body of knowledge on the utilization of stakeholder analysis to strengthen the research-policy interface in the developing world.

Khresheh R. and L. Barclay. 2008. "Implementation of a New Birth Record in Three Hospitals in Jordan: A Study of Health System Improvement." *Health Policy and Planning* 23:76–82.

Abstract

This study tested the introduction of a new integrated clinical record in Jordan, where no clinical report currently links antenatal, birth, and postnatal care for women. As a result, no continuity of information is provided to clinicians, nor are there national statistics on trends or performance of hospitals around birth. Our study was conducted in the Jordanian MOH, the maternity wards and registration departments of three hospitals in Jordan, and the Maternal and Child Health Centres located near these hospitals. We used an exploratory, descriptive design and practice-research engagement to investigate and report on the process of change to improve and implement the new birth record. Through engaging practitioners in research, care improved, the quality of reporting changed, managers developed more effective measures of hospital performance, and policymakers were provided with information that could form the basis of a national maternity data monitoring system. Quantitative and qualitative audit data demonstrated improved clinical reporting, organizational development, and sustained commitment to the new record from clinicians, managers, and policy leaders.

King, G., E. Gakidou, K. Imai, R.T. Moore, C. Nail, et al. 2009. "Public Policy for the Poor? A Randomised Assessment of the Mexican Universal Health Insurance Programme." *The Lancet* 373(9673): 1447–1454.

Abstract

Background: We assessed aspects of *Seguro Popular*, a programme aimed to deliver health insurance, regular and preventive medical care, medicines, and health facilities to 50 million uninsured Mexicans.

Methods: We randomly assigned treatment within 74 matched pairs of health clusters—i.e., health facility catchment areas—representing 118,569 households in seven Mexican states. We measured outcomes in a 2005 baseline survey (August 2005 to September 2005) and a follow-up survey 10 months later (July 2006 to August 2006) in 50 pairs (n = 32,515). The treatment consisted of encouragement to enroll in a health insurance programme and upgraded medical facilities. Participant states also received funds to improve health facilities and provide medications for services in treated clusters. We estimated intention to treat and complier average causal effects non-parametrically.

Findings: Intention-to-treat estimates indicated a 23 percent reduction from baseline in catastrophic expenditures (1.9 percentage points; 95% CI 0.14–3.66). The effect in poor households was 3.0 percentage points (0.46–5.54); in experimental compliers it was 6.5 percentage points (1.65–11.28)—30 percent and 59 percent reductions, respectively. The intention-to-treat effect on health spending in poor households was 426 pesos (39–812), and the complier average causal effect was 915 pesos (147–1684). Contrary to expectations and previous observational research, we found no effects on medication spending, health outcomes, or utilisation.

Interpretation: Programme resources reached the poor. However, the programme did not show some other effects, possibly due to the short duration of treatment (10 months). Although Seguro Popular seems to be successful at this early stage, further experiments and follow-up studies with longer assessment periods are needed to ascertain the long-term effects of the programme.

Kruk, M.E. and M.R. Prescott. 2012. "The Role of Health Systems and Policies in Promoting Safe Delivery in Low- and Middle-Income Countries: A Multilevel Analysis." *American Journal of Public Health* 102(4): 645–650.

Abstract

We aimed to measure the contribution of national factors, particularly health system characteristics, to the individual likelihood of professionally attended delivery ("safe delivery") for women in low- and middle-income countries. Using DHS data for 165,774 women in 31 countries, we estimated multilevel logistic regression models to measure the contribution of national economic and health system characteristics to likelihood of attended delivery. More health workers, higher national income, urbanization, and lower income inequality were associated with higher odds of attended delivery. Macrosocial factors increase utilization of attended delivery and may be more efficient in reducing maternal mortality than interventions aimed at individual women.

Larsson, E.C., A. Thorson, G. Pariyo, P. Conrad, M. Arinaitwe, et al. 2012. "Opt-out HIV Testing During Antenatal Care: Experiences of Pregnant Women in Rural Uganda." *Health Policy and Planning* 27: 69–75.

Abstract

Two years after the introduction of provider-initiated, opt-out HIV counselling and testing during ANC in Uganda, HIV testing uptake is still low. This study was carried out to explore pregnant women's experiences of and views on the policies for opt-out and couple HIV testing, and to understand how policy implementation could be improved to increase access to PMTCT services. The study was conducted at three ANC health facilities at different levels of care in rural eastern Uganda. Data were collected through sit-in observations during ANC and 18 semi-structured interviews with pregnant women receiving ANC, and then analysed using latent content analysis. Pregnant women who received ANC from facilities that provided HIV testing on site perceived HIV testing as compulsory without actually fully realizing the benefits of HIV testing and PMTCT. No referral for HIV testing or information about testing was given at ANC facilities that lacked HIV testing on site. A major challenge of couple HIV testing was that pregnant women were made responsible for recruiting their spouses for testing, a precarious dilemma for many women who tried to fulfill health workers' requests without having the power to do so. To increase uptake of PMTCT services, the pre-test counselling in groups that precedes the provider-initiated HIV testing should be adjusted to inform women about the benefits of PMTCT. Further, if testing is perceived as compulsory, it could potentially deter some women from seeking ANC services. To increase HIV testing of male partners, new strategies are needed—for example, peer sensitization and male clinics. Moreover, to achieve the desired outcomes of the PMTCT programme, M&E should be built into the programme.

Macinkoa, J., M. de Souza, F. Guanais, and C. da Silva Simoes. 2007. "Going to Scale with Community-based Primary Care: An Analysis of the Family Health Program and Infant Mortality in Brazil, 1999–2004." *Social Science & Medicine*, 65: 2070–2080.

Abstract

This article assesses the effects of an integrated community-based primary care program (Brazil's Family Health Program, known as the PSF) on microregional variations in infant mortality (IMR), neonatal mortality, and post-neonatal mortality rates from 1999 to 2004. The study utilized a pooled cross-sectional ecological analysis using panel data from Brazilian microregions and controlled for measures of physicians and hospital beds per 1,000 population, hepatitis B coverage, the proportion of women without prenatal care and with no formal education, low birth weight births, population size, and poverty rates. The data covered all of the 557 Brazilian microregions over a six-year period (1999–2004). Results show that IMR declined about 13 percent from 1999 to 2004, whereas Family Health Program coverage

increased from an average of about 14 to nearly 60 percent. Controlling for other health determinants, a 10 percent increase in Family Health Program coverage was associated with a 0.45 percent decrease in IMR, a 0.6 percent decline in post-neonatal mortality, and a 1 percent decline in diarrhea mortality ($p<0.05$). PSF program coverage was not associated with neonatal mortality rates. Lessons learned from the Brazilian experience may be helpful as other countries consider adopting community-based primary care approaches.

The Maximizing Positive Synergies Academic Consortium. 2009. *Interactions Between Global Health Initiatives and Health Systems: Evidence from Countries.*

Excerpt

The scale-up of selected services by GHIs has placed new demands on national health systems, revealed weaknesses in those systems, and rekindled debates on how countries can best combine disease-specific programmes with broader agendas to improve the health of their people. The "Maximizing Positive Synergies" (MPS) project has engaged stakeholders in a collaborative effort to build new knowledge on how GHI-supported programmes are impacting national health systems and harness this evidence for policy and implementation.

The core section of the document then presents 21 country case studies on GHI-health systems interaction, along with a comparative analysis of the internal structures and policies of four major GHIs: the GAVI Alliance (formerly the Global Alliance for Vaccines and Immunization); the Global Fund to Fight AIDS, TB and Malaria (Global Fund); PEPFAR; and the World Bank's MAP. The conclusion of the report outlines priorities for an ongoing agenda of research on GHIs and health systems.

Recent public health history has been marked by: (1) recurrent tensions between vertical and horizontal models of disease control; and (2) ongoing debates about whether health should be understood primarily as a national concern, or as a global responsibility. The rise of GHIs has underscored the importance of these discussions as well as the need to frame problems and solutions in new ways.

Specific sub-research questions pursued by MPS research partners included the following:

- How are major GHIs interacting with health systems at national and subnational levels? How are these interactions affecting the main components or "building blocks" of countries' health systems?
- How are they influencing processes such as scale-up of services, coordination of services, and harmonization of donor priorities and activities?
- In selected local settings, is GHI support translating into impacts at the facility level? What initial lessons emerge for improving policy and service delivery?
- Are the major GHIs interacting with health systems in similar ways, or can significant differences among them be observed?
- How are major GHIs engaging civil society and communities? What is the role of civil society and community organizations in strengthening synergies between GHIs and health systems?

What specific areas of interplay between GHIs and health systems appear to be most critical/strategic in accelerating action to improve health outcomes?

May, J. 2012. *World Population Policies: Their Origin, Evolution, and Impact.* New York: Springer.

Summary of Book (self-written)

This book examines the history behind the formulation, implementation, and evaluation of population

policies in the more developed, the less developed, and the least developed countries from 1950 until today, as well as their future prospects. It links population policies with the theories of demographic, epidemiological, and migratory transitions. It begins by summarizing the demographic situation around the world, with an emphasis on population policies and their underlying theories. It then reviews the early efforts to reduce mortality and fertility in the developing countries. This is followed by a description of the internationalization of the debate on population issues and the transformation of these programs into more formal population policies, particularly in the developing countries. The book also reviews the situation of the developed countries and their specific challenges—sub-replacement fertility, population aging, and immigration—and examines the effectiveness of population policies. It also explores the way forward and future prospects for population policies over the next decades.

The book provides numerous concrete examples from all over the world and shows how population policies actually are implemented, and their successes as well as their constraints. Above all, the book highlights the importance of understanding underlying demographic trends when assessing the development prospects of any country. The book is recommended for not only for demographers, social scientists, and policymakers, but also economists and political scientists interested in social and demographic change around the world. Demography students and researchers interested in applying knowledge on population trends and prospects in designing and evaluating public policies also will find this to be an invaluable reference work.

McConnell, A. 2010. "Policy Success, Policy Failure and Grey Areas In-between." *Journal of Public Policy* 30(3): 345-362.

Abstract

Policy protagonists are keen to claim that a policy is successful, whereas opponents are more likely to frame policies as failures. The reality is that policy outcomes are often somewhere in between these extremes. An added difficulty is that policy has multiple dimensions, often succeeding in some respects but not in others, according to facts and their interpretation. This paper sets out a framework designed to capture the bundles of outcomes that indicate how successful or unsuccessful a policy has been. It reviews existing literature on policy evaluation and improvement, public value, good practice, political strategy, and policy failure and success to identify what can be built on and gaps that need to be filled. It conceives policy as having three realms: processes, programs, and politics. Policies may succeed and/or fail in each of these and along a spectrum of success, resilient success, conflicted success, precarious success, and failure. It concludes by examining contradictions between different forms of success, including what is known colloquially as "good politics but bad policy."

Milton, B., M. Moonan, D. Taylor-Robinson, M. Whitehead, eds. 2010. *How Can the Health Equity Impact of Universal Policies Be Evaluated?: Insights into Approaches and Next Steps*. Geneva: World Health Organization.

Abstract

Taking population-level action on the wider social determinants of health in efforts to reduce health inequities is an international public health imperative. However, an important barrier to action is the perceived lack of evidence about what works to reduce health inequities. This is particularly evident in relation to universal welfare policies, which can have profound effects on health inequities, both positive and negative. Because universal policies usually are applied to whole populations and are often complex in nature, with long causal chains, these factors preclude a true experimental design; other approaches to evaluation are required. This report presents arguments and case studies from an expert group meeting convened to clarify the importance and challenges of evaluating universal policies and outline potential approaches to assessing their impact on health inequities. The report also identifies key research and policy questions that need evaluating as a matter of priority, and sets the agenda for partnerships working to develop these methods further.

Palumbo, D., S. Maynard-Moody, and P. Wright. 1984. "Measuring Degrees of Successful Implementation: Achieving Policy Versus Statutory Goals." ***Evaluation Review*** **8(1): 45–74.**

Abstract

The Oregon Community Corrections Act was passed in 1977, partly due to the need to relieve overcrowding in the state's prisons. Our research was undertaken to determine whether degrees of successful achievement of the goals of the Act are due to the way in which community corrections legislation is being implemented and, specifically, to determine if the roles of street-level bureaucrats and modifications of the program during implementation are the keys to successful achievement of goals. In Oregon, we found that there is wide variation from county to county in the way the legislation is being implemented and the degree to which goals are being achieved. Even though not all specific statutory goals are being achieved, the general policy goals are being met. The more successful counties have reached a higher level of implementation in individual and county efforts than the least successful. In addition, the former are more likely to have a "fixer" active in getting the program established and making it work, street-level implementers who often have a higher level of commitment to the program, modifications to meet local needs, and a higher degree of support from elected officials and the community.

Pan American Health Organization. 2007. ***The Essential Public Health Functions as a Strategy for Improving Overall Health Systems Performance: Trends and Challenges since the Public Health in the Americas Initiative, 2000–2007.*** **Washington, DC: PAHO.**

Excerpt

PAHO/WHO define the Essential Public Health Functions (EPHF) as the indispensable set of actions, under the primary responsibility of the state, that are fundamental for achieving the goal of public health, which is to improve, promote, protect, and restore the health of the population through collective action.

Through the Public Health in the Americas Initiative, PAHO/WHO defined the 11 Essential Public Health Functions and developed a methodology that allows countries to evaluate their public health systems in a comprehensive manner. As part of the Initiative, 41 countries and territories of the Region of the Americas applied the assessment tool in the period 2001–2002. The experience was extremely successful, both in process and outcomes.

Through the EPHF performance assessment, health ministries and/or secretariats were able to identify the strengths and weaknesses in the public health system and, based on the results, develop interventions designed to sustain good practices and bridge gaps. The rationale behind the Initiative was always to go beyond the assessment of the EPHF and foment concrete action to improve public health practice, thus ultimately strengthening the performance of the overall health system.

As the experience in the Region of Latin America and the Caribbean (LAC) reveals, countries have spontaneously appropriated to themselves the knowledge, concepts, and methods developed within the context of the EPHF, spurring a movement towards continuous monitoring of the status of EPHF not only at the national but at the subnational level, and the implementation of strengthening plans targeting those functions most in need of improvement. Similarly, several countries outside of the LAC Region have also taken steps to evaluate and strengthen the EPHF.

It is the purpose of this document to briefly document some of these experiences and thus demonstrate the importance of the EPHF assessment instrument as a tool for strengthening the performance of health systems as a whole.

Panisset, U., T.P. Koehlmoos, A.H. Alkhatib, T. Pantoja, P. Singh, et al. 2012. "Implementation Research Evidence Uptake and Use for Policy-making." *Health Research Policy and Systems* 10, 20.

Abstract

A major obstacle to the progress of the MDGs has been the inability of health systems in many low- and middle-income countries to effectively implement evidence-informed interventions. This article discusses the relationships between implementation research and knowledge translation, and identifies the role of implementation research in the design and execution of evidence-informed policy. After a discussion of the benefits and synergies needed to translate implementation research into action, the article discusses how implementation research can be used along the entire continuum of the use of evidence to inform policy. It provides specific examples of the use of implementation research in national-level programmes by looking at the scaling up of zinc for the treatment of childhood diarrhoea in Bangladesh and the scaling up of malaria treatment in Burkina Faso. A number of tested strategies to support the transfer of implementation research results into policy making are provided to help meet the standards increasingly expected from evidence-informed policy-making practices.

Rahmani, A.M., B. Wade, and W. Riley. 2013. "Evaluating the Impact a Proposed Family Planning Model Would Have on Maternal and Infant Mortality in Afghanistan." *International Journal of Health Planning Management*. DOI: 10.1002/hpm.2206

Abstract

Objective: This study aimed to assess the potential impact a proposed FP model would have on reducing maternal and infant mortality in Afghanistan.

Background: Afghanistan has a high total fertility infant mortality, and maternal mortality rates. Afghanistan also has tremendous sociocultural barriers to and misconceptions about FP services.

Methods: We applied predictive statistical models to a proposed FP model for Afghanistan to better understand the impact increased family planning can have on Afghanistan's maternal and infant mortality rates. We further developed a sensitivity analysis that illustrates the number of maternal and infant deaths that can be averted over five years according to different increases in contraceptive prevalence rates.

Results: Incrementally increasing contraceptive prevalence rates in Afghanistan from 10 percent to 60 percent over the course of five years could prevent 11,653 maternal deaths and 317,084 infant deaths, a total of 328,737 maternal and infant deaths averted.

Conclusion: Achieving goals in reducing maternal and infant mortality rates in Afghanistan requires a culturally relevant approach to family planning that will be supported by the population. The FP model for Afghanistan presents such a solution and holds the potential to prevent hundreds of thousands of deaths.

Rau, B. 2013. *From Isolation to Solidarity: How Community Mobilization Underpins HIV Prevention in the Avahan India AIDS Initiative*. Washington, DC: Futures Group. Available at: http://futuresgroup.com/resources/publications/from_isolation_to_solidarity_how_community_mobilization_underpins_hiv_preve.

Abstract

This report examines how the initiative, supported by the Bill and Melinda Gates Foundation, used community mobilization to facilitate the active participation of key populations in HIV prevention. Through the formation of community-based organizations (CBOs), the initiative helped members of key

populations work for HIV prevention and pursue self-defined agendas of improved social welfare and greater rights. This case study presents the operational inputs that helped Avahan mobilize key populations and strengthen CBOs. It discusses the role of CBOs in sustaining HIV prevention and related activities, and the tangible impact of community mobilization on individuals and communities. It will be useful for program planners and managers in government programs, NGOs, and CBOs seeking to strengthen or expand community mobilization activities using lessons learned from a large-scale program.

Robinson, W.C., and J.A. Ross. 2007. *The Global Family Planning Revolution: Three Decades of Population Policies and Programs*. Washington, DC: World Bank.

Abstract

The striking upsurge in population growth rates in developing countries at the close of World War II gained force during the next decade. From the 1950s to the 1970s, scholars and advocacy groups publicized the trend and drew troubling conclusions about its economic and ecological implications. Private educational and philanthropic organizations, governments, and international organizations joined in the struggle to reduce fertility. Three decades later, this movement has seen changes beyond anyone's most optimistic dreams, and global demographic stabilization is expected in this century. The Global Family Planning Revolution preserves the remarkable record of this success. Its editors and authors offer more than a historical record. They discuss important lessons for current and future initiatives of the international community. Some programs succeeded, whereas others initially failed, and the analyses provide valuable guidance for emerging health-related policy objectives and responses to global challenges.

Ross, J. and E. Smith. 2011. Trends in National Family Planning Programs, 1999, 2004 and 2009. *International Perspectives on Sexual and Reproductive Health* 37(3): 125–133.

Abstract

Context: National FP programs in the developing world vary greatly in strength and coverage, and in the nature of their outreach. Periodic measures of their types and levels of effort have been conducted since 1972.

Methods: In 2009, expert observers in 81 developing countries completed a questionnaire that assessed 31 features of FP program efforts and other program measures. Data were compared with those from similar surveys fielded in 1999 and 2004 to examine trends over the decade.

Results: On average, national FP programs improved their effort levels slightly from 1999 to 2004, and again from 2004 to 2009. The average effort in 2009, however, was only about half of maximum; component scores for service measures and measures of access to contraception did not reach 50 percent of maximum in 2009. Differences by region and effort quartile emerged in subgroup analyses. Overall, improvement of women's health and avoidance of unwanted births were the most important program justifications, ranking higher than fertility reduction, economic development, or reduction of childbearing among unmarried adolescents. The subgroups given the most emphasis were poor and rural populations, whereas unmarried youth and postabortion women received the least. Among external influences, changes in donor and domestic funding were seen as more unfavorable than the merging of FP programs into broader health services.

Conclusions: Average program effort levels have been sustained, although deficiencies remain. Countries have not yet ensured universal access to a variety of contraceptive choices through various channels for both short- and long-term methods.

Saetren, H. 2005. "Facts and Myths about Research on Public Policy Implementation: Out of Fashion, Allegedly Dead, but Still Very Much Alive and Present." *Policy Studies Journal* 33(4): 559–582.

Abstract

Despite several decades of research on public policy implementation, we know surprisingly little, not only about cumulative research results, but also about several other key aspects of this research field. This article tries to amend these deficiencies by presenting the results of a comprehensive literature survey. Its main purpose is to challenge, revise, and supplement some conventional wisdom about implementation research. A second motivation is to lay the foundation for and initiate a much needed synthesis of empirical research results. The main results are the following: (1) the overall volume of publications on policy implementation has not stagnated or declined dramatically since the mid-1980s, as is commonly asserted. On the contrary, it has continued to grow exponentially through the 1990s and into the 21st century. (2) Even more surprising is that a large number of publications are located outside of the core fields. Hence, the literature is substantially larger and more multidisciplinary than most commentators realize. Doctoral dissertations are the most ignored but probably the richest, largest, and best source of empirical research results. (3) Tracing the origin as well as the location of the disciplinary and geographical cradle of implementation studies must also be readjusted significantly. (4) The ethnocentric bias of this research field toward the Western Hemisphere has been, and still is, strong, and some policy sectors are given much more attention than others. (5) Although positive in many ways, the predominant multidisciplinary character of implementation research still poses some serious problems with respect to theory development. Thus, I discuss whether a resurgence of interest in policy implementation among policy scholars may already be occurring. (6) Finally, the author suggests that the time is long overdue for efforts to synthesize research results in a more rigorous scientific manner than has been done hitherto.

Sakyi, K. 2008. "A Retrospective Content Analysis of Studies on Factors Constraining the Implementation of Health Sector Reform in Ghana." *International Journal of Health Planning* 23: 259–285.

Abstract

Ghana has undertaken many public service management reforms in the past two decades but their implementation has been constrained by many factors. This paper undertakes a retrospective study of research works on the challenges to the implementation of reforms in the public health sector. It points out that most of the studies identified (1) a centralised, weak, and fragmented management system; (2) poor implementation strategy; (3) lack of motivation; (4) weak institutional framework; (5) lack of financial and human resources; and (6) staff attitude and behaviour as the major causes of ineffective reform implementation. The analysis further revealed that quite a number of crucial factors obstructing reform implementation, which are particularly internal to the health system, have been either not thoroughly studied or overlooked. The analysis identified lack of leadership; weak communication and consultation; and corruption, lack of stakeholder participation, and unethical professional behaviour as some of the missing variables in the literature. The study thus indicated gaps in the literature that needed to be filled through rigorous reform evaluation based on empirical research, particularly at the district, subdistrict, and community levels. It further suggested that future research should be concerned with the effects of both systems and structures, and behavioural factors on reform implementation.

Solon, O., K. Woo, S.A. Quimbo, R. Shimkhada, J. Florentino, et al. 2009. "A Novel Method for Measuring Health Care System Performance: Experience from QIDS in the Philippines." *Health Policy and Planning* 24(3): 167–174.

Abstract

Objectives: Measuring and monitoring health system performance is important, albeit controversial. Technical, logistic, and financial challenges are formidable. We introduced a system of measurement,

which we call Q*, to measure the quality of hospital clinical performance across a range of facilities. This paper describes how Q* was developed, implemented in hospitals in the Philippines, and compares with typical measures.

Methods: Q* consists of measures of clinical performance, patient satisfaction, and volume of physician services. We evaluate Q* using experimental data from the Quality Improvement Demonstration Study (QIDS), a randomized policy experiment. We determined its responsiveness over time and to changes in structural measures, such as staffing and supplies. We also examined the operational costs of implementing Q*.

Results: Q* was sustainable, minimally disruptive, and readily grafted onto existing routines in 30 hospitals in 10 provinces semi-annually for a period of 2.5 years. We found Q* to be more responsive to immediate impacts of policy change than standard structural measures. The operational costs totaled US$2,133 or US$305 per assessment per site.

Conclusion: Q* appears to be an achievable assessment—a comprehensive and responsive measure of system-level quality at a limited cost in resource-poor settings.

Spicer, N., J. Aleshkina, R. Biesma, R. Brugha C. Caceres, et al. 2010. "National and Subnational HIV/AIDS Coordination: Are Global Health Initiatives Closing the Gap Between Intent and Practice?" *Globalization and Health* 6:3.

Abstract

Background: A coordinated response to HIV/AIDS remains one of the "grand challenges" facing policymakers today. GHIs have the potential both to facilitate and exacerbate coordination at the national and subnational levels. Evidence of the effects of GHIs on coordination is beginning to emerge but hitherto has been limited to single-country studies and broad-brush reviews. To date, no study has provided a focused synthesis of the effects of GHIs on national and subnational health systems across multiple countries. To address this deficit, we review primary data from seven country studies on the effects of three GHIs on coordination of HIV/AIDS programmes: the Global Fund to Fight AIDS, Tuberculosis and Malaria, PEPFAR, and the World Bank's HIV/AIDS programmes, including MAP.

Methods: In-depth interviews were conducted at the national and subnational levels (179 and 218, respectively) in seven countries in Europe, Asia, Africa, and South America between 2006 and 2008. Studies explored the development and functioning of national and subnational HIV coordination structures, and the extent to which coordination efforts around HIV/AIDS are aligned with and strengthen country health systems.

Results: Positive effects of GHIs included the creation of opportunities for multisectoral participation, greater political commitment, and increased transparency among most partners. However, the quality of participation was often limited, and some GHIs bypassed coordination mechanisms, especially at the subnational level, thus weakening their effectiveness.

Conclusions: The paper identifies residual national and subnational obstacles to effective coordination and optimal use of funds by focal GHIs, which these GHIs, other donors, and country partners need to address collectively.

United Nations (UN). 2013. *The Millennium Development Goals Report 2013.* UN

USAID/Africa Bureau, USAID/Population and Reproductive Health, Ethiopia Federal Ministry of Health, Malawi Ministry of Health, and Rwanda Ministry of Health. *Three Successful Sub-Saharan Africa Family Planning Programs: Lessons for Meeting the MDGs*. Washington, DC: USAID.

Abstract

Recent analysis of modern CPR from DHS shows that three countries have achieved a much more rapid increase in CPR in sub-Saharan Africa: Malawi, Rwanda, and Ethiopia. More than other countries in sub-Saharan Africa, these countries are moving more rapidly towards achieving MGD 5, which calls for universal access to reproductive healthcare and family planning. In preparation for the 2011 International Conference on Family Planning (ICFP), the Africa Bureau of USAID began exploring why and how these countries have made such great strides in recent years. The methodology included a desk review of DHS data and key documents related to each of the three countries, and structured key informant interviews in each country. From this process, MOH officials presented a summary of the findings at a USAID meeting just before the ICFP opened in Dakar. This paper expands on the four presentations made at the USAID meeting in Dakar. First, a summary of key DHS data over time shows the major common trends in the three countries. The long middle section of the paper includes three separate case studies addressing some of the questions posed above. The paper concludes with a discussion of common themes and differences, which hopefully can provide lessons for other countries as they seek to move toward meeting the MDG 5 and the demographic dividend.

Victora, C.G., R.E. Black, T.J., Boerma, and J. Bryce. 2011. "Measuring Impact in the Millennium Development Goal Era and Beyond: A New Approach to Large-scale Effectiveness Evaluations." *The Lancet* 377(9759): 85–95.

Abstract

Evaluation of large-scale programmes and initiatives aimed at improvement of health in countries of low and middle income needs a new approach. Traditional designs, which compare areas with and without a given programme, are no longer relevant at a time when many programmes are being scaled up in virtually every district in the world. We propose an evolution in evaluation design—a national platform approach that uses the district as the unit of design and analysis; is based on continuous monitoring of different levels of indicators; gathers additional data before, during, and after the period to be assessed by multiple methods; uses several analytical techniques to deal with various data gaps and biases; and includes interim and summative evaluation analyses. This new approach will promote country ownership, transparency, and donor coordination while providing a rigorous comparison of the cost-effectiveness of different scale-up approaches.

Evaluation Designs

WHO and International Health Partnership. 2011. *Monitoring, Evaluation and Review of National Health Strategies: A Country-led Platform for Information and Accountability.* Geneva: World Health Organization and International Health Partnership.

Abstract

This document provides guidance to countries and partners for strengthening monitoring, evaluation, and review of national health plans and strategies (NHS). It outlines the key attributes and characteristics of a sound country-led platform for monitoring, evaluation, and review of health sector progress and performance as the basis for information and accountability. It also aims to show how development partners can contribute to the strengthening of such a platform.

Nabatchi, Tina. 2012. *A Manager's Guide to Evaluating Citizen Participation.* Washington, DC: IBM Center for the Business of Government.

Summary of Report (self-written)

The Obama administration's Open Government Initiative is now three years old—but is it making a difference? Dr. Nabatchi's report is a practical guide for program managers who want to assess whether their efforts to increase citizen participation in their programs are making a difference. She lays out evaluation steps for both the implementation and management of citizen participation initiatives, as well as how to assess the impact of a particular initiative. An appendix to the report also provides helpful worksheets.

Why is evaluation of these initiatives important? For the foreseeable future, agencies will be under great fiscal pressures. They need to be able both to understand how to effectively engage citizens in their government and demonstrate how effective citizen involvement contributes to better-run, more cost-effective programs.

Schmeer, K. 1999. *Guidelines for Conducting a Stakeholder Analysis.* Bethesda, MD: Partnerships for Health Reform, Abt Associates Inc.

Excerpt

"Politics," as much or more than technical information, drives health sector reform. This is true at the sector, institutional, and facility levels, where politics directly affects the ability of policymakers and managers to develop and implement necessary reforms. Yet many policymakers and managers in the health sector are not trained to deal with politics, nor is there information available on how to manage the political process inherent in health sector reform.

In developing this document, Partnerships for Health Reform (PHR) addresses one aspect of managing the politics of the reform process: the need for information on key players who have an investment in proposed reforms. Policymakers and managers can use stakeholder analysis to identify these key players or stakeholders; predict whether they might support or block the implementation of health reforms; and develop strategies to promote supportive actions and decrease opposing actions before attempting to implement major reform at the national, regional, local, or facility levels.

The purpose of this document is to help policymakers, managers, and their working groups conduct an objective and systematic process for collecting and analyzing data about key health reform stakeholders. It should be noted, however, that even with application of these guidelines and the systematic methodology presented here, information produced by a stakeholder analysis is always somewhat subjective, since it is based on what stakeholders communicate to analysts. These guidelines, however, do include suggestions for checking the consistency of answers and other mechanisms to ensure that information is obtained and analyzed as objectively as possible.

Sumner, A., J. Crichton, S. Theobald, E. Zulu, and J. Parkhurst. 2011. "What Shapes Research Impact on Policy? Understanding Research Uptake in Sexual and Reproductive Health Policy Processes in Resource Poor Contexts." *Health Research Policy and Systems* 9Suppl. 1:S3.

Abstract

Assessing the impact that research evidence has on policy is complex. It involves consideration of conceptual issues of what determines research impact and policy change. There are also a range of methodological issues relating to the question of attribution and the counter-factual. The dynamics of SRH, HIV, and AIDS, like many policy arenas, are partly generic and partly issue- and context-specific. Against this background, this article reviews some of the main conceptualisations of research impact on policy, including generic determinants identified across a range of settings, as well as the specificities of

SRH in particular. We find that there is scope for greater cross-fertilisation of concepts, models, and experiences between public health researchers and political scientists working in international development and research impact evaluation. To guide attempts to ensure uptake of their findings, we identify aspects of the policy landscape and drivers of policy change commonly occurring across multiple sectors and studies to create a framework that researchers can use to examine the influences on research uptake in specific settings. This framework has the advantage of distinguishing between pre-existing factors influencing uptake and the ways in which researchers can actively influence the policy landscape and promote research uptake through their policy engagement actions and strategies. We apply this framework to examples from the case study papers in this supplement, with specific discussion about the dynamics of SRH policy processes in resource-poor contexts. We conclude by highlighting the need for continued multisectoral work on understanding and measuring research uptake, and for prospective approaches to receive greater attention from policy analysts.

Warburton, D., R. Wilson, and E. Rainbow. 2009. "Making a Difference: A Guide to Evaluating Public Participation in Central Government." [Online]. Available at: http://www.involve.org.uk/evaluation-guide/.

Summary of Report (self-written)

Public participation has become a central plank of public policy making. Increasingly, decisionmakers at all levels of government build citizen and stakeholder engagement into their policy-making processes. Activities range from large-scale consultations that involve tens of thousands of people to focus group research; online discussion forums; and small, deliberative citizens' juries.

This guide to evaluating public participation is intended to help those involved in planning, organising, or funding these activities to understand the different factors involved in creating effective public participation. It helps planners set and measure attainable objectives, evaluate impact, and identify lessons for future practice. Using clear language, simple instructions, illustrative case studies, and a glossary, the guide is a valuable tool for anyone involved in running or commissioning public participation in central government and beyond.

Wholey, J.F., H.P. Hatry, and K.E. Newcomer. 2004. *Handbook of Practical Program Evaluation*. Somerset, NJ: John Wiley & Sons Inc.

Summary of Book (self-written)

This handbook contains insights from dozens of expert contributors about the program evaluation process. It begins with an overview of the planning and design phase of evaluations, including how to use logic models, engage stakeholders, recruit participants, and understand various study designs. Next, it describes procedures for both qualitative and quantitative data collection, followed by methods for data analysis, including statistics, cost-effectiveness, and cost-benefit analyses. The handbook ends with methods for using evaluation, such as writing recommendations and contracting services.

6. TOOLS FOR POLICY DEVELOPMENT AND IMPLEMENTATION

The following is a bank of resources, tools, manuals, software, and handbooks that, when implemented, can add effectiveness and efficiency to the policy development and implementation process. Each tool has been tested and proven effective in pursuing a variety of chosen objectives: advocacy training, assessing the political sphere, supporting NGOs, effective examination of program impact, finance, cost estimation, and more. These objectives are achieved through a collection of spreadsheets, tools, methodologies, and interview guides.

Author and title	Year of publication	Type of reference	Country of Focus
UNFPA and Harvard School of Public Health. *A Human-Rights Based Approach to Programming: Practical Implementation Manual and Training Materials*	2010	Tool	Global
Adamchak, S., and L. Weiss. *Assessing the Policy Environment: What Influences Population Policy*	1997	Tool	Global
International HIV/AIDS Alliance. *Advocacy in Action: A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS*	2002	Toolkit	Global
Beardsley, K. *Policy Analysis and Advocacy Decision Model for HIV-related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers*	2013	Tool	Global
Beardsley, K., and A. Latypov. *Policy Analysis and Advocacy Decision Model for HIV-related Services: People Who Inject Drugs*	2012	Tool	Global
Bhuyan, A., A. Jorgensen, and S. Sharma. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool*	2010	Tool	Global
MSH. *Cost Revenue Analysis Tool Plus*		Tool	Global
Cottingham, J.C., E. Kismodi, A. Martin Hilber, O. Lincetto, M. Stahlhofer, et al. "Using Human Rights for Sexual and Reproductive Health: Improving Regulatory Frameworks"	2010	Journal article	Global
Foreit, J.R. and K.G. Foreit. *Willingness to Pay Surveys for Setting Prices for Reproductive Health Products and Services: A User's Manual*	2001	Report	Global
Futures Constella. *A-Squared Advocacy Training Manual: Analysis and Advocacy*	2007	Report	Global
Policy Project. *The GOALS Model*		Model	Global
Grant, K., M. Lewis, and A. Strode. *HIV/AIDS and Human Rights in Southern Africa: An Advocacy Resource & Training Manual*	2008	Manual	Global
Hare, L., C. Hart, S. Scribner, C. Shepherd, T. Pandit (ed.), et al. *SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation*	2004	Tool	Global
National AIDS Control Council (NACC) and POLICY Project. *HIV/AIDS and Gender Training: A Toolkit for Policy and Senior Level Decision Makers*	2004	Toolkit	Global
Kamau, J., P. Odundo, and J. Korir. *Measuring the Degree of S&D in Kenya: An Index for HIV/AIDS Facilities and Providers*	2007	Tool	Kenya

Author and title	Year of publication	Type of reference	Country of Focus
Kuduma, I.N.W. *Toolkit: Community Empowerment in MNH Towards the Alert Village (Desa Siaga)*	2009	Toolkit	Global
National Public Health Performance Standards Program (NPHPSP). *Local Public Health Governance Performance Assessment Instrument. Version 2.0*		Tool	Global
The POLICY Project. "The Planning and Finance Checklist"	2002	Checklist	Global
Pollmap. *PolicyMaker 4 Software*	2012	Tool	Global
The Policy Project. *The Policy Stakeholder Analysis Matrix. The Policy Circle*		Tool	Global
Government of Australia. *Public Sector Innovation Toolkit*		Toolkit	Global
MEASURE Evaluation. *Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning*	2001	Guide	Global
Reshevska, I., K. Foreit, K. Beardsley, and L. Porter. *Policy Advocacy Toolkit for Medication-assisted Treatment (MAT) for Drug Dependence*	2010	Guide	Global
The Policy Project. *Reproductive Health Legislation Index (RHLI)*		Tool	Global
The Policy Project. *The Resource Needs Model*		Tool	Global
Rubin, D.S. and B. Herstad. *Integrating Gender in Policy Implementation Barriers Analysis: A Methodology*	2009	Tool	Global
Avenir Health. *Spectrum*		Tool	Global
The Policy Project. *The Strategic Planning for the Reproductive Health and Population Sector Training Module*		Tool	Global
Affiliated Network for Social Accountability in East Asia and the Pacific (ANSA-EAP). *The Tools of Social Accountability Stocktaking: Getting to Know the Lay of the Land.*		Tool	Global
Futures Group. *Workplace Policy Builder*		Tool	Global

UNFPA and Harvard School of Public Health. 2010. *A Human-Rights Based Approach to Programming: Practical Implementation Manual and Training Materials.*

Excerpt

This manual provides step-by-step guidance on how to apply a culturally sensitive, gender-responsive, human rights-based approach to programming in each of the United Nations Population Fund's (UNFPA) three core areas of work: population and development, reproductive health, and gender. It also covers how to apply such an approach in the context of a humanitarian emergency. This pdf includes a facilitator manual.

This Manual was designed primarily for use by UNFPA country staff but also will be useful for UNFPA implementing partners and others working in the fields of population and development, SRH and reproductive rights, gender equality, and women's empowerment.

In addition to serving as a standalone reference tool, the manual may also be used in conjunction with the accompanying training materials (PowerPoint) as a basis for conducting training in human rights-based programming.

Adamchak, S., and L. Weiss. 1997. *Assessing the Policy Environment: What Influences Population Policy?* Population Technical Assistance Project (POPTECH).

Excerpt

This POPTECH tool describes a framework for assessing the population policy environment. The policy environment continuously affects the decisions, actions, and efficacy of those involved in the population policy process, so it is important to identify the array of factors that influence and shape that environment. The purpose of this tool is to provide, in one source, a comprehensive list of factors that characterize the environment within which population policies are developed.

The tool can be applied in a variety of policy and program contexts, and will benefit users by identifying fundamental areas of support or resistance that can be targeted for specific project interventions. It can also be used in carrying out a population sector assessment and designing and developing population and RH programs. Using the checklists included here, country program staff or consultants can review key elements of the environment and identify factors that either facilitate or discourage the formation of effective population policies and programs.

Drawing on studies of organizational behavior, the tool identifies seven elements of the policy environment and provides an overview, an illustrative checklist of key issues, and at least one country-specific example of each. The following are the seven environmental elements:

- Legal
- Political
- Economic
- Technological
- Demographic
- Ecological

Cultural

International HIV/AIDS Alliance. 2002. *Advocacy in Action: A Toolkit to Support NGOs and CBOs Responding to HIV/AIDS*. 2002. Hove, UK: International HIV/AIDS Alliance. Available at: www.aidsalliance.org.

Excerpt

This toolkit aims to support NGOs and CBOs in developing countries to plan and implement effective advocacy work around HIV/AIDS.

This toolkit aims to help NGOs/CBOs have a clear understanding of what advocacy is and how it might support the work of NGOs and CBOs, and provide practical assistance in how to actually undertake advocacy work.

For NGOs/CBOs involved in HIV/AIDS, this means understanding the role of advocacy in relation to other responses to HIV/AIDS, such as information, education, and communication (IEC); community mobilisation; and service provision.

The toolkit addresses the advantages of planning advocacy work systematically and how this can be achieved. It also helps organisations consider how advocacy could help them to achieve their missions and recognise the potential impact of advocacy work on their organisations.

It also aims to introduce NGOs/CBOs to advocacy methods that have worked in the past to address HIV/AIDS and understand when their use is appropriate.

Beardsley, K. 2013. *Policy Analysis and Advocacy Decision Model for HIV-related Services: Males Who Have Sex with Males, Transgender People, and Sex Workers.* Washington, DC: Futures Group, Health Policy Project.

Excerpt

The Decision Model provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate for policies that affect access to and sustainability of key services for MSM, TG people, and SWs. The model maps service-specific policies to international human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services even while broader, long-term human rights initiatives are implemented.

The Decision Model addresses policies that specifically affect services related to MSM/TG/SWs, including service coordination; data use and decision making; participation in decision making, service delivery, and evaluation; consent; personal data; stigma and discrimination; criminal sanctions; gender-based violence; human rights; procurement and supply management; funding; and service eligibility and delivery protocols. These policies are assessed for services delivered in community and prison settings.

The Decision Model can address the following fundamental questions related to developing and implementing an incremental advocacy strategy for MSM/TG/SWs or integrating population-specific policies into prevention and treatment strategies for SRHR, STIs, and HIV:

1. What is the legal basis for services to reduce the risk and address sexual transmission as a component of national SRHR, STI, and HIV strategies?
2. Do national policies conform to standards and guidelines developed by international multilateral bodies and leading international, regional, and local organizations?
3. Are there national policies and guidance to support the establishment of and access to services for MSM/TG/SWs?
4. Are policies disseminated and implemented at the local level?
5. What are the feasible policy targets for advocacy?
6. Who are the in-country advocates for service scale-up, and how can a scale-up strategy be developed?

The Decision Model specifically aims to address three types of policy barriers to services for MSM/TG/SWs: restrictive, inadequate, and absent policies. The more easily detected of these are restrictive policies—policy document provisions that explicitly deny or rule out scientifically proven services (e.g., a policy that expressly outlaws the distribution of condoms in prison settings). Inadequate policies are those that are unclear or do not respond to current science, current accepted guidelines, or international best practices.

Beardsley, K. and A. Latypov. 2012. *Policy Analysis and Advocacy Decision Model for HIV-related Services: People Who Inject Drugs.* Washington, DC: Futures Group, Health Policy Project.

Excerpt

The Decision Model provides country stakeholders—such as advocates, policymakers, and service providers—with tools to inventory, assess, and advocate for policies that affect access to and sustainability of key services for people who inject drugs (PWID). The model maps service-specific policies to international human rights frameworks to identify needs and opportunities for policy advocacy that will help improve access to services even while larger, long-term human rights policies may remain deficient.

The Decision Model addresses policies that specifically affect services related to PWID, including service coordination; data use and decision making; participation of PWID in decision making, service delivery, and evaluation; consent; personal data; stigma and discrimination; criminal sanctions; gender-based violence; human rights; procurement and supply management; eligibility; funding; and service delivery protocols. These policies are assessed for services delivered in community, pre-trial detention, and prison settings, and in settings and institutions that have custody of minors.

Bhuyan, A., A. Jorgensen, and S. Sharma. 2010. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Excerpt

The USAID | Health Policy Initiative, Task Order 1 designed a user-friendly approach and tool for assessing policy implementation, based on a review of the literature and the project's experiences in the field. The Policy Implementation Assessment Tool comprises two interview guides that explore the perspectives of policymakers and program implementers/other stakeholders. From 2007–2009, we collaborated with in-country partners to carry out four applications of the tool. These applications have assessed the implementation of national and state policies related to reproductive health, HIV, and health and population issues in Guatemala, El Salvador, and India. Based on these applications, we have revised and finalized the tools. These individual interview guides can also be used to design focus group discussion (FGD) guides to gather perspectives from other key stakeholders, including community-level health workers, local leaders, and clients.

This document provides guidance to help readers adapt the tool to different policies and contexts in their own countries. Although the tool emerged out of the desire to assess national FP and RH policy implementation, as country teams have shown, the assessment questions are flexible enough to allow for quick adaptation to other policy areas (e.g., HIV) and different levels (e.g., national, state, district). This paper briefly reviews the theoretical underpinnings of the tool, outlines steps for applying it, and describes key processes and findings from its four applications to date.

Management Sciences for Health (MSH). n.d. *Cost Revenue Analysis Tool Plus*. Cambridge, MA: MSH. Available at: http://www.msh.org/resources/cost-revenue-analysis-tool-plus.

Description

The purpose of the Cost Revenue Analysis Tool Plus (CORE Plus) is to help managers and planners estimate the costs of individual services and packages of services in primary healthcare facilities, as well as total costs for the facilities. The cost estimates are based on norms; they can be used to determine the funding needs for services and compared with actual costs to measure efficiency.

CORE Plus is a spreadsheet-based tool developed by MSH with USAID and other funding to help determine projected and actual costs of integrated primary healthcare services, broken down by individual interventions. It is a "bottom-up" costing tool that allows the user to estimate a standard cost for each intervention, broken down by drugs, tests, medical supplies, and staff. The standard costs are multiplied by the number of each type of intervention to build the total direct costs for a facility, to which indirect costs are allocated. The tool also allows users to estimate service utilization based on a catchment population and compare it with actual service utilization. Costs can be compared easily for different numbers of patients and different service delivery models. A strength of the tool is its ability to predict the cost of different numbers of particular interventions, such as child survival, within the context of an integrated primary healthcare system, and the impact of changes in those interventions on the cost of the system as a whole. The tool has been used in many countries, including South Africa, where it was used to estimate the total cost of a primary healthcare package for the MOH.

Cottingham, J.C., E. Kismodi, A. Martin Hilber, O. Lincetto, M. Stahlhofer, et al. 2010. "Using Human Rights for Sexual and Reproductive Health: Improving Regulatory Frameworks." *Bulletin of the World Health Organization* 88: 551–55.

Abstract

This paper describes the development of a tool that uses human rights concepts and methods to improve relevant laws, regulations, and policies related to SRH. This tool aims to improve awareness and understanding of states' human rights obligations. It includes a method for systematically examining the status of vulnerable groups, involving non-health sectors, fostering a genuine process of civil society participation, and developing recommendations to address regulatory and policy barriers to SRH with a clear assignment of responsibility. Strong leadership from the MOH, with support from the WHO or other international partners, and the serious engagement of all involved in this process, can strengthen the links between human rights and SRH, and contribute to national achievement of the highest attainable standard of health.

Foreit, J.R. and K.G. Foreit. 2001. *Willingness to Pay Surveys for Setting Prices for Reproductive Health Products and Services: A User's Manual.* New York: The Population Council.

Abstract

This paper examines the reliability and theoretical and predictive validity of willingness-to-pay (WTP) surveys for setting prices for RH services in developing countries. Four country applications were conducted; the surveys used similar elicitation methods (a series of three closed-ended questions to cover the range of target prices, followed by a single open-ended question to elicit maximum WTP) and samples of current or potential users of FP, gynecology, and prenatal care services. In all four applications, respondents were able to understand WTP questions and responded with high levels of internal consistency. Evidence supporting theoretical validity also was found in all surveys. Higher-income and more highly motivated users had higher WTP than lower-income and less motivated users. Predictive validity was assessed in one study. Services utilization predicted by a WTP survey was compared with actual post-price increase utilization. Adding WTP to information already possessed by program managers resulted in a threefold increase in the ability to predict utilization change as a result of a price increase; in nearly half of the cases, predicted percentage change in utilization was within 10 percent of observed change. When used for reproductive services price setting, WTP surveys appear reliable and valid, and improve a program manager's ability to predict client responses to price changes.

Futures Constella. 2007. *A-Squared Advocacy Training Manual: Analysis and Advocacy.* Washington, DC: Health Policy Initiative.

Abstract

Beginning in 2006–2007, HPI-TO1 developed the *A-Squared Advocacy Training Manual*, which was adapted from the POLICY Project's (1999) *Networking for Policy Change: An Advocacy Training Manual*. The manual draws from numerous HIV and advocacy resources and material from the Asia-Pacific region, and integrates innovative approaches to advocacy and involvement in the policy development process specific to HIV epidemics in Asia, particularly China, Thailand, and Vietnam.

The A-Squared Project aims to promote effective advocacy for evidence-based responses to HIV in Asia. The project is jointly implemented by Family Health International, the East-West Center, and the USAID | Health Policy Initiative. It is hoped that this manual will foster a greater understanding of the role of advocacy in policy making and decision making, and build advocacy skills that will promote the development of effective policies and appropriately targeted and funded HIV and AIDS programs in Asia.

Policy Project. n.d. *The GOALS Model*. Washington, DC: Futures Group, Policy Project. Available at: http://www.policyproject.com/policycircle/content.cfm?a0=4c.

Description

GOALS is an interactive computer program that can be used to improve resource allocation decisions for HIV/AIDS programs by enhancing the understanding of decision makers. Providing better information to decision makers about the consequences and trade-offs involved in resource allocation decisions will result in improved programming.

Grant, K., M. Lewis, and A. Strode. 2008. *HIV/AIDS and Human Rights in Southern Africa: An Advocacy Resource & Training Manual*. Windhoek, Namibia: AIDS & Rights Alliance for Southern Africa (ARASA).

Excerpt

This manual is divided into two parts: Part A is an advocacy and resource manual designed to give readers information about HIV/AIDS and human rights in southern Africa, as well as ways of strengthening a human rights-based response to HIV/AIDS in the region. Part B is a training manual developed for use in conjunction with Part A. It provides trainers with practical exercises to train participants on the way in which laws and policies can protect and promote human rights, and how the laws and policies in the South African Development Community (SADC) have met this challenge. The manual is intended for a wide range of people—paralegals, lawyers, social workers, counsellors, people working in AIDS service organisations (ASOs) and NGOs, educators, and trade union members.

Hare, L., C. Hart, S. Scribner, C. Shepherd, T. Pandit, (ed.), et al. 2004. *SPARHCS: Strategic Pathway to Reproductive Health Commodity Security. A Tool for Assessment, Planning, and Implementation*. Baltimore, MD: Information and Knowledge for Optimal Health (INFO) Project/Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health.

Summary of Tool (self-written)

The SPARHCS Tool is designed to help countries develop and implement strategies to secure essential supplies for FP and RH programmes. It provides a framework for bringing together a wide range of stakeholders to achieve reproductive health commodity security (RHCS) at the subnational, national, or regional levels. SPARHCS can be customized to meet local needs and resources, and used for contraceptives alone, contraceptives and condoms for HIV/STI prevention, or a broader set of RH supplies. To date, SPARHCS has been used in 50 countries, all reflecting different stages of RHCS experience, donor support, and health sector reform. In addition to being used at the national level, SPARHCS is appropriate for use at the regional (e.g., West Africa) and subnational levels.

The "SPARHCS process" seeks to strengthen RHCS measurably through attention to each phase of the cycle of RHCS activities—from awareness raising to monitoring the effectiveness of a strategic plan for RHCS. The tool can frame activities at each phase and guide strategic planning. Typically, it has been used for RHCS assessments of family planning or broader RH supply programmes. Such assessments (or joint diagnoses) often catalyze a comprehensive approach to improving RHCS.

National AIDS Control Council (NACC) and POLICY Project. 2004. *HIV/AIDS and Gender Training: A Toolkit for Policy and Senior Level Decision Makers*.

Abstract

The National AIDS Control Council has realized the need to mainstream gender issues in programmes/projects, since mainstreaming these issues in the planning, implementation, and evaluation of programmes strengthens the effectiveness of the response to HIV and AIDS. The overall goal of this toolkit is to sensitise policy and senior-level decisionmakers on key HIV, AIDS, and gender issues. It

offers guidelines to use when planning and formulating gender-responsive policies and programmes relating to HIV and AIDS.

Kamau, J., P. Odundo, and J. Korir. 2007. *Measuring the Degree of S&D in Kenya: An Index for HIV/AIDS Facilities and Providers*. Washington, DC: Futures Group, USAID | Health Policy Initiative, Task Order 1.

Abstract

HIV/AIDS-related stigma and discrimination (S&D) is a major impediment to effective and sustained responses to prevention, treatment, and care; thus, an appropriate index is needed to gauge changes in types and levels of S&D. Against this background, the USAID Interagency Working Group on S&D Indicators developed specific tools to measure S&D in communities and among facilities/providers and people living with HIV (PLHIV). The tools focus on specific aspects of S&D, including existence, awareness, and enforcement of policies; demonstration of nondiscriminatory attitudes; and reporting on nondiscriminatory care, blame, shame, and fear of casual contact with PLHIV. These aspects formed the basis for designing indicators used to construct an S&D index for facilities/providers based on a weighted average of the indicators.

The objective of this study was to field test the tools in the Kenyan context, focusing on facilities and providers of health services. A non-probability multistage sampling method was adopted to select five provinces out of the total eight provinces in Kenya, including two provinces with the highest prevalence of HIV. A similar procedure was adopted to select the districts for the study, out of which facilities and providers were selected for interviews. The providers and facilities, respectively, later were stratified by ownership (e.g., public, private, faith-based organization (FBO)/NGO) and level of HIV and AIDS care (e.g., comprehensive care centers (CCCs), semi-CCCs, and voluntary counseling and testing (VCT) clinics).

Kuduma INW. 2009. *Toolkit: Community Empowerment in MNH Towards the Alert Village (Desa Siaga)*. Deutsche Gesellschaft fuer Technische Zusammenarbeit.

Excerpt

This toolkit is a resource for everyone who is committed to reducing maternal and neonatal death. It is designed to help program managers of mother and neonatal health (MNH), and community empowerment programs in general. It can be used for advocacy to decisionmakers in raising awareness on reducing maternal death. It also will help the practitioner who works at increasing community participation, such as those working in NGOs.

National Public Health Performance Standards Program (NPHPSP). *Local Public Health Governance Performance Assessment Instrument. Version 2.0*. Atlanta, GA: Centers for Disease Control and Prevention. Available at: http://www.cdc.gov/NPHPSP/documents/07_110300%20Gov%20Booklet.pdf.

Excerpt

The National Public Health Performance Standards Program (NPHPSP) assessments are intended to help users answer questions such as "What are the activities and capacities of our public health system?" and "How well are we providing the Essential Public Health Services in our jurisdiction?" The dialogue that occurs in answering these questions can help to identify strengths and weaknesses, and determine opportunities for improvement.

The NPHPSP is a partnership effort to improve the practice of public health and the performance of public health systems. The NPHPSP assessment instruments guide state and local jurisdictions in evaluating their current performance against a set of optimal standards.

The following three assessment instruments have been designed to assist state and local partners in assessing and improving their public health systems or boards of health:

- State Public Health System Performance Assessment Instrument
- Local Public Health System Performance Assessment Instrument
- Local Public Health Governance Performance Assessment Instrument

The Policy Project. 2002. *The Planning and Finance Checklist*. Washington, DC: POLICY Project. Available at: http://www.policyproject.com/policycircle/content.cfm?a0=4d.

Summary of Tool (self-written)

The Planning and Finance Checklist is a planning checklist that specifies key elements of the planning process, such as finance, operational policies, and M&E, and asks multiple choice questions to determine whether the plan has addressed these issues adequately. The tool was pilot tested in Russia in December 2002.

Policy Project. *The Policy Stakeholder Analysis Matrix. The Policy Circle*. Washington, DC: POLICY Project. Available at: http://www.policyproject.com/policycircle/content.cfm?a0=3a.

Summary of Tool (self-written)

Guidelines for Conducting a Stakeholder Analysis were developed to provide users with a framework for assessing the identity of key actors and their interests, knowledge, positions, alliances, resources, power, and importance. It is important to conduct a stakeholder analysis before implementation of a policy so that areas of resistance can be identified and acknowledged, and areas of support can be enhanced.

Policy Project. *Reproductive Health Legislation Index (RHLI). The Policy Circle*. Available at: http://www.policyproject.com/policycircle/content.cfm?a0=6j.

Summary of Tool (self-written)

The Reproductive Health Legislation Index measures the integration of gendered issues in a country's legal system and the subsequent rights and equity afforded to women.

Policy Project. *The Resource Needs Model. The Policy Circle*. Available at: http://www.policyproject.com/policycircle/content.cfm?a0=5g.

Summary of Tool (self-written)

The Resource Needs Model is an Excel worksheet for calculating the funding required for an expanded response to HIV/AIDS at the national level. It includes 14 prevention programs, six care and treatment programs, and orphan support.

Polimap. 2012. *PolicyMaker 4 Software*. Available at: http://www.polimap.com/poliwhat.html.

Overview

PolicyMaker is a rapid assessment method for analyzing and managing the politics of public policy. Politics affect all aspects of public policy—what gets on the agenda, who supports an issue, who opposes an issue, whether an issue receives official approval, and whether the official policy is implemented. PolicyMaker is a logical and formal procedure to provide practical advice on how to manage the political aspects of public policy. The method helps decisionmakers improve the political feasibility of their policy.

The Process: PolicyMaker is carried out through five main analytic steps. The software helps you to define the following:

- *Policy Content*: Define and analyze the content of your policy. Identify the major goals of the policy and specify a mechanism intended to achieve each goal. Determine whether the goal is already on the agenda.
- *Players*: Identify the most important players and analyze their positions, power, and interests, and assess the policy's consequences for the players. Also, analyze the networks and coalitions among the players.
- *Opportunities and Obstacles*: Assess the opportunities and obstacles that affect the feasibility of your policy by analyzing conditions within specific organizations and in the broader political environment.
- *Strategies*: Design strategies to improve the feasibility of your policy by using the expert advice provided in the program. Then evaluate your strategies and create alternative strategy packages as potential action plans.
- *Impacts of Strategies*: Estimate the impacts of your strategies on the positions, power, and number of mobilized players—the three factors that affect the feasibility of your policy. Compare the future and current Position Maps and Feasibility Graphs to show the impacts of your strategies. Monitor the implementation of your strategies and compare the results to your predictions.

Government of Australia. *Public Sector Innovation Toolkit*. Available at: http://innovation.govspace.gov.au/.

Summary of Tool (self-written)

The Toolkit has been developed to assist individual public servants, public sector teams, and agencies that want to increase the extent and effectiveness of their innovation efforts. The tools on this website have been developed to give practical advice on fostering innovation within your agency. Although this Toolkit is designed for use by the Australian Public Service, we welcome the use of the tools it contains by other public servants.

MEASURE Evaluation. 2001. "Quick Investigation of Quality (QIQ): A User's Guide for Monitoring Quality of Care in Family Planning." *MEASURE Evaluation Manual Series, No. 2*. Chapel Hill, NC: MEASURE Evaluation. Carolina Population Center, University of North Carolina at Chapel Hill.

Abstract

This user's guide contains materials needed to design and implement the Quick Investigation of Quality (QIQ) in a given country. QIQ refers to the set of three related data-collection instruments designed to monitor 25 indicators of quality care in clinic-based FP programs. This volume includes an overview of the QIQ (including objectives, a short list of indicators, and methodological and ethical issues), guidelines for sampling and training of field personnel, instruments and guidelines for data collection, and summary results from the short list of indicators in tabular and graphic form.

Reshevska, I., K. Foreit, K. Beardsley, and L. Porter. 2010. *Policy Advocacy Toolkit for Medication-assisted Treatment (MAT) for Drug Dependence*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Abstract

The human, economic, and social costs of opioid dependence have increased exponentially with the advent of HIV and AIDS. In several regions of the world, most notably Eastern Europe and Eurasia, the unsterile sharing of needles, works, and drugs related to injecting drug use is the principal driver of HIV transmission, and puts drug users, their partners, and sexual networks at risk. Medication-assisted treatment (MAT) programs are evidence-based drug treatment programs that result in drug users stopping

drug use, changing risk behaviors, and reducing the risk of contracting or transmitting HIV. Most experts agree that the HIV epidemic in these countries cannot be contained without sustainable, widespread access to MAT and removal of barriers to MAT use.

The Toolkit's organizing principles were derived from the most up-to-date (as of mid-2010) international best practices for MAT, including guidance from WHO, the United Nations Office on Drugs and Crime, and the Joint United Nations Programme on HIV/AIDS (UNAIDS). The developers assembled an international advisory group and consulted extensively with group members throughout the process, as well as with various USAID bureaus and field missions, the Office of the Global AIDS Coordinator, and the Substance Abuse and Mental Health Services Administration (SAMHSA) of the U.S. Department of Health and Human Services (HHS). The European Harm Reduction Network identified national consultants to field test the instruments.

Rubin, D.S. and B. Herstad. 2009. *Integrating Gender in Policy Implementation Barriers Analysis: A Methodology*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

Abstract

The PIBA activity was designed to pilot a methodology and set of tools to identify key barriers to implementing programs under PEPFAR. Specifically, the activity focused on identifying barriers to reaching a targeted goal for one or more of the PEPFAR indicators. The project integrated gender into the PIBA activity to help underscore the various needs of women and men within the context of barriers to implementation. Health policies affect women and men differently, as do policies that influence service delivery systems, available resources, patient treatment options, medical costs, and other aspects of healthcare services, such as hours of operation or site location. These differences often are the product of local gender norms and values that shape the freedom and opportunities open to both women and men. Identifying and addressing these differences are crucial to ensuring that women and men benefit equally from health programs.

This report outlines a methodology for integrating gender into the PIBA activity and describes the main activities to be carried out by gender experts, ideally with skills in gender analysis, HIV/AIDS issues, and specific country knowledge. The report also presents examples of how each activity was developed and/or used in several of the country PIBA surveys.

Avenir Health. *SPECTRUM*. Glastonbury, CT: Avenir Health. Available at: http://www.futuresinstitute.org/spectrum.aspx.

Summary of Tool (self-written)

SPECTRUM is a suite of easy-to-use policy models that provide policymakers with an analytical tool to support the decision-making process.

SPECTRUM consists of several software models, including the following:

- DemProj: Demography
- FamPlan: Family Planning
- LiST: Lives Saved Tool (Child Survival)
- AIM: AIDS Impact Model
- Goals: Cost and impact of HIV Intervention
- Resource Needs Module: Costs of implementing an HIV/AIDS program
- RAPID: Resources for the Awareness of Population Impacts on Development

Policy Project. *The Strategic Planning for the Reproductive Health and Population Sector Training Module. The Policy Circle*. Available at: http://www.policyproject.com/policycircle/content.cfm?a0=5e.

Summary of Tool (self-written)

Strategic planning can be used to enable governments or organizations to accomplish the following: do a better job; focus their energy; look at the "big picture"; ensure that staff or stakeholders are working toward the same goals; and assess and adjust direction in response to a changing environment. It is a tool for making informed decisions regarding how to move from where the government or sector is today to a desired state sometime in the future.

This training module on strategic planning was designed to assist governments and organizations working in the RH and population sector develop an understanding of the fundamental principles, concepts, and analytic techniques of strategic planning as well as foster an understanding of the linkage between strategic planning and budgeting.

The Tools of Social Accountability Stocktaking: Getting to Know the Lay of the Land. Affiliated Network for Social Accountability in East Asia and the Pacific (ANSA-EAP).

Excerpt

ANSA EAP has adopted "stocktaking" as the collective term given to tools used for getting to know and understand the social accountability situation of a specific area or sector. For ANSA EAP, stocktaking means a reappraisal (or assessment) of a social accountability situation, including its key players and stakeholders, the processes and dynamics, the tools and methods, and the like.

ANSA EAP's stocktaking framework uses four tools: scanning, scoping, mapping, and profiling. Each one precedes and prepares the other, as in a funnel.

The templates serve as guides. Hence, the "areas of inquiry" and the "descriptors" are suggestions to help steer the investigator in scrutinizing the wider arena of social accountability; the investigator may add details and revise the items according to the goals, objectives, and specific outputs of the study.

CONCLUSION

Policy is the roadmap to action, as it contains the objectives, plans, and targets for governments and organizations. In health, policies aim to correct problems, strengthen health systems, and ultimately improve health outcomes. There are several steps to the policy process, from agenda setting and policy development to policy implementation and evaluation. Furthermore, factors such as the political environment, the culture of social participation, the preceding policies, and the existing health system contribute to the success or failure of new policies.

Policy making comes with its own particular set of challenges, such as the fact that policy outcomes are the product of complex, interacting factors that can be difficult to predict or attribute to specific events. Because policy actors typically include numerous organizations and governments, accountability and communication can suffer. Effective surveillance and monitoring can be difficult to achieve in low-capacity environments.

Because of the complex nature of the policy framework, and the time it takes for a policy intervention to translate to improved health systems and outcomes, it is difficult to link a policy to a given outcome. In response to these challenges, policy research, including this annotated bibliography, helps to bridge the knowledge gaps from policy development to policy implementation and from policy implementation to health outcomes. Using the most effective methodologies to study the impact of policy environments on health systems and outcomes will enable researchers and implementers to provide clear, practical recommendations when presenting policy research findings. This bibliography seeks to clarify the complex field of health policy by disseminating research findings to fellow stakeholders.

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