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# POLICY IMPLEMENTATION BARRIERS ANALYSIS: CONCEPTUAL FRAMEWORK AND PILOT TEST IN THREE COUNTRIES

**OCTOBER 2009**

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The views expressed in this publication do not necessarily reflect the views of the U.S. Agency for International Development or the U.S. Government.



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## EXECUTIVE SUMMARY

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 President's Emergency Plan for AIDS Relief (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 the 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.

These lessons include the following:

- **Conflicting/intersecting policies.** National policies include broad and general language and are not always supported by operational or local policies and guidelines. In addition, traditional health programs are often vertical (i.e., they do not coordinate with other relevant programs such as HIV, tuberculosis, reproductive health, maternal and child health, and immunization) and have unresolved policy conflicts or inconsistencies that can be resolved fairly easily once identified.
- **Low motivation and commitment.** Personal, organizational, or institutional motivation and commitment can facilitate the policy implementation process. Numerous factors can result in low motivation or commitment, such as different priorities, a lack of incentives, and limited resources.
- **Implementation at multiple levels.** The roll out of any policy often meets some level of community resistance or low engagement that thwarts effective implementation. The early engagement of all stakeholders is essential to resolving this kind of barrier. Barriers analysis serves to engage stakeholders and increase commitment and understanding of their roles during implementation, in addition to informing effective implementation.
- **Stigma, discrimination, and gender.** These issues often are not considered in policy development, and yet they contribute significantly to the success/failure of policy implementation.
- **Policy formulation versus implementation.** There are key differences between policy formulation and implementation that must be addressed to maximize the impact of a new policy.

To respond to these lessons, a final stakeholder assessment process can best generate specific recommendations. This process should focus on harnessing local expertise to identify the best solutions to findings from the policy implementation barriers analysis. The Health Policy Initiative was able to pilot test this assessment process in Vietnam, where the research team and other stakeholders successfully produced specific recommendations for action. These recommendations include a targeted approach to strengthen and focus on weak areas of national programs, such as information systems; planning processes; and suggested educational campaigns about specific legislation.

## ABBREVIATIONS

ART	antiretroviral therapy
ARV	antiretroviral
ASA	Aski Stop AIDS
BOH	Bureau of Health
CA	cooperating agency
CDC	Centers for Disease Control and Prevention
CEDC	children in especially difficult circumstances
CIT	Contextual Interaction Theory
CUP	condom use program
FFOC	Four Free One Care Policy
FHI	Family Health International
GIPA	Greater Involvement of People Living with HIV/AIDS
IDU	injecting drug user
INGO	international nongovernmental organization
KPAD	Provincial AIDS Committee (Indonesia)
MARP	most-at-risk population
MOLISA	Ministry of Labor—Invalids and Social Affairs (Vietnam)
MSM	men who have sex with men
NAC	National AIDS Commission
NGO	nongovernmental organization
NPA	National Plan of Action (for children)
OGAC	Office of the Global AIDS Coordinator
OHA	Office of HIV/AIDS
OI	opportunistic infection
OVC	orphans and vulnerable children
PEPFAR	President’s Emergency Plan for AIDS Relief
PIBA	Policy Implementation Barriers Analysis
PLHIV	people living with HIV
PSB	Public Security Bureau (China)
S&D	stigma and discrimination
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
USG	United States Government

## I. INTRODUCTION

In the last decade, donors and multilateral organizations have provided extensive technical assistance and considerable funding to governments around the world to develop evidence-based HIV-related policies and strategic action plans. Concerns remain, however, about how quickly and effectively those policies are translated into prevention, treatment, and care programs and services. In most countries, programs and services are delivered via under-resourced national healthcare systems and governmental administration infrastructures that experience frequent turnover and transfer of staff at all levels (Williamson, 2001). For these reasons, stakeholders are giving increasing attention to strengthening the systems within which these policies are managed so that policy formulation and implementation will improve. However, the transformation of policy into specific programs has long been recognized by scholars and practitioners as fraught with implementation difficulties that are not easily remedied.

The complexity of the policy implementation process has challenged researchers to develop theories or models with a limited number of explanatory variables that predict how and under what conditions policies are implemented (O'Toole and Montjoy, 1984). However, there is a serious lack of empirical data that provide an adequate understanding of how to overcome the barriers, delays, and disincentives associated with implementing policies (Alesch and Petak, 2001; Matland, 1995; Sabatier, 1991). This lack of understanding has important implications for health programs seeking to reduce the global burden of tuberculosis and maternal mortality, improve child survival, and meet global goals to reduce the impact of HIV and AIDS in relatively short time periods.

For those concerned with scaling up sustainable HIV and AIDS programs, the dearth of generalizable approaches to policy implementation limits understanding not only of the development of HIV policies in less-resourced countries but also the relative impact of policy initiatives on the epidemic. Without a better understanding of the underlying factors that affect the implementation process and how those processes are influenced within each country's political context, new policies may not contribute to program scale-up as governments and donors intend and, as a result, fail to reach laudable global goals (Parker et al., 2000).

To gain an understanding of the underlying factors that influence the implementation process, the USAID | Health Policy Initiative, Task Order 1 designed and conducted a Policy Implementation Barriers Analysis (PIBA) to create and field test a methodology that seeks to systematically answer the following questions:

- If a policy has been written and approved and includes up-to-date guidelines, why is it not being implemented?
- What are the barriers to implementing the policy?
- Which approaches and interventions can be recommended to improve policy implementation?

This activity fits within the project's overall objective of promoting an improved enabling environment for health policies, especially those related to HIV/AIDS, family planning and reproductive health, and maternal health. The strategy of the Health Policy Initiative focuses on responding to the priorities of the Office of HIV/AIDS (OHA) and the Office of the Global AIDS Coordinator (OGAC). This strategy involves providing technical assistance to government and other local organizations and communities to (1) manage HIV prevention, treatment, care, and support programs through effective policy implementation; (2) develop tools and approaches to improve access to health services, including reducing stigma and discrimination, especially for the poor and most-at-risk populations; and (3) build the capacity of policymakers, program implementers, and communities to recognize and address gender issues that affect access to services and programs.

This is the final report on the PIBA activity in the Asia region. It is organized into three sections, including a brief review of the policy implementation framework; the methodology used to field test the framework for addressing policy implementation barriers; and the findings from the field-tests in China, Indonesia, and Vietnam. The paper concludes with lessons learned related to key findings and the methodology and includes ideas for moving the methodology forward in other countries.

## Policy Implementation Framework

After an extensive review of policy implementation literature, the activity team created a central framework for the activity based on the Contextual Interaction Theory. While the framework remained the same during the research, the activity teams revised the guide during the pilot process to better reflect the constructs. This section explores the theory that informed the development of the activity framework.

**Contextual Interaction Theory.** Finding a model for policy implementation does not mean that implementers then can employ a simple process, using quick fixes to create rapid change in an implementation network—long-term behavior change rarely happens that way. Instead, a simplified model provides a framework for systematically identifying and addressing factors that implementers have some chance of influencing. The activity team identified such a model in the Contextual Interaction Theory (CIT).<sup>1</sup>

CIT uses a deductive, social process approach that employs explicit consideration of several variables, including the policy tools (or “instruments”) and the strategic interactions between implementers and target groups over extended periods of time (O’Toole, 2004).<sup>2</sup>

The basic assumption of the Contextual Interaction Theory is thus that the course and outcome of the policy process depend not only on inputs (in this case the characteristics of the policy instruments), but more crucially on the characteristics of the actors involved, particularly their motivation, information and power. All other factors that influence the process do so because, and in so far as, they influence the characteristics of the actors involved...The theory does not deny the value of a multiplicity of possible factors, but claims that theoretically their influence can best be understood by assessing their impact on the motivation, information, and power of the actors involved (Bressers, 2004).

This discussion of actors includes the role of the public in policy implementation. Communities and individuals are the ultimate “target groups” of policies and programs and therefore are the ultimate “street-level” implementers, able to demand or reject specific programs. For example, in Vietnam, a policy to reintegrate children living in orphanages (including children affected by HIV) back into the community has failed to get off the ground because few community members will accept these children due to unfounded fears of casual transmission of HIV to their children (see the Vietnam section for further information).

One of CIT’s key assumptions is that the factors influencing the implementation process are interactive. The influence of any factor, whether positive or negative, depends on the particular contextual circumstances. The theory distinguishes a set of “core circumstances” or constructs related to the actors involved, which jointly contribute to implementation. The constructs include the following:

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<sup>1</sup> CIT was developed during the last 20 years by Dutch researchers, including Hans Bressers, at the University of Twente in the Netherlands and their U.S.- and European-based collaborators working on governance and sustainable natural resource management.

<sup>2</sup> Bressers defines “target groups” as actors further down the network, as well as the ultimate beneficiaries of the program (i.e., consumers, clients, and community members).

**Motivation.** The level of importance actors place on a particular policy or program and the degree to which the policy or program contributes to their goals and objectives affects implementation. For example, if actors have low motivation regarding a specific issue, they may ignore the policy; issue a “symbolic policy” not supported by a serious commitment of resources; or, in some cases, actively work to undermine the policy or program.

Examining motivation helps stakeholders understand the perspectives of implementers—their belief systems, value priorities, and perceptions of the importance and magnitude of specific problems and policy solutions—often revealing the root causes of implementation barriers (Sabatier, 1991; Kayaba et al., 2005; Deibert et al., 2006).

**Information.** Successful policy or program implementation requires that those involved have sufficient information. Information includes technical knowledge of the matter at hand and levels and patterns of communication between actors. For example, do those responsible for implementation actually know with whom they should be working and who the policy is supposed to benefit (target groups)? Do they know, for instance, which department is assigned to lead the implementation and how the program will be monitored? Do they know the culture and processes of other organizations in their network? Have guidelines and protocols been developed, and are they readily available? How is information and communication between actors coordinated? Do beneficiaries have sufficient and appropriate information to benefit from the program?

**Power.** It is important to understand who is empowered to implement a policy and to what degree they can implement it. Power may derive from formal sources (such as legal or regulatory systems) or informal sources (such as being dependent on another party for the achievement of other objectives). In most interactive processes, informal sources of power may be highly important and, in many cases, can balance the more formal powers of the implementing authorities.

**Interaction.** Interactions between actors must be considered to further analyze barriers to implementation. Types of interaction include the following:

- *Cooperation.* Active cooperation occurs when both parties share a common goal (including the goal of blocking implementation of a policy). Passive cooperation refers to one or more actors adopting a relatively passive approach to implementation of the policy instrument. Forced cooperation is a form of passive cooperation imposed by a dominant actor.
- *Opposition.* Opposition occurs when one actor tries to prevent implementation of the policy or program by another actor.
- *Joint learning.* Joint learning occurs when multiple stakeholders overcome a lack of information standing in the way of implementation (Bressers, 2004).

Actors at a particular organization or level within a network know their own and their organization’s role in implementing a policy or program but cannot see the larger pattern of interactions within the network, making it difficult for individuals or single organizations to fully identify where barriers to implementation are occurring (Senge, 1990). Examining the network within which policies and programs are implemented is critical to identifying where barriers arise in the network. Also important is the recognition that relationships between actors within these networks entail different levels of interdependency (O’Toole and Montjoy, 1984). Studies from information network diffusion, systems analysis, and game theory suggest that improving implementation may not require large-scale efforts throughout the entire network but rather well-focused actions that create small changes among a few actors in a setting of interdependence (Senge, 1990; O’Toole, 2004; Gibbons, 2007).

The following views must be weighed when determining how and if actors respond to a policy. Collaboration between actors is more likely when each actor

- Perceives the problem addressed by the policy as a priority for itself;
- Is convinced that there is an acceptable solution to the problem;
- Concludes that taking action now is in its own best interest; and
- Has the capacity to implement the interventions (Alesch and Petak, 2001; Gagnon et al., 2007).

Interaction predicts the level of collaboration among actors, which, in turn, influences policy implementation. Specifying these constructs allows for the development of tools to measure the level at which each of the core constructs contributes to implementation barriers, thus informing the design of interventions that will reduce barriers more effectively. As CIT provides a relatively simple, empirically tested framework for identifying the fundamental issues underlying barriers within an implementation network, the activity team selected it as the framework for the activity.

## **Activity Design**

The impetus for this activity was to build on experience gained through USAID’s POLICY Project to contribute to the Health Policy Initiative’s mandate to improve policy implementation. The activity goal was to develop a standardized tool to assess operational policy barriers to program implementation and field test it in several countries funded by the President’s Emergency Plan for AIDS Relief (PEPFAR). Under the POLICY Project, operational policies were defined as the following:

...the rules, regulations, codes, guidelines and administrative norms that governments use to translate national laws and policies into programs and services. While 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 operational policies that are inadequate, inappropriate, or outdated (Cross et al., 2002, p. v).

In summer 2006, the activity began as the “Operational Barriers Analysis,” with the focus on better understanding underlying factors that determine if and when a policy is implemented. Three U.S.-based and two field-based staff (one each from Haiti and Vietnam) constituted the team that developed the activity’s conceptual framework and tool. In addition, members of the project’s Gender Working Group collaborated to ensure that gender issues were incorporated into the activity design. Following data collection in all three countries, the activity was renamed the “Policy Implementation Barriers Analysis” to better reflect the central goal of the activity to assist program managers in overcoming implementation challenges.

Thus, the overall objective of the activity was to develop a data collection tool based on policy implementation constructs and pilot the tool to test the hypothesis that these constructs explain barriers to policy implementation in low-resource countries. Based on the literature review, the team designed a structured interview guide that aimed to identify the core constructs of motivation, information, power, interaction, and networks as critical determinants of policy implementation. The team decided to use an iterative process—learning and adapting the interview guide in each country. To capture the core constructs, the interview guide included the following:

## **Motivation**

- Levels of support for the policy/program from various sectors, such as national, provincial, and local policymakers; the private sector; religious communities; public security departments; the media; and the community
- Levels of opposition for the policy/program from the various sectors
- Determination of whether HIV was a priority for the informant's organization and collaborating partners
- Benefits to the informant's organization from collaborating with other organizations in implementing the policy/program
- Costs/disincentives of collaboration for informants' organization

## **Information**

- Policy development process, such as who was involved and to what extent (e.g., were men and women equally involved in policy discussions, technical review teams, and policy leadership roles? Were people living with HIV (PLHIV) and/or members of most-at-risk groups included in policy development or monitoring?)
- Knowledge of the intention (if not the exact wording) of the policy
- Knowledge of the lead implementing organization and its capacity to implement the policy
- Availability of guidelines and other information needed for implementation
- Source and adequacy of funding to support implementation
- Services provided by informant's organization
- Determination of monitoring—ascertaining whether the policy/program was being monitored and, if so, by which organization
- Determination of how implementation was affecting men versus women
- Challenges faced by men/women in accessing services/programs

## **Interaction/Power**

- Organizations with which informant's organization collaborates to implement the specific policy/program
- Level of collaboration with other organizations (from high to low)
- The effectiveness with which the lead organization communicated with implementing organizations and the public
- Actions taken by supporters or opponents to affect the policy/program's implementation

## **Research Methodology**

The research methodology incorporated the following five steps:

1. Program selection and team development
2. Informant selection
3. Data collection
4. Data analysis
5. Dissemination and follow-up

The activity team piloted the interview guide and approach in Indonesia (December 2006–February 2007), China (April–September 2007), and Vietnam (April–October 2007).

**Program selection and team development.** Several weeks prior to conducting the field work, in-country Health Policy Initiative staff met with United States Government (USG) staff backstopping PEPFAR. After introducing the activity, project staff asked the USG team to (1) advise on PEPFAR

program areas for analysis; (2) suggest specific communities and districts in which data collection should be focused; (3) recommend policymakers and program implementers to interview at the national, provincial, and local levels regarding the policy or program; and (4) identify which government, civil society, and donor representatives should be briefed about the analysis or interviewed. After selecting the program area, the USG and local Health Policy Initiative staff or consultants obtained buy-in from the country's appropriate ministries (i.e., those relevant to the program area chosen for pilot testing).

*Program selection.* The following programs and policies were included in the pilot-test:

- In China, on the advice of the USAID Regional Development Mission in Asia, the activity team met with cooperating agency (CA) partners to discuss which program area to select. In Yunnan Province, the Bureau of Health (BOH) supported the team in analyzing barriers to access to antiretroviral therapy (ART) by injecting drug users (IDUs). The National “Four Free One Cares” (FFOC) policy guarantees ART for those eligible, but implementing agencies were concerned that IDUs were not accessing treatment.
- With USAID/Indonesia's support, the activity team met with the provincial directors of USAID's main implementing partner to discuss challenges they faced at the field level and which program to address through the activity. The team decided to analyze the lack of implementation of the 100% Condom Use Program (100% CUP). While the national HIV/AIDS strategies of 2003–2007 and 2007–2010 endorse condom use in high-risk sex situations, the policy was not being implemented at the local level.
- In Vietnam, the USG team identified several program areas for analysis, including voluntary counseling and testing, treatment, and orphans and vulnerable children (OVC). The team decided to address OVC and received support from the Ministry of Labor—Invalids, and Social Affairs (MOLISA) to undertake an analysis of the barriers to reintegrating OVC from orphanages into communities. The national government created a policy—Decision 65—requiring that models under development reintegrate children from state protection centers into communities by 2010, but very few children affected by HIV were benefiting from the decision.

*Team development.* Teams comprised 5–6 people—the majority from the study country. A senior HIV/AIDS technical advisor based in Washington, D.C., led the team in each country. The in-country teams comprised local Health Policy Initiative staff and consultants, who were required to have experience in qualitative data collection methods.

**Informant selection.** In-country project staff or consultants identified possible informants and set up a first round of interviews with either policymakers or program implementers. The teams identified informants by contacting organizations that implement a particular policy or program; asking staff for other contacts; and asking the government partners, the USG team, and other CA partners who to include in the interview pool. Once the interviews began, the team asked informants for additional people to contact and interview.

Policymaker criteria included the following:

- National, provincial, district, or local government leaders whose departments had been tasked with direct responsibility for implementing or monitoring the policy
- National, provincial, district, or local government leaders whose departments had been tasked with multisectoral engagement in implementing or monitoring the policy (e.g., Ministry of Tourism, Ministry of Women's Affairs)

- National and local government leaders involved in the development of the policy (e.g., donors, parliamentarians, staff of the ministries of health or finance, and National AIDS Committee members)

Program implementer criteria included the following:

- Local staff responsible for the provision of services or programs related to the policy [these staff included service delivery site directors or supervisors; service delivery providers (e.g., healthcare providers delivering HIV-related prevention, treatment, care, and support); and peer counselors, directors, supervisors, and staff from faith-based, nongovernmental, or community-based organizations providing programs or services.

*Focus group discussions.* The methodology also included conducting focus group discussions with stakeholders or clients who were the intended recipients of the policy and resulting services or programs. With assistance from NGO networks or partner CAs who worked directly with NGOs and most-at-risk populations (MARPs), the teams identified participants for the focus groups. In each country, teams created focus group guides relevant to the particular program or service and the local context. The teams designed questions to identify challenges that program users faced in accessing a program or service, including challenges related to broader social and economic issues, such as gender norms, poverty, and stigma and discrimination.

*Number of interviews.* In Vietnam, the team conducted 31 in-depth interviews (9 with policymakers and 22 with program implementers). The team also facilitated four focus group discussions (2 with caregivers for OVC, 1 with a PLHIV support group, and 1 with parents). China's activity team undertook six interviews with policymakers and 14 with program implementers. The team also conducted five focus group discussions with a total of 47 participants. In Indonesia, the team held nine interviews with policymakers, 14 with program implementers, and 11 with additional stakeholders. The team also conducted five focus group discussions with 38 participants.

**Data collection.** Before data collection began in each country, the team leader conducted a three-day training with in-country team members to (1) familiarize them with the framework and concepts in the interview guide so they could probe further when an informant referred to the key concepts; (2) review each question in the guide so the team understood the purpose of the question and could clarify questions for an informant; (3) reach consensus about the appropriate translation of each question; (4) adapt the interview guide to the particular study topic and country context; (5) discuss good interviewing skills; and (6) review data collection and recording procedures. In addition, in Vietnam, project staff conducted a brief gender training to assist the team in identifying and exploring gender issues throughout the activity.

As soon as the translated interview guides were available, teams conducted 3–4 joint interviews, with one team member conducting the interview, one taking notes, and the rest of the team observing. The team debriefed after each of these interviews to discuss the flow of the interview, the appropriateness of the questions, and any concerns or issues that arose during the interview. The group then split up into teams of two to undertake the remaining scheduled interviews; members of these smaller teams alternated between the roles of interviewer and note taker. With permission of the informant or focus group participants, interviewers also tape-recorded their interviews.

**Data analysis.** All interviews and focus group discussions were transcribed and translated into English. In Indonesia and China, the research teams translated the interviews; the Vietnam team used a professional translator. All country files were sent to the team leader in Washington, D.C., for data analysis; and the Vietnam data also were sent to a consultant based in India, who provided technical

support to the Vietnam team. The team leaders and consultants reviewed and clarified text with the country teams before analyzing the data.

The data analysis team developed data analysis codes and standardized their coding process using Atlas Ti 5.2 qualitative analysis software. Some codes were predefined based on the framework, but others were free codes based on themes arising from the data. The team leader analyzed data from China and Indonesia; shared their initial findings with the in-country teams; and sought clarification, interpretation, and feedback on analysis from the team. The Indian consultant led the data analysis for Vietnam, in collaboration with the Vietnam Health Policy Initiative staff and consultants and with input from the team leader.

**Dissemination and follow-up.** Ultimately, overcoming policy implementation barriers will require commitment and perseverance by a wide range of stakeholders in each country, possibly over a prolonged period. To inspire such action and commitment, the methodology included a stakeholder meeting as the final step in piloting the activity. At the stakeholder meeting, the team presented findings from the data collection and analysis. During the meeting, project staff presented data, facilitated discussions around the findings, worked with local stakeholders to prioritize the identified barriers, and determined if and how to address them.

*Indonesia.* In Indonesia, stakeholders met with the Vice Mayor of Surabaya City in November 2007 to present analysis findings and discuss recommendations. Participants included a key religious leader, a local Parliament member, the head of the health department, representatives from social services and STD centers, a legal advisor, and Family Health International (FHI) and Health Policy Initiative staff and consultants. The Vice Mayor agreed to support the legal drafting of a city *perda* (local regulation) on HIV prevention, including specific references to the 100% CUP as one element of prevention.

In addition, findings of the data analysis suggested to the Indonesian team that advocacy is needed to address the identified major barriers. Advocates must work with several powerful actors opposed to the program to help them understand the program's goals and encourage them to take a neutral position.

In light of this insight, the project facilitated an HIV advocacy training workshop in November 2007 for 25 participants, representing NGOs, health workers, groups at risk for HIV, health clinic staff, PLHIV, religious leaders, and FHI staff. The training included an orientation to advocacy, an examination of the policymaking process from both governmental and religious perspectives, an overview of the use of data in HIV advocacy, and practice with key steps in planning and conducting advocacy activities. The training served as an appropriate forum to share the results of the PIBA activity with a range of stakeholders in the province and begin identifying possible champions and opportunities for increasing attention to prevention issues in East Java.

Building on these findings, the Health Policy Initiative conducted several policy dialogue events during 2008 to strengthen the capacity of government and private and community sector actors to formulate and advocate for policy formulation or revision; this ensures that programs have a solid policy base. In addition, the project held a regional workshop for Islamic leaders in Surabaya to discuss existing HIV policies at the local level, including the compilation of *fatwa* (religious guidance) on HIV prevention; these leaders can then translate the policies into a more realistic plan of action to relay HIV prevention messages to their communities.

In March 2008, the project facilitated a brainstorming meeting to discuss elements of available *perdas*. An ad hoc working group came together to create a guide or framework for developing effective regulations. The group includes representatives of FHI, the Ministry of Health, the National AIDS Commission (NAC), and Indonesia's HIV/AIDS Prevention and Care Project, funded by AusAID,

lawyers, and women's groups. Project staff compiled local regulations related to HIV prevention in East Java and the lawmaking process. Policy champions and stakeholders can use the guidance from the working group and the compilation of regulations and the policymaking process to build the capacity for drafting the *perda* for Surabaya.

*Vietnam.* The Vietnam activity team held a one-day stakeholder meeting in Hanoi in January 2008 to disseminate the study findings to policymakers, policy implementers, international nongovernmental organizations (INGOs), and NGOs. The workshop objectives included the following:

- Disseminate the study findings on policy implementation barriers, specifically to Decision 65
- Develop recommendations and guidelines for implementing Decision 65
- Provide a forum for stakeholders to discuss policy implementation in relation to OVC in Vietnam
- Provide a forum for discussions in which the Health Policy Initiative findings can inform the National Plan of Action (for Children) (NPA)

Twenty-nine participants attended the session, including participants from the national and provincial governments, UN agencies and INGOs, local NGOs, OVC service providers, media, and leaders of PLHIV groups. One key issue discussed was whether the findings could be used to train policymakers and policy implementers in Vietnam. The training could include the various steps of policy implementation and the differences between the processes of policymaking and policy implementation. In addition, there was a presentation on the community homes that Decision 65 supports and a discussion on how planning processes at the district level can be strengthened to include the implementation of Decision 65. Other discussion topics included stigma and discrimination and how study findings will inform the NPA. The following inputs from the study will be incorporated into the NPA:

- Development of a detailed dissemination plan to publicize the new policy at all levels of government and civil society
- A focus on strengthening local planning mechanisms in the NPA
- Creation of a detailed implementation plan for the NPA

*China.* No follow-up was possible because the project office closed in December 2007, soon after the analysis was done.

The next section focuses on development of the PIBA data collection tool, as used with the enhanced framework, and the challenges encountered in its development and testing in China, Indonesia, and Vietnam.

## II. COUNTRY REPORTS

### China: Analysis of Barriers to Providing ART to Injecting Drug Users

#### Country Context

*HIV.* While China's first HIV cases were identified in 1989, the government did not earnestly begin to address the potential of a wider epidemic until 2001. Since 2003, the national government's commitment to addressing HIV has increased dramatically, with the national budget for HIV growing from approximately \$12.5 million in 2002 to about \$185 million in 2006. Although HIV has been reported in all 31 Chinese provinces, about three-quarters of infected persons reside in the five provinces of Guangdong, Guangxi, Henan, Xinjiang, and Yunnan. In 2006, the World Health Organization and the Chinese Government estimated that there are approximately 650,000 PLHIV in the country (Bates and Okie, 2007). According to the Ministry of Health, it is estimated that approximately 37 percent of PLHIV in China contracted the virus by sharing needles for drug use. The estimated number of IDUs in China ranges from 1.14 million to 3.5 million (Qian et al., 2006).

Because the HIV epidemic in China is driven by high-risk behavior, such as injecting drug use and sex work, laws and policies related to these behaviors also shape the policy environment related to HIV prevention, treatment, and care programs. Policymakers and the general public in China tend to view drug dependence as a personal weakness rather than a chronic disease and see IDUs as nonproductive criminal elements or social outcasts. For the most part, the Chinese view HIV infection acquired through injecting drug use as the result of behaviors that are the fault of the individual. In China, government policies and laws related to drug use generally take a strictly "zero tolerance" approach, with declarations of a "people's war" to end drug use and quotas for the public security sector to remove drug users from the community. Use of drugs such as opium or morphine is illegal and subject to punishments. Drug addicts are mandated for compulsory detoxification, treatment, and education. Those who relapse receive education through labor and compulsory detoxification.

To address HIV, the national government has promulgated a series of policies fully supporting prevention, care, and treatment programs. Since 2003, the policy environment supporting a national response to the HIV epidemic has improved dramatically following the announcement by Premier Wen Jiabao and Vice Premier Wu Yi of the Four Free and One Care Policy: The Overarching Policy for Care and Treatment. Sections 15 and 16 of the Four Free and One Care Policy require that public security [Public Security Bureau (PSB)] and departments of judicial administration cooperate with the Bureau of Health to conduct HIV testing on drug users who have been arrested, detained, or are serving prison sentences for the purposes of detoxification. The purpose of testing is to provide medical treatment to HIV-positive individuals. In addition, the Department of Health is to provide free HIV antibody testing and ART for all HIV-positive persons and AIDS patients who meet the requirements set in national and provincial regulations and will step-by-step reduce the costs of OI treatment. Thus, detention centers, which fall under the PSB, have the responsibility for providing HIV testing and providing treatment, in cooperation with the Bureau of Health.

In January 2006, the Chinese Cabinet issued regulations for HIV prevention and control, outlining the responsibilities of the central and local governments and stipulating the rights and responsibilities of infected persons. Policy implementation in China is complex, as there are numerous levels through which policies pass. China's political system includes the Center, covering the entire country; 31 provinces; more than 600 cities; more than 2,000 counties; nearly 100,000 townships; and approximately 1 million villages. With that number of counties, the task of ensuring an effective response to the epidemic is enormous. Implementation of the central government's mandates varies widely, depending on local

resources and priorities. The HIV epidemic has been most prevalent in the poorest, most remote areas, which are hard-pressed to provide the necessary money, training, and personnel.

*Yunnan Province.* In Yunnan Province, HIV is a concentrated epidemic among MARPs, especially IDUs and sex workers. There is an urgent need to scale up prevention efforts, including the provision of ART to these at-risk groups. A 2007 Yunnan Centers for Disease Control (CDC) report showed that IDUs make up only 10–15 percent of those currently receiving treatment, while they constitute 50 percent of all those infected. In 2006, there were 97 compulsory detention centers in Yunnan Province holding approximately 30,000 drug users—of which an estimated 25 percent is HIV positive (almost 7,500 people). Except for a few pilot sites, none of these HIV-positive inmates are receiving ART or treatment for OIs—nor are clients of methadone maintenance treatment sites. Considering only the number of IDUs in detention and the usual progression of HIV to AIDS, it is reasonable to assume that 10–15 percent of HIV-positive inmates (approximately 1,125 people) are already eligible for ART.

In November 2006, the project’s China office and the activity team decided to focus on access to ART among PLHIV in Yunnan Province—specifically in Kunming. In light of the Four Free One Care Policy that fully supports treatment for all eligible PLHIV, the team highlighted the need to provide access to IDUs. After briefing the BOH and CDC senior staff on the activity, authorities gave permission to the project team to conduct the PIBA in Kunming.

## **Methodology**

The PIBA team in China included a program officer from the project’s China office, three researchers from the Medical College of Kunming School of Public Health, one PLHIV (who subsequently got a full-time job and had to withdraw from the team), and the team leader from Washington, D.C. In Kunming, the team used the policy implementer interview guide for government staff in leadership or administrative positions and the program implementer guide for government staff providing services; NGOs operating under the supervision of government departments; INGOs, such as the Salvation Army or the Clinton Foundation; and bilateral donor implementing agencies, such as Health Policy International. As part of the overall activity methodology, the China team adapted the interview guides to include specific questions related to access to ART for and by IDUs.

After training on the activity methodology, the team met with partner organizations to introduce them to the activity, seek their comments and questions on the methodology, and ask for names of potential informants to interview. The team then conducted four field-tests of the interview guides and one focus group, revising and finalizing the guides based on these experiences.

From April to September 2007, the team interviewed six policymakers (2 women and 4 men) and 14 program implementers (6 women and 8 men). In addition, it conducted five focus groups with a total of 47 participants (20 women and 27 men). The policymaker interviews lasted 30–90 minutes and the implementer interviews lasted 60–120 minutes.

## **Key Findings**

### **Motivation**

The answers to questions exploring motivation clustered around several themes: the motivation of government agencies to work together; the motivation of hospitals and healthcare providers to provide care and treatment to PLHIV, especially IDUs; and the motivation of PLHIV and IDUs to seek care.

*Different policy priorities.* Data revealed that, while the government in Yunnan is working hard to implement a multisectoral approach to the epidemic, not all government departments or communities see

HIV as a priority. Several informants thought that the PSB, while acknowledging the severity of the HIV epidemic, still considers IDUs as criminals and prioritizes compliance with the Yunnan anti-narcotics “no tolerance” policy.

“The PSB do not collaborate well with the BOH and organizations like INGOs working with IDUs and other MARPs and there is little incentive for the PSB staff not to arrest sex worker[s], IDUs and even peer counselors doing community outreach. The PSB does not get funding to deal with MARPs, but rather gets funding from the government to build detoxification centers. The Bureau has little incentive to work with the health, social services, or education sectors, since it is a vertical agency.” —Policymaker in Yunnan

At the community and commune levels, program implementers received many policies from the government level above them but lacked the staff, funding, or expertise to implement all of them. Thus, communities and communes may have prioritized other issues rather than addressing HIV.

*Economic incentives.* According to respondents, hospitals had little incentive to provide care to PLHIV. With the decentralization of the health system and the requirement that hospitals raise most of their own revenues, hospitals were focused on generating funds. The Public Health Law stipulates that hospitals cannot refuse treatment to patients, but respondents said that hospitals report having insufficient funding for HIV-related services. In addition, hospital officials were concerned about accepting AIDS patients, as they may prevent other patients from coming to the same hospital.

*Structural/institutional barriers for PLHIV.* While the FFOC allows for economic support for PLHIV living in poverty, the system that establishes poverty status is complex and overwhelming for many people, as it entails interacting with multiple government agencies. To obtain a poverty certificate, people must document their HIV status and local residency. PLHIV fear stigma and discrimination in reporting their HIV status, as their confidentiality is not guaranteed by non-health-related departments involved in the process, such as Civil Affairs. Furthermore, many MARPs do not have documents proving local residency because they have immigrated to Kunming to seek employment. It is a difficult bureaucratic process to transfer the document from one’s native village to Kunming—a transfer that many PLHIV cannot negotiate.

As revealed through focus group discussions, MARPs and IDUs were not inclined to seek treatment, even when familiar with the FFOC policy and knowing that ART is free. They reported not seeking treatment due to a lack of money to cover costs not included under the FFOC, such as treatment for OIs, CD4 counts, and viral load testing.

Furthermore, the policy of the PSB to arrest and detain IDUs for long periods can work as a negative incentive for IDUs to seek whatever drug dependency treatment is available in hospitals and specialized clinics.

*Gender related to services.* When asked about possible differences in men’s and women’s access to ART, most policymakers thought that there were no gender differences. Other informants said that more men accessed treatment because the majority of PLHIV and IDUs are male. While most program implementers acknowledged differences based on gender, they usually had not made specific adaptations to their programs to address these differences. When naming specific challenges men and women face in accessing services, most respondents said that men had less stable jobs and incomes but were more willing to seek services, whereas women were less likely to disclose their serostatus and had domestic responsibilities that clinical service schedules did not accommodate.

Focus group findings support the implementers' observations. In a separate group for men, participants acknowledged that access to ART was difficult due to their unemployment and the stigma they experience as IDUs. Women's group participants said that their access was reduced due to their lower social status and that they had more problems with their families than men. For example, accessing treatment takes a lot of time, and women had difficulty spending that much time away from home without their status being disclosed to their families.

In the combined gender focus groups, men and women disagreed about the impact of gender on access to services. For example, a man argued that accessing ART was the same for men and women, whereas a woman disagreed, saying,

“We face extra issues. Women's status is different than men's. Government officials are men. Cleaners are women. Women get less information. If a couple [are] both positive and [the] family [has] treatment for only one, definitely men will get priority for ART because of traditional culture. Family members are PLHIV. Men are taken care of by family but for women, PLHIV families don't take care.” —Female focus group participant

### **Information**

*Knowledge of the policy.* To successfully implement a policy, those involved in operationalizing it need to have sufficient information. This includes knowing with whom to work and the appropriate beneficiaries of the policy. Data show that all policymaker and program implementer informants were familiar with the FFOC policy and could accurately state what it provided. However, some participants in the focus groups did not have a good understanding of what it provides. For example, one participant reported being angry after being told at the hospital that he had to pay for treatment for an OI. While he thought the staff was denying him care, they actually were complying with the policy.

PLHIV and IDUs who do know about the policy need more information about how to navigate the system, including knowing those connected to organizations doing direct outreach. Focus group participants reported not knowing who to go to at a specific hospital and not being advised on the full costs of tests or treatment.

Interview informants and focus group participants alike felt that the general community was not well informed about the policy. This was especially problematic when PLHIV went to hospitals for treatment and found that they had to pay for diagnostic tests and non-antiretroviral (ARV) medications. This situation created anxiety for the PLHIV and their families because many are too poor to be able to afford healthcare. The situation also was stressful for healthcare providers—some of whom have been abused by clients because they could not provide all care for free.

“It is a good policy, but when it comes to the practical implementation at the grass roots, it is problematic. For example, one of the big problems is the treatment fee for patients. The policy stipulates that ART treatment is partially free, and this makes the practical implementation difficult. In some occasions, our personal safety was threatened by patients and their relations when we could not offer completely free treatment.”—Hospital personnel

*IDUs and treatment.* Several policymaker informants reported a shortage of qualified staff to offer ART to PLHIV or treat their opportunistic infections. More specifically, there was a shortage of qualified staff familiar with providing ART either to actively using IDUs or those no longer injecting.

Informants were almost unanimous in their support for providing ART for PLHIV. However, only two of the 67 informants agreed that actively using IDUs should be offered ART. Informants were concerned that these individuals would not be able to adhere to ART and would prioritize drug use over looking after their health. Focus group participants were able to relate only two success stories when asked if they knew of any actively using IDUs adhering to ART. While participants offered suggestions for improving adherence, such as cell phone reminders, alarm clocks, and peer supporters, few focus group participants thought that these methods would work for actively using IDUs. The participants expressed discriminatory attitudes toward actively using IDUs, describing them in negative terms.

### **Interaction/Power**

Policy implementation is influenced by the relationship of organizations and their various target groups. For example, for a national policy, the provincial government is considered a target group. As an implementing organization for the national policy, the provincial government's target groups include district- and commune-level government cadres and PLHIV, the intended policy beneficiaries. Because actors have different levels of authority over other actors, interaction among them may be characterized as collaborating with each other, working in opposition, or making efforts to learn how to improve collaboration.

Most informants in China felt that cooperation between government departments had greatly improved as a result of the FFOC. They felt that the number of departments recognizing that HIV is not just a health problem and acknowledging that it was appropriate to network and coordinate with other departments had increased.

“Now we all can cooperate. Before Four Free One Care Policy, [the] task was only for [the] Health Department but now more agencies [are] involved. Before, I worked at the Division of Medical Administration but did not know how our work was related to other departments. Now we all work together.” —Chinese informant

However, respondents reported some disagreements among organizations with responsibility for implementing the FFOC. For example, while the CDC and BOH have systems in place to protect PLHIV's confidentiality, other departments do not. PLHIV have reported being afraid to apply for the allowed subsidy because the Department of Civil Affairs does not guarantee their confidentiality. Several informants said that there have been discussions with the department to resolve this problem, but a solution has not been found.

Some collaboration is more complex, as policies from the BOH and PSB often conflict on issues such as HIV testing of detoxification center detainees and treating PLHIV in the centers. One key rule of the Chinese system is that units of the same rank cannot issue binding orders to each other, sometimes resulting in poor collaboration between these and other agencies because ministries may have different priorities. Many informants mentioned the challenge of coordinating policies among bureaus as the most pressing barrier to policy implementation, complicating treatment for PLHIV, particularly IDUs. The lack of coordination between PSB and BOH policies makes it difficult for government and community-based organizations and other groups to reach out to MARPs—especially IDUs—to provide them with prevention, care, and treatment programs.

“According to the state policy, PLHIV should be informed of their status, but judicial departments don't allow us to inform PLHIV in detention center[s] and detox center[s] when inmates are tested to be positive. PSB believe[s] that will have an impact on their management of inmates. After negotiating with PSB, they have agreed that we can

inform PLHIV just before they are discharged from the centers. But still the work is not satisfactory, and follow-up visits are difficult.” —BOH official

### **Other Findings**

*Resources.* Most informants spoke positively about the Chinese Government’s growing commitment to address HIV, especially in the last three years. While the central government has made numerous changes to policies, provinces and localities are struggling to keep up. A majority of informants said that, even with increased central government support, there is insufficient funding to implement the FFOC. One informant noted that it is difficult for local counties to ensure funding, due to shifting priorities and constrained budgets. As a result, funding is not dependable because it relies mostly on central government funds and international donors’ support. Thus, several informants were concerned about sustainability.

“As for the work, the major problem is financial difficulty. Many patients need reduced or free charge of treatment, especially on OI, but we are incapable of supporting them. As for the treatment technique, we are unable to provide treatment and test[ing] on some cases, and we have to refer them to superior hospitals to confirm our diagnoses. Moreover, different patients may have different kinds of OI, and our doctors have to rely on their personal clinical experience to make diagnoses. As for the administration, upper officials don’t attach importance to our work, and we often work without any administrative support.”—Hospital personnel

Informants also discussed a lack of human resources. Programs need not only more outreach and peer counselors but also more doctors trained in provision of ARVs, management of IDUs on methadone maintenance programs, and ART with active and inactive IDUs. In addition, program implementers said they occasionally were short of supplies and equipment.

*Stigma and discrimination.* While several informants stated that stigma and discrimination (S&D) against PLHIV had decreased significantly in the last few years, most felt that stigma and discrimination are still extensive among policymakers, healthcare providers, communities, and even PLHIV themselves. PLHIV react to stigma and discrimination with a fear of arrest when they seek out prevention programs or treatment for OIs or HIV. IDUs generally experience S&D as a result of their drug addiction; HIV-positive IDUs are doubly stigmatized. The policy of disallowing treatment for detoxification center detainees for curable OIs and access to life-extending ART exemplifies the level of S&D faced by HIV-positive IDUs. With actively using IDUs, S&D results in denial of ART. Patients eligible for ART but still actively using drugs may not be honest with healthcare providers, realizing that such honesty may make them ineligible to access ART. Having labeled actively using IDUs as untrustworthy, the system creates the conditions in which IDUs have little choice but to be dishonest, thus catching them in a double bind.

*Policy development.* In assessing the policy development process, informants reported that there were no discussions on gender or how women’s and men’s unique challenges may affect access to services provided by the FFOC.

“Fewer women participated. Men are leaders, less women work in government. Women’s education, abilities are lower due to traditional ideas; they take less initiative. Some people do not pay much attention to women. It is a universal phenomenon, even in America. Not just a Chinese problem. It is a universal problem. In general, women are not involved in policymaking... If you are not capable, no need to attend meetings. At higher level[s] of government, there are fewer women. Women do not study policy in university.”—Informant

When examining the greater involvement of people living with AIDS (GIPA), data show that, for the most part, PLHIV are included at the policy level, albeit in minor ways, such as giving testimony or being invited to meetings in which they contribute little to decisionmaking. Several informants noted that, because NGOs are not run by PLHIV or MARPs, government staff who provide services or other kinds of support to PLHIV and IDUs speak “on their behalf.”

## Conclusions

Results from this activity in China show that the response to the HIV epidemic has largely been a medical one applying technological solutions. There is still no widespread understanding that high-risk behavior is embedded in the social and economic environment. People at risk for HIV need education, employment, and opportunities to choose a different path than the one leading them to engage in high-risk behavior. There still is little understanding that IDUs and many other PLHIV would benefit from community-based approaches that reduce barriers to accessing treatment. These approaches could include combining different kinds of services at easily accessible sites and supporting adherence strategies through peer counselors, directly observed therapy, and innovative reminders. High-risk behavior also can stem from gender norms. For example, if society views drug use as part of masculine behavior, men may be more likely to become IDUs. In this activity, several informants mentioned that they had never really thought about gender in terms of policy and access to services and would need to do some research to understand this aspect better.

Given the significant policy changes the government has made to promote prevention, care, and treatment programs in China, it is possible that a truly multisectoral approach—one that reduces barriers resulting from conflicting policies between departments of health, public security, and civil affairs—will be realized so that the promise of the FFOC can become a reality. The solution to these policy conflicts depends on understanding and appealing to the values and priorities of actors who are central to the success of FFOC but not yet convinced that the policy and its goals are under their mandate and contribute to their own goals and objectives. Stakeholders must advocate at the highest level of the Yunnan Province government to bring together men and women living with or at risk for HIV and the bureaus most closely involved in containing drug abuse and HIV transmission. Until this collaboration is truly established, developing treatment guidelines or tailored capacity-building approaches for service providers, communities, and PLHIV are unlikely to result in widespread access to treatment for IDUs—the people most severely affected by the HIV epidemic in Yunnan Province.

Collaboration might improve if stakeholders can work to understand the PSB’s incentives<sup>3</sup> to collaborate. There is an urgent need for high-level discussion and negotiations to reconcile a limited number of policies so that implementers can scale up treatment and outreach work. Because the national anti-narcotics law is unlikely to be changed in the foreseeable future, finding common ground on the laws’ interpretations might be an achievable goal. For example, officials could (1) agree that carrying a needle and syringe or condom is no longer evidence of drug use or commercial sex; (2) relax the legal punishment for drug use, while toughening the punishment for cultivation of drug-producing plants, trafficking, and manufacturing; or (3) develop mechanisms by which BOH staff could provide ART to a limited number of detoxification center detainees and methadone maintenance treatment clients. These treatment sites could undertake operational research to provide information to all bureaus involved in the FFOC as to how best to provide ART to IDUs and secure good adherence; this, in turn, could lead to the revision of unfavorable policy components.

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<sup>3</sup> Incentives do not refer only to monetary rewards, which are not always available. Other incentives, such as technical assistance and public recognition of an organization’s contribution, can be effective. It is important to understand what an organization values and may consider an appropriate incentive.

# Indonesia: Analysis of Barriers to Implementation of 100% Condom Use Policy

## Country Context

As is the case in many countries, policy implementation remains a challenging area for HIV efforts in Indonesia, where many economic, environmental, and social issues vie for policymakers' and program implementers' attention and action. Prevention has been a prominent concern in Indonesia's national HIV policies and strategies. The new *National AIDS Commission 2007–2010 AIDS Response Strategies* exemplifies this concern, with a specific endorsement of 100 percent condom use as a critical component of prevention efforts related to high-risk sex.

All policy implementation has been fundamentally altered by Indonesia's initiation of decentralization, beginning in 1999, when two laws transferred substantial responsibilities to municipal- and district-level governments. Thus, districts and municipalities have become the administrative units responsible for providing key government services. Further amendments to the Constitution in 2002 stipulate that each province, regency, and town have regional governments regulated by law. These regional governments can regulate and administer matters of government. The Ministry of Health reserved for itself the tasks of "exercising functional control and supervising the planning and use of resources," while at the same time indicating that districts were accountable for the planning, implementation, and supervision of health services and provinces were responsible for supervising policy implementation and handling activities "beyond the scope of districts." While the roles and responsibilities of district, provincial, and central health authorities have yet to be finalized, local governments currently have authority for implementing health policies and programs because districts own and operate health centers and public hospitals and are responsible for supervising most health staff (Lieberman and Marzoecki, 2002).

The Provincial Government of East Java has endorsed several *perdas* related to HIV prevention: Perda 7/1999, which forbids the use of buildings as brothels (among other provisions) and 5/2004 on HIV Prevention and Mitigation, which mentions 100 percent condom use—although the language is vague. For the policy statements outlined in the national strategy to be implemented at the municipal level, the city government must develop *perdas*, which include the operational guidelines for regulators and program implementers. The *perda* can be implemented with the approval of the mayor. In Surabaya, a draft *perda* was developed in 2004, but no further progress has been made to finalize it.

Under the PIBA activity, the Health Policy Initiative, with additional funding from USAID/Indonesia, collaborated with the FHI Aksi Stop AIDS (ASA) Program to address factors constraining HIV-related policy implementation. In August 2006, project staff met with ASA regional directors to discuss the most important policy issues they face in implementing their programs. The majority of the directors stated that prevention, particularly implementing the 100% Condom Use Program (100% CUP) endorsed in the Indonesia National HIV/AIDS Strategy, was a key priority. Few municipalities had approved local legislation required to operationalize the program. In further discussions with ASA, the project team identified East Java, including the three priority districts of Surabaya, Bangyuwangi, and Malang, as a target district for analyzing barriers to implementation of the 100% CUP, due to its high HIV prevalence. The project team decided to examine why ordinances that support implementation of HIV prevention had not been approved in Surabaya, given that prevention is a priority endorsed at the highest levels of national government.

## Methodology

Project staff and consultants from the Atma Jaya Catholic University in Jakarta conducted structured interviews in Surabaya from December 2006 to February 2007. The team interviewed nine policymakers, 14 program implementers, and 11 brothel staff or managers. To obtain information from the target group, the research team conducted five focus group discussions with 38 sex workers, clients, and brothel managers to learn more about their perspectives on HIV prevention and condom use. The team designed interviews to better understand the

- Existing policies that support HIV prevention and 100% CUP in Surabaya;
- Barriers to implementation of 100 percent condom use policies and programs; and
- Activities the local government and NGOs have initiated to promote condom use in direct and indirect sex work.

## Key Findings

### Motivation

When asked about HIV as a priority for informants' organizations and collaborating organizations, most survey participants said that HIV was not a priority for most officials at the provincial, district, or city levels. A majority of policymaker informants stated that it was more important to focus on poverty alleviation programs, programs that generate income for the district, or other concerns, such as avian influenza. Only a few informants seemed to recognize the link between poverty, the sex industry, and HIV-risk behaviors.

When discussing the provincial *perda*, informants mentioned the clause on fining those who intentionally infected others with HIV; many informants stated that it would be impossible to monitor this provision, as it would cause disruptions in brothels. Several informants mentioned that 100% CUP was not a priority because it might disrupt the way the brothel industry is run, as the local regulation mandates a fine for not using a condom. Brothel managers and sex workers had little motivation to insist on condom use. In fact, they had an economic disincentive to do so voluntarily, as clients easily can go to another brothel or entertainment site (massage parlor, karaoke club) where condom use is not required. In addition, community members themselves did not want to see brothels closed. Many were dependent on the brothel areas for jobs, given the limited opportunities in such disadvantaged neighborhoods. For these reasons, implementing the *perda* was perceived as potentially disruptive to business. Finally, respondents believed that community leaders did not want brothel complexes to have disputes with each other.

Clients also were not motivated to use condoms. A program manager who worked in HIV prevention noted that clients did not try to learn their HIV status. A participant in a focus group with seamen from a freighter stated that he should receive some sort of compensation, such as a free drink, if he is willing to use a condom.

Currently, no government organization is accountable for implementation of the CUP. When asked about the *perda*, informants at the Health Office said they did not have a mandate to implement it. Brothel owners and managers claimed that they had a limited role in ensuring condom use. Most informants said that others had to take the lead. Given the intense competition within the *lokalisasi* (brothel area), the municipal government is the only sector with the authority to coordinate implementation of a 100% CUP.

**Morality/Legality.** Some officials expressed concern about supporting HIV prevention, believing that their constituents would think they were supporting illegal or immoral behavior. Many informants mentioned that, because brothels are illegal, it would be difficult to implement the CUP, as the sanctions in the existing regulations applied only to legal businesses. Many of the policymaker informants expressed the

view that if the city officially endorsed 100% CUP, it would be seen as legitimizing or legalizing sex work.

### **Information**

*Existing policy.* One of the first challenges to implementing a policy is learning about it. Even though the 100% CUP is endorsed as a national policy and at the provincial level, decentralization allows local districts and municipalities to produce *perdas* that address local needs. However, the content of these governments' *perdas* should not conflict with existing national or provincial regulations. A majority of informants stated that the existing policies had not been well disseminated within the government or to communities and NGOs. The program implementer informants reported disseminating the information to their "target groups" when they accessed the services. However, no one reported dissemination to the general public or target groups in different locations, such as port areas, truck stops, and other areas that have sex workers.

Most informants were familiar with provincial *perdas* 7/1999 and 5/2004. One informant noted that Regulation 7/1999 has never been implemented "because the brothels would have disappeared." Several informants mentioned that 5/2004 focused on prevention but was not being implemented because several of the sanctions mentioned in the Perda, particularly the sanction against HIV-positive people not using condoms, would be difficult to enforce.

Informants' knowledge of the entire content of the provincial *perda* was limited, and they tended to mention only the sanctions. Only one informant mentioned clauses in the *perda* that referred to the rights of PLHIV to treatment and protection against stigma and discrimination. If policy and program implementers do not have accurate information about the wording of policies and regulations, it is difficult for them to design, implement, or monitor appropriate programs to support the policy.

*Guidelines.* Without a mayoral regulation, government departments, NGOs, and community leaders lack a unified plan for implementing a 100% CUP. Hence, most informants stated that they did not have appropriate information about this policy. They also had conflicting opinions about the availability of operational guidelines to implement a 100% CUP. Several program implementers mentioned that they did have guidelines developed by their own organization or international NGOs for providing their services, such as treatment for sexually transmitted infections or community outreach programs.

Respondents indicated awareness of which organizations have a role in implementing programs and mentioned that there is a well-established forum for regular communication and exchange of information. When asked for the name of the lead organization responsible for the 100% CUP, most policymakers mentioned the Health Office, as did program implementers; the implementers also suggested the municipal government, private sector, Office of Social Welfare, and the Provincial AIDS Committee (KPAD) BPKN.

*Transfer of staff.* Survey respondents cited staff turnover—through transfers among departments—as a key issue related to policy and program implementation. Given this high rate of turnover, which happens every 2–3 years, knowledge of the HIV programs—and, more important, of previous advocacy efforts for implementing prevention and treatment programs—also are lost. In addition, KPAD membership is linked to specific government posts and is not related to the staff concerns for, or expertise in, HIV. If the head of the KPAD is not interested in HIV, the committee may meet infrequently. To disseminate information to all 11 government departments that constitute the multisectoral KPAD, information must move from the committee meetings to the staff's home departments. Dissemination of information by staff who are tasked to the KPAD but do not see HIV as a priority may reduce the likelihood of accurate or timely information reaching those with a role in implementation of HIV prevention programs.

## **Interaction/Power**

When asked about interaction between organizations, informants had positive responses. They reported good collaboration among international and local NGOs, donors, and a limited number of government agencies, such as BKKBN (National Family Planning Board), Putat Jaya (a satellite public health clinic located near a brothel area), *puskesmas* (community health clinics), and Muspika (government coordinating group). NGOs generally reported good collaboration with other NGOs, as they focused on capacity building to create a foundation for a sustainable, long-term local response. Many of the NGOs received most of their funding from donors and INGOs.

However, program implementers reported difficulties in collaborating with more powerful stakeholders, such as neighborhood authorities and brothel managers. Currently, coalitions of individuals and groups supporting the 100% CUP do not have as much power as the groups opposed to the policy. They have not yet found ways to motivate opponents or those taking a passive stance to support any nascent efforts by the local governments. Coalitions supporting the policy have yet to craft advocacy strategies that reposition condom use as a prevention of harm rather than an endorsement of inappropriate behaviors.

## **Other Findings**

### **Resources**

*Donors.* Most informants said that the local government and donors were their primary sources of funding, with the majority dependent on donor funding, especially from USAID. Policymakers mentioned that funds were provided by the local government to cover costs of ART and other services for PLHIV. Although the amount of funding may vary from year to year, based on the local government's priorities, funding for HIV prevention had been fairly reliable, according to most informants. Donors also contributed some additional funds, which were used to buy computers and set up data-sharing systems among the clinics.

*Financial.* Only two program implementers said that they had insufficient funds; they were from small NGOs serving men who have sex with men (MSM) and transgender sex workers (*waria*). The *waria* NGO informant said that its members often are very ill by the time they ask for help, so the NGO would like to provide healthcare services, food, and other necessities not funded by donor programs.

*Materials.* Most of the program implementers said that they had enough supplies, especially condoms. However, sex workers reported that community health clinics were not providing them with enough free condoms. During focus group discussions, sex workers and brothel managers said that each sex worker got one condom from the clinic when they went for a checkup, even though some had more than one client a day. Several focus group informants mentioned that the brothel managers require sex workers to buy a condom from the brothel (with a markup on the price) if the client stays overnight. For these clients, condom use was a "requirement." Condom use was still a "requirement" with other customers but harder to ensure if the client refused. Sex workers had to buy condoms in the brothel or at a kiosk or ask the client to buy them.

The brothel managers in the focus group said they agreed to collect condoms from NGOs or *puskesmas* and distribute them in their brothel in an effort to support 100 percent condom use. One participant said he had distributed (sold) 3,000 condoms in one month to the 70–80 sex workers in his brothel—some of whom had customers stay the night. Another said he had distributed 900 condoms in the last six months. However, there were reports that clients often do not want to use condoms. As one participant said, "We do the dissemination seriously, but the fact is from the side of the customer, not from the side of the sex worker, there is a low response [from the client]."

## Policy development

Informants explained that, in 2003–2004, the Health Office collaborated with NGOs working on HIV to draft a city-level regulation on HIV prevention, including 100% CUP. The draft *perda* then was launched as a provincial *perda* in 2004 (Perda No. 5/2004). Only three program implementers reported that their organizations had been seriously involved in developing the local regulation. “We did an extensive lobby that took three years. In the end, the ones who were ready to develop a local regulation were in East Java [not in the City of Surabaya].” Others reported being invited once to a meeting or being asked to provide comments on the regulation after it was drafted.

*Gender.* In looking at the issue of gender as related to policy development, policymakers clearly did not consider the specific needs of women or men. The provincial *perda* does not specify such needs. Most policymaker informants noted that few women participated in the drafting of the *perda* because “In terms of numbers...there are more men on the committee.” A few women from NGOs were included in some meetings because they are the ones who work on these issues, according to informants. Most informants felt that men and women were equally at risk for HIV infection, and only one mentioned that there may be gender differences related to that risk. As one participant noted, “Although there is a condom-must sticker [in the brothel], the decision [to use a condom] is in their hands. The customer/user and the sex worker. If the man refuses to use condom, it is up to them, because no one can forbid them.” This participant went on to say that the decision to use a condom is really in the hands of the customer: “Actually some sex workers are aware that they are under threat of the dangerous disease. It means that there were customers who would be refused when they were not willing to use condoms...In the end, the offer [to use a condom or not] is from the men; she was ready without [a] condom.” A more common response was that the Constitution provides for gender equality, so naturally the local regulation does not discriminate based on gender. For the most part, respondents such as this policymaker indicated that, “This is not a man’s issue, it’s not a woman’s issue, but this is everyone’s problem, because there is no gender division.”

However, several informants recognized that sex workers do not always have enough bargaining power with their clients on condom use; two informants mentioned that sex workers may experience gender-based violence if they request condom use. A focus group discussion with sex workers validated this; participants mentioned experiencing violence if they try to insist on condom use. Despite these observations, survey respondents did not think gender was an important issue to consider when developing the 100% CUP and implementing the program. Most informants felt that making condoms more widely available in brothel complexes would benefit men and women alike.

*Greater Involvement of People Living with AIDS (GIPA).* According to informants, the involvement of PLHIV in policy development or dissemination was limited. NGOs working on behalf of IDUs, MSM, sex workers, and PLHIV were invited to the discussions, but it was unclear from our informants’ comments whether any individuals from these groups actually participated in any meaningful way. A few informants said that PLHIV were asked to “give information” or “give testimony” but were not involved in more substantive ways. Many informants suggested that MARPs and PLHIV were not involved because “High-risk groups were difficult to invite to participate because people were still covering it up [their status].”

*Stigma and discrimination.* In many countries and communities, S&D against MARPs influence the level of public and private sector leadership, commitment, and action taken to implement comprehensive HIV and AIDS prevention, care, and treatment services. In Surabaya, where the epidemic is concentrated among marginalized populations of sex workers, clients, MSM, and IDUs, lack of action on the 100% CUP might be due to S&D. However, interviews did not provide much insight into this issue. While some policymaker respondents stated that S&D had decreased over the past few years, none of the program implementers agreed with this assessment. They also believe that fear of S&D delays people from seeking

prevention and treatment services and social support. Several informants suggested that much more “correct” information about HIV needs to be disseminated to the general public and healthcare providers as a way to reduce S&D; this dissemination should be done through the media and socialization at schools and religious institutions.

## **Conclusions**

One major challenge to HIV prevention in Surabaya is creating a mayoral regulation quickly, so that officials can develop operational guidelines and procedures to implement the 100% CUP and put them in place. Government organizations responsible for ensuring the implementation and monitoring of HIV prevention programs, including 100% CUP, have little motivation to do so. While NGO motivation is high, these organizations have no authority to develop incentives or sanction actors who do not collaborate appropriately. Without a mayoral regulation, implementation of 100% CUP will not happen.

The provincial *perda*, based on a draft written by predominately male district and provincial committees, generally is blind to gender differences in HIV-risk behavior or decisionmaking about condom use. This influences the ways in which both policymakers and program implementers discuss condom promotion and use. The majority of policymaker and brothel manager informants put the responsibility for condom use on sex workers’ ability to persuade clients to use condoms, even though they recognized that this ability often is undermined by the worker’s economic need or the client’s threats of violence. This government inaction places the burden of complying with condom use on sex workers, rather than making it a shared responsibility among government, brothel owners, communities, sex workers, and clients. Despite efforts by sex workers and some brothel managers to “encourage” clients to use condoms, only a *perda* will have the authority to cover a wide geographic area, reducing the client’s ability to cross the street to a competing brothel where condom use is not “encouraged.”

Barriers to implementation of the 100% CUP in Surabaya reflect the axiom that “all politics are local.” Coalitions opposed to or neutral about its implementation (some government staff and religious leaders) are much more influential than the weak coalitions that support it (the NGO sector). Without greater coalition strengthening among supporters, resistance by those in opposition is preventing wider action.

Advocates supporting the 100% CUP must be nurtured at all levels of government and within civil society, NGOs, and affected communities, so that the loss of a few advocates due to transfer or relocation does not result in a collapse of the activities supporting the program. It is critical to find incentives that will increase the motivation of government departments and sex industry stakeholders to work together to reach an agreement around a limited number of means to implement the program, so that government departments with a direct role in implementation and monitoring can lead the effort.

Without greater motivation for local district and municipal government agencies to lead the effort to pass a local *perda* on HIV prevention and manage prevention programs, the likelihood of a successful 100% CUP implementation in Surabaya remains low.

## Vietnam: Assessing Implementation Barriers to Decision 65— Community-level Reintegration of OVC

“For the whole nation, regardless of the dissemination of this Decision or not, the problem is how to bring solutions down to the community. Now even with the [new] policy, but without means to implement it, without solutions for its execution, how can it be enforced?”—National-level policymaker (male)

### Country Context

As in other Asian countries, Vietnam has a concentrated HIV epidemic. While overall national prevalence remains low—less than 0.27 percent<sup>4</sup>—certain provinces face high levels of infection among injecting drug users and sex workers. In August 2007, the cumulative number of reported cases was 128,367, but the actual number of HIV infections is estimated at more than 300,000. As the HIV epidemic progresses in Vietnam, addressing the needs of children with and affected by HIV is becoming urgent. Vietnam has an estimated 283,000 HIV-affected children and about 8,500 children with HIV. The number of HIV/AIDS orphans is about 20,000 out of a total 150,000 orphans in the country. About 15,000 orphans are currently in institutional settings in Vietnam (UNICEF, 2004).

Gaps in policy implementation related to OVC have led to an overemphasis on institutionalization of children with and affected by HIV/AIDS. As a result, alternative care programs, particularly at the community level, are underdeveloped. Institutionalizing children increases their isolation, often resulting in psychosocial problems. In addition, the current approach of institutionalizing OVC explicitly and implicitly compounds stigma and discrimination against children and families, as they do not always have access to social and educational services and resources. For example, there are numerous accounts of HIV-positive or affected children being denied access to public schools.

For these reasons, Vietnam has acknowledged the need to develop new policies to provide alternate models to institutionalization, most notably, through the passing of a decree, Decision 65, in March 2005. This decree calls for the reintegration of OVC into communities as a conscious effort to reduce institutionalization.

*Decision 65 and Decree 67.* In Vietnam, Decision 65 is the National Plan of Action on “community-based care for children in especially difficult circumstances in the period 2005–2010.” Approved in March 2005, it was followed by Decree 67, which outlines a detailed implementation plan, along with the necessary budgetary allocations. Prepared by MOLISA and the Ministry of Finance, Decree 67 was formalized in August 2005 as an “interministerial circular” that provides “guidance for the implementation of Decision 65.” Decision 65 has the following three major aims:

- Increase the number of children in especially difficult circumstances (CEDC) being cared for by the community from 30 percent to 55 percent by 2010;
- Pilot a new model that moves 1,000 orphans and seriously disabled children from state protection centers into the community (i.e., incorporating one of the following: family, individuals, those who want to adopt, guardians, and the “Social House.”) (Social House is a new model managed by the Commune People’s Committee); and
- Pilot a new “community care model” for CEDC care as opposed to the previous “centralized care model.” The model will be piloted in 10 social protection centers in 2005–2007 and replicated in 2008–2010.

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<sup>4</sup> Chu Quoc An, Vice Director of the Vietnam Administration for AIDS Control, reported in the Dan Tri e newspaper 20/03/2007 <http://www1.dantri.com.vn/suckhoe/Viet-Nam-Ty-le-nhiem-HIV-van-rat-cao--/2007/3/171428.vip>.

## Methodology

In implementing the PIBA tool in Vietnam, the specific objectives were to

- Map the process of policy implementation of Decision 65 in Hanoi;
- Assess barriers to the implementation of Decision 65;
- Develop strategies based on the data to overcome implementation barriers to reintegrating OVC into communities; and
- Use and apply study findings to the development of the NPA for children.

The activity team conducted 31 in-depth interviews between April and October 2007. Of these, nine were with policymakers and 22 with policy implementers. The team also conducted four focus groups (2 with caregivers of children affected by and with HIV, 1 with a PLHIV support group, and 1 with parents at the commune level). The focus groups provided an opportunity to understand and learn about the barriers to OVC care from the perspective of caregivers living in the community. Focus group participants were mostly female caregivers and all participants were PLHIV.

## Key Findings

### Motivation

*Individual.* Understanding an individual's motivation to implement a policy is as important as an organization's commitment or mandate to execute the policy. Individual motivation is vital, as organizations constitute a large number of people that must work in tandem to implement policies effectively. Motivation to implement Decision 65 at the individual level varied across various stakeholders. This motivation was highest in the stakeholders interviewed from the international and local NGOs and teachers.

*Institutional.* When asked to rank the importance of implementing Decision 65 at their organizations on a scale of 1–10, almost all participants gave a slightly lower score to the organizational ranking compared to their individual motivation levels. There is considerable variation in motivation at the organizational level as reported in the in-depth interviews. Overall, data indicate that study participants from the national government and international NGOs felt that motivation to implement Decision 65 was high in their organizations. Respondents from the Hanoi provincial government and journalists revealed low levels of organizational commitment.

*Community.* As Decision 65 relies on communities to support alternate models of care for OVC, the motivation level of the community is important. Many stakeholders expressed reservations about the community's readiness and preparedness to accept OVC, pointing to S&D against these children. Stigma creates fear that the community is at risk of HIV infection from these children. A manager working for a leading international NGO raised the question of whether children are more vulnerable in the community than in institutional settings.

“From the community perspective, they may have to accept children they do not want. So, then children will be more vulnerable (at the community level). At the institutional level, they still have friends..... are cared for and loved by caregivers. If they are brought back to the community, then who will look after them and who will show concern for them? It is not mentioned yet [in the policy...] what their daily living conditions will be.”  
—Manager from Implementing INGO (female)

Many participants discussed the need for communities to prepare for the integration of children living with and affected by HIV. According to a senior provincial policymaker, communities must be convinced that this move is in the best interest of society, as they may believe it is the state's problem:

“But it is not easy in terms of feasibility, since in the mind of the community, they think that it is the state's work. So step by step we have to work how to make community think that the support to these targets is also for enabling a sustainable society and social security development, and so we need the community participation for the community development. Only when we reach to that level like that the feasibility of this decision is reached.”—Senior provincial policymaker

Several participants highlighted the crucial fact that the community is the main implementer in Decision 65. For this reason, community-level approaches are vital to identifying, settling, supporting, and monitoring the OVC reintegrated into communities.

### **Information**

In examining implementation barriers, it is important to assess how policy-related information is disseminated and understood at multiple levels—government, nongovernment, mass organizations, and community. If any of these stakeholders lack policy information, their ability to implement the policy is limited.

When asked if they had heard about Decision 65 and understood its intent, just over half of the participants stated that they were familiar with the decision, but this was the case with policymakers more than program implementers. This indicates that, among study participants, program implementers had much lower levels of awareness of Decision 65 than policymakers. Of the participants who had heard of it, several said they were not clear about its contents.

Interview respondents had a wide variety of information sources related to this decision. Policymakers who participated in its development said that a policy is available for the individuals responsible for the related work and those are the people who are supposed to read it. However, every decree also has an outlined dissemination and propaganda strategy. A deputy director stated that the mass media plays an important role in disseminating policies to the people. In reality, however, Decision 65 did not reach key journalists.

The existing system of disseminating policies to the provinces and districts has been described as follows:

- Provinces are oriented to the policy and its guiding documents by the central government.
- Provinces organize similar orientations for their districts and communes.
- Provinces photocopy the documents and send them to the districts.
- The districts then organize similar orientations for the commune level. There are 600 districts in Vietnam.
- The central government sends an assessment team after six months of implementation.

### **Interaction/Power**

Collaboration between organizations at various levels and within different sectors is essential for implementing policies through programs. To assess the level of collaboration, the study team asked participants to diagram their collaborators and the level of collaboration and dependency. Participants reported that their main collaborators were at the national government level, followed by international NGOs. Respondents mentioned provincial government agencies and the media the least, indicating that the density of networks is concentrated at the broader national and INGO levels (see Table 1).

**Table 1. Level I Collaboration by Type of Organization**

Type of Organization*	Level I Collaboration N = 26
National Government	18
International NGOs	16
NGOs/CBOs	13
Mass Organizations	12
Service Providers	9
Provincial Government	8
Media	3

\* Study participants mentioned collaboration with at least one organization in the above categories.

## Other Findings

### Policy development

Informants in Vietnam described policy development as a lengthy, multilayered process. It includes the following steps:

- Assessing the need for a new policy
- Drafting its various versions
- Sending it to provincial levels for feedback
- Returning it to the authorizing ministry
- Sending it for review to other ministries and sectors
- Accepting comments
- Getting experts to review and approve the policy
- Obtaining the Prime Minister's signature

In-depth interviews revealed that the central government and its various ministries are the most crucial actors in developing policies and ordinances, with an emphasis on drafting, editing, receiving feedback, and consolidation. The other actors—provincial governments, service providers, mass organizations, media, communities, and PLHIV groups—play only a peripheral role in policy formulation. For implementation, however, these actors take center stage. In addition, the focus shifts from the national to the provincial level, raising important issues such as program planning, management, and scale up. Communication and advocacy also play a central role in the policy implementation process, as people need to learn about the policy. Therefore, engaging the media, networking, mobilizing community resources, and coordinating with other actors become core functions of the policy implementation process.

### Operational gaps

*Lack of decentralized planning: defined roles, and responsibilities.* Many study participants reported on the absence of well-defined organizational roles and responsibilities for implementing Decision 65; this hindered organizations' ability to play a role in policy implementation. Participants also said that decentralized planning should be focused at the provincial, district, and commune levels.

While Decision 65 has a well-defined guiding document in the form of Decree 67, program implementers asked for more site- or locale-specific plans that go beyond the operating guidelines. In addition, guidance must incorporate clear definitions of tasks and responsibilities for planning at the district level, which then devolves to the commune level. The challenge is to build capacity for decentralized community-based planning in the provincial system.

*Supervision, monitoring, and review mechanisms.* Interview respondents indicated the need for strong supervision and review mechanisms to monitor policy implementation adequately, implying that the relevant mechanisms outlined in Decree 67 have not been operationalized. In addition, people at various levels, from the National Assembly down to the community, expressed concerns regarding supervision. A policymaker from the National Assembly identified the following areas in the existing supervision process as requiring strengthening:

- Providing timely information to members of the supervising team
- Reviewing and systematizing all decisions and regulatory documents for policy implementation
- Creating a process for ensuring that recommendations are implemented
- Finding experts who can provide independent assessments

*Building capacity.* According to several participants, Decree 67 outlines a capacity-building plan for developing social work skills in several cadres. Reintegrating OVC will require an enormous amount of capacity building at the local and community levels. However, one respondent expressed skepticism about providing professional social work skills to people not trained as social workers and who lack access to ongoing professional supervisory support.

### **Stigma and discrimination**

Several study participants cited S&D against HIV as the single greatest barrier to the implementation of Decision 65. Stigma has been defined as an “attribute that is discrediting, reduces the bearer from a whole and untainted person to a tainted, discounted one.” In the context of OVC, responses indicate that the problem lies with the adults rather than children, as parents are reported to have high levels of fear that their children are at risk of acquiring HIV from HIV-positive children in the school setting. For this reason, parents sometimes blatantly discriminate against HIV-positive children, with the aim of protecting their own children.

Respondents included the following examples of S&D:

- HIV-positive children are not allowed in several regular schools. If they are admitted, school officials often require them to sit in separate classrooms and play in separate areas.
- HIV-positive children mainstreamed in regular classes stated that they are hit, left alone, and have no playmates.
- Cleaning staff use gloves when cleaning classrooms.
- Children suspected of having the HIV virus are sent for laboratory tests without the consent of parents or guardians.
- Some families with HIV-positive children are not allowed to have meals with others in the community.
- People are afraid of living near households with HIV-positive children for fear of their own children becoming infected.

There are numerous consequences of these experiences. For example, officials of the Ba Vi Center (institution for HIV-positive children) do not allow these children to attend regular schools. As a result, they put children of different ages together in a single class. In addition, at the community level, children

with HIV often have to attend schools far from their homes if their own communities will not accept them.

Interview respondents also identified the adverse psychosocial effects discrimination can have on children with HIV. HIV-infected or affected children often have little interaction with other children and may be more used to interacting with adults. This emphasizes their feelings of isolation. Finally, parents of children with HIV face extreme difficulties as a result of observing the discrimination their children face. The following conclusions can be drawn from the data on S&D:

- Stigma against OVC is the biggest barrier to implementing Decision 65.
- Stigma stems from parents' high levels of fear that their school-going children are at risk.
- Parents of school-going children are the biggest obstacle to mainstreaming children with HIV into regular schools.
- Discrimination against OVC occurs at the education system, health system, and community levels.
- Fear of casual contact with HIV-positive children and the perceived threat of spreading the virus are key factors underlying the stigmatization of OVC.
- Some service providers (teachers, health professionals) also harbor stigma against OVC.

### **Caring for children with HIV**

*Institutional experiences.* OVC in northern Vietnam often are placed in the Ba Vi Center. As of April 2007, Ba Vi had 34 children, mostly girls, but the gender mix can vary. As the director said, "The issue of gender is not related to the abandonment of a child." In most cases, neighbors or grandparents bring the children to the center if their parents have died and often leave them with a letter saying that the relatives cannot care for them. They cite two reasons, the first being that HIV-positive children require specialized medical care and attention that cannot be provided at the community level. The second reason is the S&D the child and the family would face once the neighbors and community learn of the child's HIV status.

The Director of Ba Vi was unequivocal in her opinion that communities are not ready to accept children with HIV. She said, "Regarding children with HIV, we don't see any move in reintegrating children into the community... I think this decision can be applied only to orphans and not to children with HIV for fear of stigma." She also added that when the center sends children home to their grandparents, the relatives send them back to the center as soon as they fall ill. Grandparents often are not willing or able to look after the children when they are unwell.

*Community experiences.* To implement Decision 65, communities must buy into the premise that mainstreaming CEDC, including OVC, into the community is important. As one caregiver noted, "In general, to bring a child [in]to [a] community is difficult; it requires warm hearts and goodwill, not simply by saying and making a decision [policy] on paper." Some respondents pointed out that OVC do not constitute a homogenous group and that, while it may be feasible to mainstream orphans, the challenge continues for children with HIV.

In focus groups, mothers with HIV mentioned that they received some family support from their in-laws in terms of caring for their children. However, when the children fell ill, this support disappeared and the mother had to assume the role of the main caretaker. Focus group participants expressed concern about who would take the responsibility of caring for HIV-positive children at the community level when they fall sick. A mother with a five-year-old son with HIV said, "The grandparents do small things and I provide care for 24 hours. Sometimes I have to be awake for the whole night...and if he is alright that is fine, but if he is ill, he will not leave me even for a single step. And when I need something to buy, I ask my mother-in-law to buy it for me."

The PLHIV participating in a focus group discussion outlined the community-level problems of caring for HIV-positive children. These include (1) access and adherence to treatment, (2) caring for children when they are ill, (3) the additional time and money needed for care, (4) the additional attention needed in terms of nutrition—HIV-positive children eat less and it takes more time and effort to feed them, (5) the discrimination HIV-positive children face at hospitals, and (6) adults in the community not allowing their children to play with HIV-positive children.

Data show that young children with HIV are victims of stigma from community members, with disastrous consequences. Young children are subject to discrimination from parents, children, teachers, and adults. As a result, the children are, as one focus group participant said, “So sad, [they] play alone and sit alone at the corner, they look like dejected, so what do you do? Sometimes they look so sad that we can’t describe in words and sometimes they look so sad that we feel very sorry.” In addition, at least three of the five caregivers in the focus group felt that the children were too grown up for their age; they bear the burdens of adulthood. A woman described her son, saying, “Like my child looks like a dazed man, always dejected. They all look miserable. They have a very short childhood; they behave like the elderly, like old men or women. Many times they say things that we cannot imagine. Maybe because of discrimination they know themselves and cannot do whatever they want.”

*Support structures in the community.* The experiences of persons caring for children with HIV at the family level indicate that the entire process is an arduous one but is made manageable with support. Focus group participants revealed that there is a range of support structures and services for enabling better care of children with HIV. For example, members of the PLHIV support group “Bright Futures” spoke at length about their efforts to assist families with HIV-positive children. They provide holistic support to families by offering guidance on the health, nutrition, and psychosocial needs of the children. This includes visiting families—especially children—telling them where to access ARV and instructing them on the correct dosage of medicine or possible side effects. This assistance is valuable to many caregivers. For example, a grandfather who cares for his orphan grandson reported encountering difficulties with a hospital when his grandson was ill. When he learned of Bright Futures and a member went with him to the hospital, he learned more about child rights and the AIDS Law. He used this knowledge to argue against transferring his grandson to a different school after the school authorities had him tested for HIV and found out his status. The headmistress of the school told him that she had to dismiss the child because of pressure from parents.

The informal support network provided by Bright Futures addresses the core issue of psychosocial support for both the child and the caregiver. As a member of Bright Futures said, “Caring for a normal child is time consuming and tiring but caring for a child with HIV/AIDS is much more than that. The child often gets sick and has multiple illnesses at the same time. Nothing can compare to the tiredness and patience of the caregivers.” Another important aspect that caregivers mentioned was that they received a lot of training and guidance on home-based care, whereby they learn to care for themselves as well as the children.

## **Conclusions**

Research in Vietnam revealed key differences between policy formulation and policy implementation that authorities must address if they want to maximize the impact of a new policy. In Vietnam, the policy was created and adopted without community support. This support is critical to the success of the policy’s implementation, however. Table 2 presents a summary of barriers to implementing Decision 65 in Hanoi District at the provincial/district, commune, and community levels, along with identified barriers to institutional mechanisms for monitoring and review.

**Table 2: Barriers to the Implementation of Decision 65 in Hanoi District**

<b>Provincial/District/Commune Levels</b>	<b>Community Level</b>	<b>Institutional Mechanisms for Monitoring and Review</b>
Lack of decentralized planning	Lack of an enabling environment	Lack of specific institutional mechanisms for reviewing policy implementation
Lack of motivation to implement policy at the provincial levels	HIV stigma at the community level	Lack of monitoring mechanisms at the national, province, district, and commune levels
Lack of in-depth knowledge of the policy	Low levels of knowledge of Decision 65 and Decision 67 at the community level	Lack of defined roles and responsibilities on how to monitor policy implementation at all levels
Lack of monitoring mechanisms at the community level	General skepticism of community's capacity and capability to ensure mainstreaming	

In Vietnam, the research team was able to hold a stakeholder meeting to present the research findings. In this meeting, participants discussed the findings and drafted recommendations for agencies working at various levels.

## **Stakeholder Recommendations**

### **Provincial, district, and commune levels**

- Build capacity to develop detailed district- and commune-level plans for implementing Decision 65
- Build and sustain higher motivation to implement Decision 65 at the provincial, district, and commune levels
- Establish information channels to ensure the flow of new policies
- Establish a mechanism for sharing pilot results of alternate care models
- Increase collaboration among organizations in the context of policy implementation at and between the national and provincial levels
- Build capacity for establishing community-based approaches and alternate models of care
- Create a mechanism at the level of the MOLISA for coordinating the implementation needs of OVC programs
- Facilitate collaboration at provincial, district, and commune levels (national agencies and international NGOs)
- Add policy implementation to priority agendas (national agencies and international NGOs)

### **Community level**

- Undertake an immediate large-scale campaign on HIV stigma reduction with a focus on the following: (1) how school children are not at risk of contracting HIV if HIV-positive children attend the same school with them and (2) how families and communities are not at risk if HIV-positive children are in their midst
- Initiate a large-scale dissemination of Decision 65 and the benefits of children being in families and communities rather than institutionalized care

- Create an enabling environment in which alternate models of care, such as the Social House, are well established at the commune level
- Mobilize community resources to support the reintegration of OVC into the community

#### **Institutional mechanisms for monitoring and reviewing policy implementation**

- Create a “Policy Implementation Task Force,” including high-ranking officials from the National Assembly, relevant ministries, and INGOs
- Create similar task forces at provincial, district, and commune levels
- Outline roles and responsibilities of the task force clearly
- Define the line of authority and control
- Outline reporting outputs, their frequency, and formats

#### **Recommendations for National Plan of Action for Children**

- Define clear-cut institutional mechanisms for monitoring and reviewing policy implementation, with a mandate from the highest level
- Outline a detailed dissemination plan for the policy, with a focus on provincial, district, and commune levels
- Build in the need to develop capacity for decentralized planning at the provincial, district, and commune levels
- Incorporate Decision 65 and Decree 67 into the NPA instead of redrafting the section on mainstreaming children
- Develop an implementation plan that includes phases for dissemination and campaigns
- Focus on developing support mechanisms for OVC at the community level

### III. LESSONS LEARNED

#### Policy Implementation Barriers Analysis Findings

Findings from the barriers analysis in these three countries indicate that there are common barriers to implementing policies, which can result in ineffective programs. These barriers include the following:

**Stigma and discrimination.** All of the research revealed that high levels of S&D against PLHIV, or those perceived to be PLHIV, such as OVC who are not positive, affected policy implementation. This was found at all levels, from the community (in Vietnam) to the policy level (in Indonesia and China). For example, as the Vietnamese government moved from institutionalizing OVC to integrating them into communities, community members demonstrated S&D toward OVC, resisting their inclusion in local schools and often isolating HIV-positive and affected children and their families. In China and Indonesia, stigma was compounded by perceptions of what constitutes immoral practices (sex work) or inappropriate lifestyles (injecting drug use). S&D enacted by policymakers and communities—at all levels—impede policy implementation and must be addressed to ensure that policies achieve their goals.

**Conflicting/intersecting policies.** Implementation often is hindered by conflicting or intersecting policies, in addition to programs that may be inconsistent with policies. Teams discovered that the policies they discussed were affected by other policies that provided conflicting guidance on related topics. For example, in China, while the FFOC ensures that IDUs should have access to ART, the PSB enacts policies mandating zero tolerance of drug use. These policies subject PLHIV who are IDUs to arrest and incarceration, which often does not include the provision of ART. As a result, program implementers often choose one policy to implement, while ignoring others.

**Low motivation and commitment.** As included in the CIT framework, personal, organizational, or institutional motivation and commitment facilitate the policy implementation process. Numerous factors can result in low motivation or commitment, such as different policy priorities, a lack of incentives, and limited resources. In Indonesia, for example, different policy priorities are reflected through the conflict of the 100% CUP with national and local policies prohibiting prostitution and brothels. In addition, motivation to implement the policy has been affected by communities' perceptions that the program impedes local development initiatives, as business in the brothel areas brings income to local governments and jobs for community members.

**Implementation at multiple levels.** Full implementation of policies requires implementation at multiple levels—national, state, district, and municipal. However, national policies are often broad framework documents that are not always accompanied by guidelines or plans that specify implementation mechanisms and the roles and responsibilities of specific agencies. For example, when Indonesia approved the 100% CUP, the national government left it to local governments to move forward with implementation themselves. While some local governments did so, others issued their own *perdas* before allowing implementation of the national program locally. The lack of role clarity in rolling out the program affected implementation timeliness. In addition, communities, including civil society organizations, service providers, and program beneficiaries also must be involved in implementation. As research in Vietnam showed, communities opposed integrating OVC into their communities. This finding indicates the need for broader consultations with various stakeholders at different stages of the policy development and implementation processes.

**Gender.** Gender often was not considered to be an issue either in creating or implementing policies and programs. For example, respondents reported that gender was not seen as an important issue in

implementing the 100% CUP in Indonesia. These respondents indicated that providing condoms at the local level was sufficient for implementing the program and that both men and women would benefit from their availability. However, when asked about men’s and women’s experiences of condom use, health ministry and nongovernmental policymakers and implementers reported that sex workers have limited power and could experience violence when requesting clients to use condoms.

**Policy formulation versus implementation.** It is risky to assume that putting good policies in place will guarantee their automatic flow into successful ground-level implementation. Each implementation decision can affect the quality and the impact of the policy, so it is important to emphasize key differences between policy formulation and implementation. Table 3 compares the different processes of policy formulation and policy implementation. However, in the context of policy implementation, several gaps exist. The study indicates that the issuance of implementation guidelines does not necessarily mean that policies will be translated into programs. The crucial missing step is that of strengthened provincial-level planning and micro-planning mechanisms.

**Table 3: Differences in Policy Formulation and Policy Implementation**

	<b>Policy Formulation</b>	<b>Policy Implementation</b>
1.	Primary responsibility of national governments and their departments/ministries	Primary responsibility of provincial governments and their departments
2.	Focus of policymaking is all encompassing, all inclusive, broad	Focus on specificity, mechanisms of operationalization, decentralized planning
3.	Concentrated within a small group of high-level ministries and departments with inputs from different stakeholders	Going to scale—often nationally—requires coordination with many stakeholders, government departments at many levels, NGOs, and CBOs
4.	Maximum effort on drafting; role of editing committee very important	No role for either drafting or editing committees; effective program planners and managers needed
5.	Action is at the highest levels of power and decisionmaking	Action is at the community level
6.	Does not require phasing or pilot testing	Needs phasing; pilot models
7.	Does not need to focus on management mechanisms and processes	Important roles of capacity building, coordination, public opinion, supervision, monitoring and review mechanisms
8.	Major role for Justice Department and law professionals	Does not require active participation of Justice Department
9.	Clear guidelines in existence in terms of steps required to develop a new policy	No guidelines or steps on how to translate policies into practice
10	Is on paper	Touches the lives of millions of people

The barriers to policy implementation identified in the study can be divided into three broad areas: the provincial level, community level, and institutional mechanisms for review and monitoring.

## Policy Implementation Barriers Analysis Process

In piloting this new methodology, the Health Policy Initiative learned throughout the process and adapted the methodology when necessary. The following section reviews key lessons learned from piloting the methodology.

### Process

*Information collection.* Prior to the field work, activity teams faced difficulties in gathering the relevant policies, regulations, guidelines, and protocols related to implementing the program. Most of the documents were difficult to obtain in English. Teams also sought sex-disaggregated data to understand who was accessing the program/service, but it was difficult to get up-to-date, program-specific, gender-disaggregated data from the USG teams, OHA, or OGAC—other than data in existing published reports, such as the annual OGAC report to Congress.

*Logistics and in-country teams.* The methodology was designed so that in-country teams could adapt the activity framework to analyze programs and policies themselves, serving to help build the capacity of project staff, partner organizations, and consultants. However, most of the teams faced conflicting work schedules and were not able to dedicate themselves to the activity full time. Also, there was staff turnover, which resulted in hiring and training new staff in the middle of the activity. This affected the timing of various components and the overall activity schedules. In particular, data collection took longer than anticipated. The activity was designed to include a three-week data collection period. However, due to conflicting activity team schedules and informants' limited availability, it took 6–12 weeks to conduct two rounds of interviews in Vietnam and China. The team in Indonesia completed interviews in approximately three weeks because their round-two interviews were limited by logistical issues. The interview team was based in Jakarta, but the interviews were conducted in the city of Surabaya in East Java.

*Stakeholders.* While piloting the activity in Indonesia, the activity team identified a third constituency of stakeholders—national or local leaders of faith-based, nongovernmental, or community-based organizations. While these leaders played only a small role in the actual implementation, they were influential in determining if the policy/program would be implemented through their support or opposition to it. For example, religious leaders in Indonesia were identified as primary stakeholders opposed to the 100% CUP. Recognizing their significance, the activity team was flexible in their approach and initiated interviews with these stakeholders, using some of the questions from the policymaker interview guide (knowledge of policy and the lead organization implementing it, support and opposition to the program). However, the interviews mainly were open ended to explore their perspectives and concerns about the policy.

*Interview methodology.* Teams found that group interviews and discussions initiated with beneficiaries or clients, such as OVC caregivers in Vietnam, worked well for gathering data. These groups focused on issues such as access to services, attitudes toward the policy and programs, and suggestions for improving access.

### Interview guide

Interviews were lengthy when teams piloted the initial interview guide in Indonesia and China, with policymakers averaging 90 minutes and program implementers averaging 120 minutes. This version of the guide included detailed questions about the policy development process and political context, which most informants—particularly those at district and local levels—could not answer. This suggests that when the policy was created at the national level, informants at the district and local levels often were not involved.

*Focusing on core constructs.* Based on the pilots in Indonesia and China, the activity teams concluded that the tool was too long and included questions not specifically linked to the core constructs of motivation, information, power, networks, and interaction. As a result, the tool was revised to include more specific questions related to these constructs and removed questions focusing on the policy development process and access to services. The revised interview guide was piloted in Vietnam.

Changes included creating a new section on motivation, in which informants were asked, “What are the overall or most important goals and objectives of your organization/department?” Under information, the questions were, “Would you say most people in your organization know about this policy? If yes, how did they hear about it? If no, why not?”

The activity teams also made changes to the power/collaboration section, which consisted of a table in the first interview guide used to record the organizations in the informant’s network. In the initial pilot, interviewers found the table and text pages with related questions cumbersome. To change this, a diagram of a network map that informants could fill in was created with guidance from the interviewer. The interviewer then probed the informant about each of the actors in the network and their levels of collaboration. For example:

- What does your organization depend on this (other) organization for?
- What does this organization depend on your organization for?
- If your collaboration with this organization is not going well, how does this impact your work?
- How can collaboration between your organizations be improved?

This component was well-received by informants and fostered more interaction between the interviewer and informant. In addition, new questions that used a quantitative scale to score levels of interdependency and power were introduced. For example:

- How important is [your organization’s role in implementing this policy/program] for your organization’s objectives and goals? Choose a number between 0–10 (0 is low and 10 very high).
- For each of [these organizations in the network map] choose a number between 0 for low to 10 for high for how much you depend on this [other] organization to reach your own objectives; put that number in the box [with the organization’s name].

With these revisions, the interview time was shortened to approximately 60 minutes, as piloted in Vietnam. Additionally, the revisions resulted in the policymaker and program implementer guides being almost identical. This subsequently reduced the number of codes needed for the analysis.

*Gender issues.* Revising the interview guide had a significant impact on the questions designed to inform gender analysis of the policy’s implementation. The first version of the tool included specific questions designed to elicit observations of gender differences in participation in the policy development process, and how gender norms affect women’s and men’s use of programs and services. As most of these questions were deleted during the revision, the Vietnam team then used some of them in the focus group discussions.

In Vietnam, the team focused on questions that explored boys’ and girls’ use of services and on gender norms in caring for children; these questions remained or were incorporated into the interview guide. In addition, the team created similar questions for use with group discussion participants to gain their perspectives. Topics included the range of work that goes into care of OVC and an exploration of who would do that work in the community. The full gender methodology is explored in a separate report, *Gender in Policy Implementation Barriers Analysis: A Methodology*.

*Exploring transparency and accountability.* In each country, teams were very reluctant to ask direct questions about transparency and accountability related to policy development and implementation, believing that such questions would make the informants shut down or agitate them. As a result, they might not respond well for the rest of the interview and could lose the trust that would be needed for follow-up interviews. As a result, teams did not specifically ask about these issues but probed if informants raised the topic. Only one informant raised the issue in Vietnam and Indonesia. Removing specific questions about transparency and accountability, however, limited the team's ability to understand how these concepts related to motivation, power, and policy implementation.

## **Moving Forward**

While the PIBA methodology has been successful in identifying barriers to policy implementation related to a variety of HIV issues, the team plans to simplify the process to make it more feasible for in-country staff to undertake. For example, the team could present the methodology in a tool format, which walks the user through each step of the process. These steps include identification and engagement of stakeholders, definition of issues and questions, data collection from key stakeholders, data analysis, and dialogue and direction.

In addition, the framework can be revised to focus more specifically on identifying policy-related barriers for service-delivery-related HIV policies and programs, including questions on particular HIV themes, such as treatment and care. For example, the pilot process revealed that stigma and discrimination impedes policy implementation. The next version of the framework will include specific questions on S&D to delve deeper into the effects on policy implementation and questions related to gender inequity. These alterations to the methodology will assist program implementers in undertaking the approach themselves, in addition to exploring barriers to implementing HIV programs that already have been identified. This approach can facilitate an emphasis on ground-level inputs and analysis of the results.

After making these changes, the methodology will be piloted in other regions and countries to test its adaptability in areas of generalized epidemics and high prevalence. It is expected that, by focusing on policy and program barriers specific to service delivery, governments and donors will be better positioned to make concrete changes to operational policies to improve overall policy implementation.

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