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# THE **ART** OF MOVING FROM POLICY TO ACTION

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LESSONS LEARNED FROM THE USAID | HEALTH POLICY INITIATIVE (2005–2010)

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**SEPTEMBER 2010**

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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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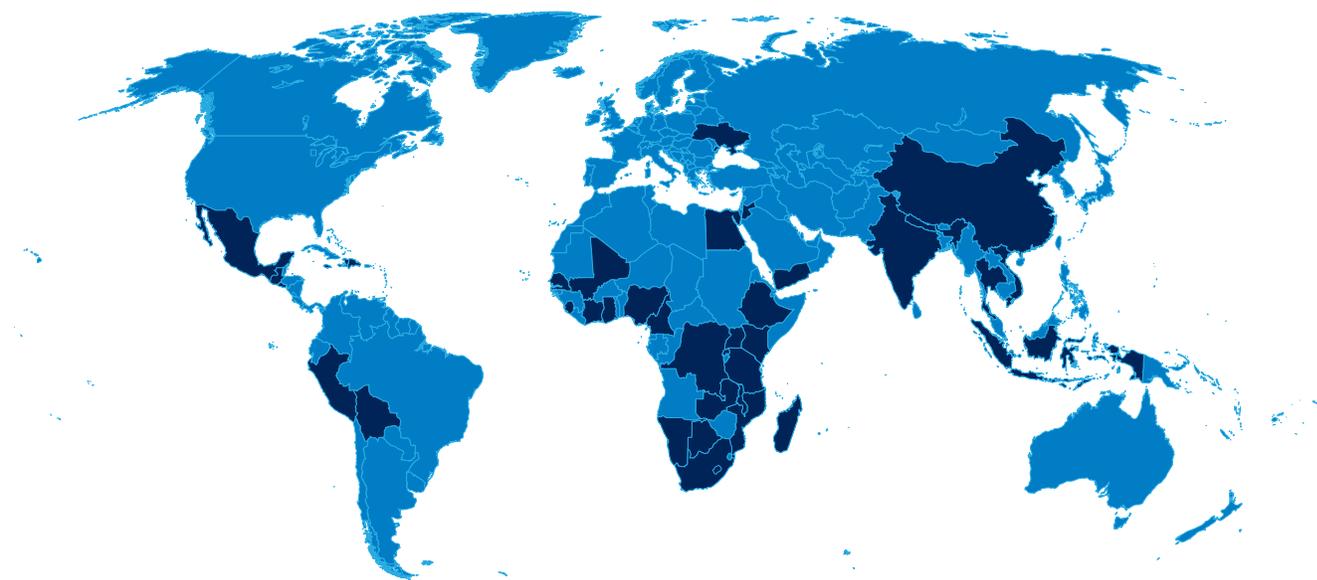
# ACKNOWLEDGMENTS

This paper, *The Art of Moving from Policy to Action*, aims to share lessons learned based on experiences from the USAID | Health Policy Initiative, Task Order 1, with a focus on putting policies into practice. The paper was prepared by staff of the Health Policy Initiative, Task Order 1, including Anita Bhuyan (Futures Group), Anne Jorgensen (CEDPA), Nancy McGirr (Futures Group), and Suneeta Sharma (Futures Group), with additional writing by Katherine Wells (CEDPA) and Rebecca Mbuya-Brown (Futures Group) and editing by Lori Merritt (Futures Group). The authors acknowledge the overall technical review provided by Sarah Clark, Farley Cleghorn, Ken Morrison, Tom Goliber, Karen Foreit, and Margaret Saunders of the Futures Group and John Stover of Futures Institute. We are also indebted to the U.S.-based and

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## USAID | Health Policy Initiative, Task Order 1, Countries



# EXECUTIVE SUMMARY

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

## Policy-to-Action Framework

The elements of the framework include the following:

- **Data analysis and use** refers to the strategic use of information to help stakeholders understand health issues, design appropriate strategies, and monitor policy implementation.
- **Policy dialogue and advocacy** that engages various sectors and stakeholders gives people a voice in the decisions that affect their lives and health; keeps attention on health issues throughout the process, from policy formulation to implementation and monitoring; and encourages consensus for policy action.
- **Policy and strategy development** requires attention to policy content (e.g., clear goals, strategic directions, institutional arrangements, indicators of success) and policy processes (e.g., evidence-based, participatory processes).
- **Addressing barriers** will be an ongoing process as implementation unfolds. It entails identifying barriers to implementation, devising solutions, revising plans accordingly, and moving forward again.
- **Leadership and governance** are needed to guide strategic policy development, harness resources, provide effective oversight and coordination, and ensure accountability and transparency for actions and goals. Strengthening networks of leaders—from parliamentarians to religious leaders to women and marginalized groups—helps to sustain leadership and commitment.
- **Action planning** is a consultative process that seeks to outline *what, how, who, when, and where* resources and efforts are needed to put policies into practice.
- **Resource mobilization** encompasses the financial, human, material, and other resources needed to carry out plans and programs. Stakeholders must maximize resources through mobilization of new resources, as well as efficient and equitable allocation of existing resources—that is, “more money, better spent.”
- **Implementation of strategies** is the actual “doing” of the actions outlined in policies and plans. It typically involves testing and rolling out new or improved services in alignment with policy goals.

- **Monitoring, evaluation, and accountability** efforts entail tracking service delivery and impact on health outcomes, as well as the process of policy implementation itself to determine what is and is not working. Monitoring should also engage government leaders, civil society, and other stakeholders to promote accountability, transparency, and ownership of policy initiatives.
- **Scale-up and sustainability** are achieved when the goals, principles, and operational guidelines contained in policy directives are normalized and consistently supported as part of the everyday practice of health service planning and provision.

## Key Considerations

Applying the Policy-to-Action Framework requires (1) understanding the policy environment and (2) building capacity to implement and sustain health policies and programs. All health policies are formulated and implemented within a particular environment, which includes the overall health system; laws and policies in other sectors; policy stakeholders (public, private, civil society); power relationships among these stakeholders; and sociocultural, political, economic, and other external factors. Part of the art of policy implementation is adapting elements of the Policy-to-Action Framework to the policy environment. Underlying the entire process of moving from policy to action is the need to build capacities for effective, sustainable implementation at individual, institutional, and systems levels.

## Country Examples and Case Studies

The paper shares project and partner experiences to illustrate the elements of the Policy-to-Action

Framework. The paper also presents case studies to demonstrate how various elements come together to foster moving from policy to action. In Malawi, a key policy change has set the stage for scaling up community-based distribution of injectable contraceptives. In Vietnam, HIV legal clinics are ensuring that the country's HIV Law is put into practice and monitored so that people living with HIV can take advantage of their rights. In Guatemala, multisectoral monitoring boards are promoting accountability for implementation of reproductive health policies and laws.

## Concluding Reflections

There is no one set way to put a policy into practice, hence, the art of moving from policy to action. Also, policy work is never totally complete. In fact, the framework presented here may be viewed as a process of moving from “policy to action, and back”—it requires implementing and monitoring policies and revising strategies to reflect changing dynamics of health issues and implementation experiences. For the way forward, it is important to consider what is needed to sustain policy implementation and success, as well as how policy implementation contributes to strong, sustainable health systems more broadly. Key considerations include the need for

- Sustained capacity at individual, institutional, and systems levels;
- Efficient, equitable, and sustainable mobilization and allocation of resources;
- Linkages between policy work and health systems strengthening initiatives, with clear indicators of the impact of policies on health systems; and
- Efforts to strengthen country ownership, leadership, governance, and accountability.

# ABBREVIATIONS

AGMM	Guatemalan Association of Women Physicians
AIDS	acquired immune deficiency syndrome
ART	antiretroviral treatment
ASHA	accredited social health activist
CBD	community-based distribution
CEDPA	Centre for Development and Population Activities
CME	constructive men's engagement
CONAES	National HIV/AIDS Business Council (of Mexico)
CPR	contraceptive prevalence rate
CS	contraceptive security
CUP	condom use policy
DHS	Demographic and Health Survey
DMPA	depot medroxyprogesterone acetate
DMPPT	Decision Makers' Program Planning Tool (for male circumcision)
EcoSIDA	Business Forum Against AIDS, Malaria, and Tuberculosis
FP	family planning
GBV	gender-based violence
GIPA	greater involvement of people living with HIV/AIDS
HIS	health information system
HIV	human immunodeficiency virus
HPC	Higher Population Council
HSA	health surveillance assistant
ICPD	International Conference on Population and Development
ICW	International Community of Women Living with HIV/AIDS
IGWG	Interagency Gender Working Group
IPPI	Ikatan Perempuan Positif Indonesia
ITAP	Innovations in Family Planning Services II Technical Assistance Project
ITWG	Integration Technical Working Group
KPAN	National AIDS Commission (Indonesia)
LAC	Latin America and the Caribbean
M&E	monitoring and evaluation
MARP	most-at-risk population
MAT	medication-assisted therapy
MC	male circumcision
MDG	Millennium Development Goal
MENA	Middle East and North Africa
MENA+	Middle East and North Africa Network of People Living with HIV/AIDS
MLS	Ministry for the Fight Against AIDS
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MSM	men who have sex with men
MSPAS	Ministry of Public Health and Social Assistance

MTG	Multisectoral Technical Group
NAP	National AIDS Program
NFPCIP	National Family Planning Costed Implementation Plan
NGO	nongovernmental organization
OGAC	Office of the Global AIDS Coordinator
OSAR	Reproductive Health Observatory
OVC	orphans and vulnerable children
PASCA	Program for Strengthening the Central American Response to HIV/AIDS
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PNH	private nursing home
PPP	public-private partnership
PPU	Population Planning Unit
PSTF	Private Sector Task Force for Monitoring and Evaluation
PTG	Provincial Technical Group
REMAPOD	Parliamentarian Network on Population and Development (Mali)
RH	reproductive health
RHAP	reproductive health action plan
RHU	Reproductive Health Unit
RNM	Resource Needs Model
SDPP	Social Development and Population Policy
SEGEPLAN	General Secretary for Planning (Guatemala)
SMART	specific, measurable, appropriate/achievable, realistic, and time-bound
STD	sexually transmitted disease
TPAPD	Tanzania Parliamentary Association on Population and Development
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
USAID	United States Agency for International Development
VMU	Voucher Management Unit
WHO	World Health Organization
WRA	White Ribbon Alliance (for Safe Motherhood)
YKP	Yayasan Kesehatan Perempuan



## SECTION I

# INTRODUCTION

Policies matter. They provide a foundation on which to build strong health systems, programs, and services. Policies and strategies articulate the goals and priorities of the country or organization, set minimum standards of quality, outline roles and responsibilities, facilitate coordination, guide resource mobilization, and determine timelines for program rollout. Lack of proper attention to the policy framework for programs often leads to health systems and services that are ineffective, inappropriate, or ill-planned. Good policies and strategies are important, but not sufficient. They must be put into practice. Yet, even the best designed policies and plans encounter challenges at the implementation stage. Thus, attention to policy work should not end with the creation of the policy, which is only the first step in moving from policy to action.

After the policy has been adopted, what comes next? Much has been learned about what makes good policies—such as a sound evidence base; clear, time-bound goals; and broad participation and buy-in (Cross et al., 2001;

Hardee et al., 2004; POLICY Project, 2006a, 2006b). Despite a growing body of literature on policy implementation,<sup>1</sup> understanding how best to implement policies remains a challenge in real-world settings. Put simply, policy implementation “refers to the mechanisms, resources, and relationships that link health policies to program action” (Bhuyan et al., 2010, p. 1). Too often, however, policies remain on the shelf and do not receive adequate attention, resources, or follow-through.

The aim of this paper is to demystify “policy implementation” and to provide stakeholders in the field—such as policymakers, advocates, program planners and managers, and service providers—with clear, user-friendly advice on how to translate policies into action. To do so, this paper draws primarily from the experiences and lessons learned from the USAID | Health Policy Initiative, Task Order 1 (Box 1). The paper is organized around the project’s **Policy-to-Action Framework**, highlighting what has worked in the countries where the project operated.

<sup>1</sup> For examples, see Sabatier, 1986; Thomas and Grindle, 1990; Matland, 1995; USAID, 2001; Brinkerhoff and Crosby, 2002; Love, 2004; Brynard, 2005; and WHO, 2009.

### Box 1. About the Health Policy Initiative

Through policy dialogue and implementation, the USAID | Health Policy Initiative, Task Order 1 (Sept. 2005–2010), was designed to improve the enabling environment for health, especially family planning/reproductive health (FP/RH), HIV, and maternal health programs. The project supported policy formulation and implementation, built capacity of leaders and champions, fostered efficient and equitable resource allocation, helped to mobilize multisectoral responses, and promoted evidence-based decisionmaking.

The project carried out more than 40 country or regional programs. Most activities were led by national staff who helped to encourage country-driven, sustainable policy responses. Over its performance period, the project assisted in the formulation and adoption of nearly 100 policies, plans, and strategies and the mobilization of US\$186 million in new or increased resources for health. The project helped to form or strengthen 47 networks, as well as 52 multisectoral mechanisms that advise on, set, and monitor policies. In addition, the project prepared 44 new models, curricula, manuals, guidelines, frameworks, and other tools to aid policy work.

Learn more: [www.healthpolicyinitiative.com](http://www.healthpolicyinitiative.com)

## Policy-to-Action Framework

To share the project's lessons learned and make the components of effective policy implementation more accessible, the Health Policy Initiative developed the Policy-to-Action Framework. Based on a synthesis of the project's in-country activities and feedback from technical and field staff, the project outlined the key elements of the framework. Over the past two years, the framework has been revised and updated based on feedback from staff, partners, and external experts; new experiences; and emerging trends in international development practices and priorities.

In the diagram below, the Policy-to-Action Framework is depicted as an array of colors, with each color representing a key element that goes into moving policies to action—from data analysis and use to scale-up and sustainability. Understanding that the core flow of the policy process progresses from problem identification to policy formulation, implementation, and monitoring, the diagram illustrates how the elements cluster around and



influence the process. However, the framework also recognizes that moving from policy to action is a dynamic, iterative process that unfolds differently in different contexts. In practice, the various interdependent elements or “colors” must be mixed together—sometimes out of sequence, often many elements at once, and over and over again—to achieve effective policy implementation. While implementation does involve certain processes that should be carried out in a more intentional, methodical way—from using evidence to inform decisions to establishing clear mechanisms to ensure accountability—bringing all of the components together is indeed an “art.” The art of policy implementation requires an understanding of policy issues, the context, and stakeholders; anticipating potential roadblocks; seizing windows of opportunity; and building and sustaining commitment, capacity, and resources over time.

## Understanding the Policy Environment

Before applying the different elements from the Policy-to-Action Framework, it is essential to understand the policy environment. All policies are formulated and implemented within a particular environment. The policy environment is dynamic and unpredictable. It includes factors that influence policies but are not under the direct control of the policies. Elements of the policy environment that influence how implementation unfolds include

- The overall health system, including facilities, personnel, commodities, and information systems;
- Existing laws, policies, and regulations within the health sector, at the organizational or facility level, and in other sectors that affect the provision of health services (e.g., operational guidelines, criminal codes, labor laws and practices, international trade and procurement policies, etc.);
- Diverse stakeholders—such as policymakers and government leaders at national and subnational levels; ministries (e.g., health, education, finance,

planning, women and children’s development); healthcare providers; civil society organizations; private sector groups; faith-based leaders and organizations; the media; community leaders and members; and clients and beneficiaries—who may have common or competing interests;

- Power relationships and dynamics that govern who participates in policy processes and at what level (e.g., do civil society groups and beneficiaries have a voice?, are other sectors involved?, what is the relationship between the central government and the provinces and districts?);
- Sociocultural, political, and economic issues, such as poverty, gender inequalities, stigma and discrimination, and level of political will; and
- External factors, which could run the gamut from international aid policies and priorities, to natural disasters that disrupt health services, to global financial crises, and more.

Part of the art of policy implementation is being responsive to the policy environment and understanding the nuances in the context and the needs and interests of the stakeholders involved in the policy process.

## Building Individual and Institutional Capacity

Underlying the entire process of moving from policy to action is the need to build capacities for effective, sustainable implementation at individual, institutional, and systems levels. Gaps in health policy capacity arise for many reasons and are barriers to lasting change. For instance, high turnover among government officials, outmigration of skilled professionals, and low and inconsistent compensation all hinder in-country leadership, policy and program implementation, motivation, and ongoing oversight. Underresourced training and education facilities, particularly in decentralized settings where more health policy is now managed, result in staff shortages and inadequate numbers

of people with technical skills in planning, data use, advocacy, finance, and other crucial skill sets; this continues the need for ongoing support and capacity building.

Setting up systems for sustainable, local institutional capacity will require long-term commitments by both host and donor governments. The current focus on in-country ownership in the Global Health Initiative and other donor mechanisms accelerates a positive and proactive trend toward sustainability. Several important principles must be enacted to support a robust, effective, and sustainable approach to capacity development for policy implementation. Capacity development is rooted in empowerment, local leadership, and shared learning; based on buy-in and commitment from partners; designed to meet expressed in-country needs; and implemented with locally feasible, effective methods that are in sync with local decisionmaking timeframes.

The technical areas of the Policy-to-Action Framework are interrelated and interdependent and may require many similar competencies and skills sets. That said, each technical area calls on different competencies, and these core competencies are evident at varying levels of complexity by the diverse groups of stakeholders who participate. Indeed, given the broad range of individuals and institutions required for successful policy implementation—from national and local government officials, to grassroots groups and networks (e.g., people living with HIV, most-at-risk populations, citizen groups, women’s collectives), to “grass tops” organizations (e.g., NGOs, coalitions, faith-based organizations) (Example 1), to the private sector and service providers, as well as the

media, professional associations, and universities—the Health Policy Initiative approached capacity development with a diverse menu of tools and approaches. Throughout the paper, examples highlight how training workshops, on-the-job technical assistance, curriculum development, financial support and small grants, and participation in regional and global networking and advocacy enhanced in-country capacity and moved policy implementation forward.

## Using This Paper

Section 2 explores each element in the Policy-to-Action Framework, providing the rationale for why the element matters for implementation as well as advice and country examples for how to accomplish each element. Section 3 delves deeper into country case studies that illustrate how the various elements mix together to put policies into practice. Section 4 shares thoughts for sustaining policy action and the challenges ahead.

It is important to be flexible in applying the advice contained in this paper and to adapt approaches based on the context, key players, specific health and policy issues, and available resources at hand. It is also essential to be on the lookout for and seize windows of opportunity. For example, a change in political parties could make way for new commitment and resources for health. Similarly, beware of pitfalls, hazards, and other barriers, such as weak capacity, that could hinder rollout of a health policy or program. It is important to be proactive in identifying and planning for these potential challenges to ensure that policy implementation stays on track.



Photo credit: Curt Carnemark / World Bank.

### Strong Civil Society Network Bolsters Response for Orphans and Vulnerable Children

Estimates suggest that, by the end of 2010, more than 20 percent of children in Botswana will be orphans. The country needs supportive policies and local organizations with capacity to meet the needs of orphans and vulnerable children (OVC). Since its founding in 2005, the Marang Childcare Network's membership has doubled in size, from an original 20 members to about 40 members. This expansion, along with strengthened capacity, has significantly increased its recognition at the national and regional levels as a prominent partner in OVC policy dialogue, advocacy, and planning. In five short years:

- Marang has been instrumental in drafting the *National OVC Guidelines* and advocating for the Children's Bill, both adopted in 2009.
- Marang was given responsibility for establishing district NGO forums to coordinate and monitor activities relating to the care and support of children, as called for in the Children's Bill. In 2009, the network helped to establish forums in Boletli, Chobe, Gaborone, Kgatleng, Kweneng, North East, North West, and Okavango. The committees, which include government and NGO representatives, will monitor implementation of the Children's Bill and other OVC- and child-related policies, ensuring that services are provided in accordance with national standards and regulations.
- Marang has mobilized resources from the government, private sector, and other donors to strengthen its organizational development and sustainability. For example, in 2007, Marang secured \$35,000 in government funding to conduct leadership and governance training for member organizations and community service providers. In 2008, the government awarded Marang a US\$200,000 grant to expand the reach and improve the quality of OVC services provided by its members.
- The Regional Psychosocial Support Initiative—a capacity-building and knowledge management organization for psychosocial care and support for children affected by HIV, poverty, and conflict in East and Southern Africa—has recognized Marang as the lead agency for training providers and caregivers in providing psychosocial support.

The Marang Childcare Network was formed with technical assistance from the POLICY Project. Since 2006, the Health Policy Initiative has been instrumental in strengthening Marang's organizational abilities, including governance, operations, sustainability, and proposal writing and fundraising.



## SECTION 2

# APPROACHES FOR MOVING FROM POLICY TO ACTION

Moving from policy to action involves four primary stages:

- Problem identification—refers to the health issue at the center of the policy process and requires understanding the magnitude and urgency of the issue and recognizing the need for policy action.
- Policy formulation—involves bringing together various stakeholders and sectors to devise appropriate policies, guidelines, and action plans in response to the identified problem.
- Policy implementation—entails mobilizing leadership, capacity, and resources for action to carry out the strategies contained in policies and plans in alignment with policy goals.

- Policy monitoring—tracks policy implementation progress and ensures that relevant stakeholders, such as government officials and healthcare providers, are accountable for achieving policy goals.

The Policy-to-Action Framework outlines 10 key elements that facilitate moving from problem identification, to policy formulation, to policy implementation and monitoring. This section explores the 10 elements, providing examples of each element.

As noted above, the framework presents the elements in a sequence for ease of explanation; however, moving from policy to action is not a linear process. The elements must be adapted and mixed together, often out of sequence and many elements combined together at once, to put policies into practice.

## 2.1 Data Analysis and Use

HIV campaigns urge “Know your epidemic, know your response.” The same principle should apply to every health issue. It is important to know the health challenge and, based on this understanding, design an appropriate evidence-informed response.

Data analysis and use underpins each element in the Policy-to-Action Framework. Strategic use of data can help to

- Enhance advocacy to raise awareness of health issues, trends, needs, and gaps (including the groups with highest disease burden, most-at-risk, or in greatest need for services);
- Set priorities and goals, inform the design of effective approaches, and estimate resource needs during the policymaking and planning stages;
- Reveal operational and implementation barriers; and
- Monitor progress, impact, and unforeseen consequences.

Sound data analysis and use are increasingly important for initiatives that call for integrated health programs, results-oriented approaches, and strengthened health systems. Policymakers, program managers, healthcare providers, and advocates need access to and ability to apply information to help coordinate resources and multisectoral efforts as well as to be accountable for achieving goals. Strong evidence is also crucial for “making the case” for neglected or sensitive issues, especially for reaching audiences beyond traditional allies—such as repositioning family planning (FP) within national development efforts (Example 2); highlighting inequalities faced by women and the poor; and increasing resources for and attention to most-at-risk populations (MARPs) for HIV.

### Evidenced-based Advocacy Sparks National Commitment to Family Planning

Rwanda is the most densely populated country in Africa and rapid population growth threatens both household and national development. Beginning in the mid-2000s, Rwanda stepped up efforts to address the issue of rapid population growth. Many stakeholders attribute changes in political commitment and attitudes toward family planning, in part, to the RAPID analysis. The RAPID Model is a computer-based tool that stakeholders can use to demonstrate the effect of rapid population growth on different sectors and the benefits of FP programs (Health Policy Initiative, 2009e).

“... [RAPID] had a powerful impact because it put a positive spin on things by talking about the advantages of having smaller families in terms of improved health and education opportunities ... The RAPID Model brought home the idea that the goals of poverty reduction simply could not be met with high rates of population growth, and that lowering fertility—in part through family planning—was essential” (Solo, 2008, pp. 12–13).

Beginning in 2005, the Health Policy Initiative supported partners to present the model to Parliament, Ministry of Health (MOH) officials, and others. In February 2007, the Minister of Health presented RAPID findings to the President and members of the Cabinet, which was one of the factors that contributed to increased presidential-level commitment for family planning. Demonstrating strong commitment, the government designed a *National Family Planning Strategy*, included FP programs in Rwanda’s *Vision for 2020*, and created an FP technical working group. Due to these combined efforts, use of modern contraceptives among married women has increased dramatically, from 10 percent in 2005 to 27 percent in 2008.<sup>2</sup>

<sup>2</sup> Preliminary data from Rwanda’s 2008 Demographic and Health Survey.

Data must be available, accessible, responsive to in-country and local needs, and linked to use. Data can come from a variety of sources: population-based surveys/routine surveillance; service delivery statistics; expenditure tracking data; client interviews/scorecards; and tailored studies and analyses (both quantitative and qualitative). Common challenges are lack of data; information that is too technical or not technical enough; and information overload (too much data, not in a user-friendly format). Moreover, key stakeholders, from advocates to policymakers, may lack capacity to gather, analyze, and share data, especially at decentralized levels. Inadequate linkages between data collection/analysis and advocacy, policymaking, and accountability mechanisms, as well as conflicts over data sources and interpretation, can further hinder evidence-based decisionmaking.

### **Box 2. Country Ownership of Health Information Systems Forum**

The Country Ownership of Health Information Systems (HIS) Forum aims to strengthen and accelerate nationally-owned and led strategies for managing HIS in 11 focal countries in sub-Saharan Africa. The Health Policy Initiative supported this ongoing multi-partner effort by gathering feedback from in-country stakeholders about the status and needs of HIS in the participating countries.

**Learn more:** [www.hisform.org](http://www.hisform.org)

### **Box 3. Spectrum System**

The Health Policy Initiative regularly updates and provides training on using the Spectrum System of Policy Models. Spectrum includes user-friendly models to project health and demographic trends and assess the impact of alternative resource allocation strategies on achievement of FP/RH, HIV, and maternal health goals. Models include DemProj, the AIDS Impact Model, RAPID, Goals, FamPlan, and others. These models help policymakers and planners understand the dynamics of health issues and explore the feasibility and impact of different policy options.

**Learn more:** [www.healthpolicyinitiative.com/index.cfm?id=software](http://www.healthpolicyinitiative.com/index.cfm?id=software)

The art in data analysis and use involves getting the *right information in the right format in the right hands at the right time and place*. Strategies for using data in different situations (e.g., advocacy, planning, monitoring) are highlighted throughout this report. Overall considerations for integrating data analysis and use throughout the Policy-to-Action process are described below.

**Data availability and quality.** Data must be available, of a high quality (e.g., up-to-date, gathered using sound methods, free of errors), and validated (e.g., integrity of the data can be verified). It is important to engage stakeholders in the collection, validation, and use of data. Doing so builds country-owned information systems and encourages transparency and consensus around the validity of data and the decisions they inform (Example 3). Ensuring that data quality and validity are in accordance with regional and international standards gives further credibility to application of the findings by in-country stakeholders. It is also advisable to involve people from whom information was gathered (e.g., the poor, MARPs, service providers, etc.) in the validation and verification of data. They can fill data gaps, offer insights to interpret data, and help explain the findings revealed by data analyses. Involvement in validating the data is also a learning experience, offering opportunities for participants to better understand and subsequently use data themselves.

**Capacity for data analysis.** Individuals, institutions, and systems must have the capacity to regularly gather, interpret, use, share, and store data. At the individual level, while the level of skill required depends on the person's role, all policy stakeholders benefit from the ability to manipulate data, identify themes, and use information to inform decisions. Such capacity helps advocates to promote action, policymakers to lead the discourse on health issues and guide implementation, planners and managers to make program decisions, and stakeholders such as journalists and citizens watchdog organizations to monitor accountability. At the institutional level, organizations must have processes in place to use evidence for

project planning, implementation, coordination with other stakeholders, and monitoring. At the systems level, mechanisms must be set up to regularly gather data (e.g., on health trends, service delivery, expenditures, impact) and ensure flow of information throughout the health system (Box 2).

**Linkages between data and use.** Linkages between data and its effective use can be strengthened by understanding data needs and demands—such as who makes decisions, how and when decisions are made, and what information influences decisions.<sup>3</sup> Opportunities to bring diverse stakeholders together, including high-level

policymakers, local officials, advocates, program and budget planners, representatives of other sectors, and researchers, to discuss findings and implications are also essential (Example 3). Another key strategy is to make data more accessible, which can be aided by the use of computer models (Box 3), online mechanisms, and data visualization techniques. Finally, data and analyses must be shared with all relevant audiences. In particular, this requires closing the “feedback loop” because, too often, data may be reported up the chain, but feedback is not shared back down to the field level to improve policy and program implementation.

### Multisectoral Technical Groups Enhance Availability and Use of HIV Strategic Information

Planning appropriate strategies to address HIV, allocating enough resources where they are most needed, and tracking progress require a clear understanding of the HIV epidemic and the groups most affected. Often, however, stakeholders lack clear understanding of and consensus about the HIV situation in the country.

In Mozambique, the Multisectoral Technical Group (MTG) advises the government on improving HIV sentinel surveillance and data collection, analyzes and interprets surveillance data, and produces periodic HIV and AIDS impact projections that are recognized as the “gold standard” for information on the epidemic in the country. The MTG brings together the National AIDS Council, four line ministries (health, planning and development, education, and agriculture), the National Statistics Institute, and two faculties from the national university. Each member institution seconds technical staff, who work together on MTG activities. The national MTG also supports two provincial technical groups (PTGs), whose members include the same government sectors, as well as civil society groups.

“The strategic information generated by the MTG is discussed and approved in national consensus forums, involving national and international partners. MTG reports and analyses have been used as the most reliable sources of information about HIV prevalence and demographic impact. National advocacy groups and policy programs use MTG information for advocacy, resource mobilization, monitoring and evaluation, and for programmatic purposes such as estimating the number of people to be covered by specific interventions” (Office of the Global AIDS Coordinator, 2006, p. 140).

The national MTG was formed in 1999, with assistance from the USAID-funded POLICY Project and, subsequently, has received technical assistance from the Health Policy Initiative. The latter project has assisted stakeholders to replicate the approach in the provinces, with the launch of PTGs in Manica and Niassa. A key objective of the PTGs is to improve local planners’ and implementing organizations’ access to up-to-date information on the epidemic at the provincial level.

## 3. MOZAMBIQUE

<sup>3</sup> For examples, please see the MEASURE Evaluation Data Demand and Use Tools available at <http://www.cpc.unc.edu/measure/tools/monitoring-evaluation-systems/ddiu-tools/ddiu-strategies-and-tools>.

## 2.2 Policy Dialogue and Advocacy

Often hosted by government, policy dialogue brings diverse interests to the table to exchange information and reach consensus on solutions to complex problems.

With the Latin root “voc” or voice, advocacy is “giving a voice to.” Policy advocacy can be defined as a set of targeted actions directed at decisionmakers in support of a specific policy issue.

The FP/RH, maternal health, and HIV policy arenas are strikingly different than they were before 1994, the year of the International Conference on Population and Development (ICPD) in Cairo and the declaration on Greater Involvement of People Living with HIV/AIDS (GIPA) at the Paris AIDS Summit. Indeed, it is hard to imagine a truly effective policy formulation process that does not include the voice of civil society, networks and coalitions, or people living with HIV (PLHIV). Committed, capable, and informed advocates have made all the difference in getting issues on the agenda, pushing for policy change, and, increasingly, leveling the playing field for the underrepresented, the marginalized, and affected populations.

Policy dialogue and advocacy are closely related communication processes that have a similar goal of improved health and well-being of citizens. Vibrant advocacy and inclusive policy dialogue are essential at the beginning but need

to continue throughout the Policy-to-Action process to mobilize resources for programs and monitor progress as policies and programs roll out. Advocates play a crucial role in “bringing policy to the people and people to the policy.” When operational issues arise, when inequities become clear, and when unintended consequences crop up, advocates must be on the forefront—calling these to the attention of decisionmakers and engaging effectively in dialogue to hammer out solutions and share ownership in the continued response. Advocacy and dialogue promote transparency and accountability and, ultimately, the effectiveness of policy implementation. As governments increasingly embrace participatory processes, they also recognize that, nowadays, most international donor mechanisms encourage or require participation of those most affected by health policy decisions to foster local ownership and country-level sustainability. In countries without a tradition of social participation or in those just developing one, policy dialogue and advocacy lead to greater trust between government and civil society.

### **Box 4. Virtual Communication Network for Contraceptive Security**

Through USAID’s Latin America and Caribbean (LAC) Contraceptive Security (CS) Initiative, the Health Policy Initiative provided ongoing technical and financial assistance and training to the national CS committees to effectively engage in policy dialogue around CS issues, FP programs, and laws and to incorporate equity issues into the national CS agenda. These multisectoral committees include health ministry officials and NGO and donor representatives. The project also supported development of a virtual network of CS committees to facilitate South-to-South sharing of best practices.

**Learn more:** [www.lacdaia.org](http://www.lacdaia.org)

**Multisectoral dialogue spurs policy formulation and implementation.** Policy dialogue brings together diverse stakeholders, provides a forum to review an issue and assess evidence, deliberate on alternative actions, and—likely through a series of meetings—produces a roadmap for policy action. Multisectoral dialogue can take many forms (Box 4 and Example 4). Recognizing that HIV, family planning, and maternal health are more than just health issues alone—each affects and is affected by other sectors—dialogue across government



Photo credit: Ed Forest,  
www.educateforlife.org.uk

## Multisectoral Dialogue Promotes Constructive Men's Engagement

Constructive men's engagement (CME) aims to improve health outcomes, reduce gender-based violence (GBV), and achieve gender equality by involving men as clients of health services, supportive partners, and agents for social change. In Mali, the Health Policy Initiative worked with in-country partners to build an enabling policy and institutional environment for CME in reproductive health (Doggett and Herstad, 2008), based on a successful pilot effort in Cambodia (Greene et al., 2006). The project facilitated dialogue with nearly 50 representatives from the MOH, NGOs, faith-based organizations, and USAID and other international organizations. In March 2007, the stakeholder group discussed key issues related to men's engagement in reproductive health; shared insights from existing initiatives and approaches, including the Cambodian CME guidelines; and brainstormed about what should be included in Mali's CME guidelines. Ten representatives from various sectors formed an Advisory Committee to lead the drafting of CME guidelines.

The committee carried out various consultations to draft and revise the guidelines. The committee incorporated stakeholders' concerns and suggestions from the March 2007 meeting. In January 2008, the committee presented the draft guidelines to the larger stakeholder group for review and validation. The Minister of Health approved the guidelines and signed them into effect on May 20, 2008 (Republic of Mali, 2008). The guidelines encompass seven key areas of intervention, including improvement of existing RH services for men; community mobilization; promotion of couple's communication for shared decisionmaking; and capacity building for actors undertaking CME-RH activities.

The stakeholder group's active participation in the policy dialogue and formulation process has led to increased visibility of CME in Malian discourses on policy, gender, and health. The group members have also made strong commitments to implement the guidelines as part of their work. In addition, training based on the Interagency Gender Working Group (IGWG) CME-RH training module has increased the capacity of stakeholders to address CME, which will help ensure that commitments are translated into effective action.

## 4. MALI

ministries is essential not only for raising awareness of the intersections among the sectors but also for planning and resource allocation. As governments decentralize, dialogue between national- and local-level decisionmakers, as well as opportunities for sharing among subnational units, bolsters lines of communication necessary for effectively devolving authority. Multisectoral dialogue marks an opportunity to bring new partners into the policy process, who bring new perspectives to the discourse and increased resources and skills to address implementation challenges. Often, multisectoral dialogue is the beginning of the longer process of building partnerships among government, civil society, and private sector groups.

**Advocacy and networks in action.** Advocacy ensures that the voices of citizens, beneficiaries, and the marginalized are heard in policy circles. As any advocate would surely agree, advocacy is both a science and art. Advocacy is best when it is well grounded in reliable evidence, the issues and objectives well researched, the steps in the process strategically planned, messages tailored and pretested for different target audiences, and its activities diligently monitored and retooled as necessary. Yet, advocates must call on their collective creativity to know and feel the right time to act, know when to listen, to seize policy windows that open, or find just the right messenger or twist of phrase to ignite government action

without becoming adversarial. A cornerstone of the Health Policy Initiative and its predecessor projects has been creating adaptable learning tools, building the capacity of advocates, and supporting their campaigns through small grants and technical assistance.

The more voices expressing key messages, the stronger and more legitimate is the advocacy. Thus, advocacy typically involves the process of developing networks and coalitions, often drawing from many sectors and types of partners, who come together around a common vision and recognition of the value in sharing resources. Particularly for groups that have been outside the margins of the policy world, it is important to strengthen their social capital that comes from connection to each other and partnerships with

global networks such as the Global Network of People Living with HIV/AIDS, International Community of Women Living with HIV/AIDS (ICW), and Global White Ribbon Alliance for Safe Motherhood. As a central tenet of the Global Health Initiative, involving women and girls in advocacy and policy will be an important—and effective—step in the direction of health equity (Example 5).



Photo credit: Max Taylor Photography.

### Women Lead in Repositioning Family Planning

In September 2009, FP providers, researchers, and government officials came to Washington, D.C., for a three-week program—*WomenLead in Repositioning Family Planning and Reproductive Health*—designed to reinvigorate their leadership and advocacy around FP/RH (Richiede et al., 2010). The 26 women represented eight countries with some of the world's highest rates of maternal death and unmet need for FP services—Ethiopia, India, Kenya, Malawi, Nigeria, Pakistan, Tanzania, and Uganda. Hosted and facilitated by the Health Policy Initiative implementing partner, the Centre for Development and Population Activities (CEDPA), the program linked personal leadership training and technical content with applied advocacy and communication methodologies through dialogues with U.S. policy audiences in order to develop confident and successful women policy champions. The United Nations Foundation interviewed and videotaped eight of the participants to educate U.S. audiences about the importance of investing in family planning. The interviews were produced as a short video that was aired at the State Department in conjunction with Secretary of State Hillary Clinton's January 2010 speech commemorating the 15-year anniversary of ICPD (see [www.youtube.com/cedpatv](http://www.youtube.com/cedpatv)).

# 5. WOMEN LEADERS

Now back in their home countries, these women are forging ahead in the FP/RH policy arena, meeting with health ministries and parliamentarians, garnering media coverage, and providing advocacy skills training to others. Within a few months of the workshop, 68 percent of the *WomenLead* champions had met with public officials to advocate for improved RH funding and policies, and 74 percent had participated in policy dialogues or advocacy events. For instance, a Nigerian participant was determined to prevent future contraceptive stockouts at the teaching hospital where she works. Thanks to her pioneering advocacy efforts, the Usmanu Danfodiyo University Teaching Hospital launched the first revolving fund and fund oversight committee to ensure contraceptive security within the hospital.

## 2.3 Policy and Strategy Development

Proper attention at the policy development stage lays the foundation for more effective program implementation and scale-up.

A key consideration for moving from policy to action is, naturally, the policy itself. Policies are important because they

- Create a common vision, priorities, and goals;
- Establish authority and legitimacy;
- Obligate the government to take appropriate legislative, regulatory, economic, and other measures to achieve policy goals and objectives;
- Outline the strategic direction for programs, organizational structures, and implementation;
- Enumerate the rights, roles, and responsibilities of various actors, including clients and service providers;
- Guide resource mobilization, allocation, and use; and
- Outline mechanisms for monitoring progress toward achieving goals and objectives (POLICY Project, 2006b).

“Policies” come in various forms, such as national or organizational policies and strategies, laws and legislation, and operational guidelines and regulations that set minimum quality standards and guide implementation of all aspects of how programs and services are provided. Policies are essential for scale-up and sustainability because they authorize actions, outline operating procedures, and foster continuity in programs even as individual stakeholders—from political leaders to healthcare personnel—change over time. Policies are also crucial for meeting the needs and protecting the rights of those with limited access to health services, especially women, the poor (Example 6), PLHIV, and MARPs.

The content of the policy or strategy, formulation process, and extent of dissemination influence whether the necessary groundwork is in place to support effective implementation.

**Policy content.** Policy content should clearly frame the underlying problem area, the policy’s goals and objectives, and the population to be benefited, along with the broad actions and strategies to address the problem (Nakamura and Smallwood, 1980; Walt and Gilson, 1994; Hardee et al., 2004). Other crucial elements include time horizons, rationale, and clarity of content. Unclear or confusing policy objectives or actions may be one reason why some policies are not implemented. At a minimum, written policy documents should include

- Rationale (including a statement of the problem and justification for the policy);
- Goals and objectives (what the policy will achieve, by when);
- Program measures (broad categories of activities);
- Implementation and institutional arrangements (including ministries and organizations involved);
- Funding and other resources (levels and sources, human resources);
- Indicators of success; and
- Monitoring and evaluation (M&E) plans (Hardee et al., 2004).

**Policy formulation process.** The formulation process also matters. There are many paths to policy formulation, with considerable variations

in the length of time for drafting and approval, stakeholder engagement, review processes, and lead agencies guiding the task (Stover and Johnston, 1999). Nonetheless, main components of the policy formulation process include identification of problems and recognition of the need for a policy response; situation analysis and assessment of policy options; policy drafting; review and revision; and, ultimately, approval (Stover and Johnston, 1999; Goliber and Cross, 2006). Essential ingredients for the design of responsive, actionable policies are evidence-based planning and meaningful engagement of multiple stakeholders, including non-health sectors, civil society, and the private sector. A policy designed without meaningful stakeholder engagement may be more difficult to implement because it does not consider the needs of nor engender buy-in and ownership from those who will implement or “benefit” from the policy (Klein and Knight, 2005).

As a process, policies that come about through an evidence-based, participatory manner can

- Build cooperative relationships and networks that will facilitate implementation;
- Educate the various stakeholders of the viewpoints, needs, and assets of other affected groups;
- Encourage consensus on priority issues and approaches;
- Promote ownership and buy-in across sectors;
- Empower those who take part in the process;
- Promote open community dialogue on policy issues and break the silence surrounding sensitive health issues; and
- Bestow greater legitimacy on the policy approaches adopted, thereby increasing likelihood of effective implementation.

**Linking policy to implementation.** Following approval, attention needs to quickly shift to what is needed to implement the policy. If the policy formulation process involved a wide range of stakeholders, there will already be familiarity with the basics embodied in the policy. Some portions of policies may be amenable to immediate implementation, through simple administrative actions or internal memoranda. Other portions of the policy may require more in-depth operational planning for implementation. Resources become a key issue at this point, as well as assignments of who has responsibility for translating policy into action. Policies that result in new programs, services, or operational guidelines need to be disseminated to and understood by those people responsible for implementing and using them (Brinkerhoff and Crosby, 2002). If the public is going to access services or benefits brought about by a new policy, it must also be made aware of any new provisions and programs.

Ultimately, policies designed with an eye to best practices and feasibility for implementation are more likely to be put into practice. Some of these key ingredients are ownership and participation of key stakeholders/beneficiaries; reasonable goals and strategies based on data and evidence of what works; clearly identified roles and responsibilities; M&E processes; and plans for rapid dissemination. Furthermore, policies are not static; they are dynamic. While a broad national policy may capture major commitments and consensus on the way forward, gaps may emerge over time in areas or issues not addressed. Policies will need revisions to reflect emerging issues and changing priorities.

## National RH Policy and Strategy Seek to Meet the FP/RH Needs of Underserved Groups

While Kenya has long had an active national FP program, until recently, the country did not have a national policy framework to guide implementing an effective FP/RH program. The health ministry's Division of Reproductive Health and the RH-Interagency Consultative Committee, with support from the Health Policy Initiative, led a policy formulation process. As a result, in 2007, Kenya adopted its first-ever *National Reproductive Health Policy*, with the theme, "Enhancing the RH Status for All Kenyans." The policy addresses key issues such as RH commodities security, the prevention of mother-to-child transmission of HIV, emergency obstetric care, adolescent RH issues, GBV, and RH needs of persons with disabilities.

With a new policy in place, the country needed to update its RH strategy. The project provided assistance to facilitate the strategy development process, paying particular attention to the policy theme of enhancing the RH status of all Kenyans. To understand the FP/RH needs of underserved groups and their challenges in accessing services, focus group discussions were carried out with women and men from poor communities (Health Policy Initiative, 2010a). The project and partners organized policy dialogue sessions at community and provincial levels to share findings and gather reactions from local health authorities, program implementers, service providers, and poor communities. During these sessions, the poor interacted with service providers and decisionmakers to discuss the challenges they face in accessing FP/RH services and pose potential solutions.

The government then convened a national policy dialogue session, which brought feedback from the community and provincial deliberations to national decisionmakers. Informed by this feedback and additional analyses, the *National Reproductive Health Strategy (2009–2015)* includes clear, time-bound equity indicators and specific strategies to target resources and efforts to the poor.



Photo credit: Curt Carmemark / World Bank.

## 2.4 Addressing Barriers

Often, barriers to implementation have their roots in non-existent, inadequate, or conflicting policies. Appropriate legal or policy action may also help to address barriers rooted in other (non-policy) causes. Throughout the policy process, it is important to address what is not working and do more of what is working.

Policies and programs rarely roll out exactly according to plan; they inevitably face barriers and challenges. These barriers may crop up at any point in the Policy-to-Action process. For example, the need to overcome a particular service delivery issue—such as delays and stockouts in receiving commodities—may be the catalyst for initiating policy dialogue and reform. Or, in the act of implementing a newly-adopted

policy, implementation and monitoring processes may reveal unintended consequences that must be remedied—such as differences in HIV treatment adherence by women and men. Even before implementation begins, at the problem identification and policy formulation stages, it is important to consider and plan solutions to address barriers, as well as seek ways to capitalize on facilitators of implementation (e.g., existing supporters, capacity, resources).

### Box 5. Approaches for Identifying Barriers

- Focus group discussions, client exit interviews, and secondary analysis of population-based surveys (such as market segmentation analyses of Demographic and Health Survey data) to understand the needs and challenges of users and non-users of health services
- Policy and legislative audits to explore policy gaps or conflicts
- Operational assessments, which could include review of facility records, service statistics, and monitoring reports; interviews and focus group discussions with program managers and implementers; and observations of information- and work-flow processes
- Mapping exercises to examine the distribution of resources, infrastructure, and human capacity, as well as identify the areas and populations most in need of services
- Adaptation and application of existing tools, such as the Policy Implementation Assessment Tool (Bhuyan et al., 2010), program implementation barriers analysis (Feranil et al., 2010), or Stigma Measurement Tool for Health Facilities and Providers (Health Policy Initiative, 2010d)
- Studies and assessments to examine key issues, such as cost-effectiveness studies, gender analyses, or citizen monitoring activities

Addressing barriers will be an ongoing process as implementation unfolds. It entails identifying barriers to implementation (Box 5), devising solutions, revising plans accordingly, gaining buy-in and support of key stakeholders to carry out needed actions, and moving forward again.

**Barriers to implementation.** There are myriad potential barriers to policy and program implementation to consider. *Policy barriers* could include policy gaps, inadequate operational guidelines, and ill-designed, out-dated, or conflicting policies (Cross et al., 2001). *Financial constraints*—such as insufficient funding, lack of coordination of funding sources, inefficient or inequitable use of resources, limited capacity of implementers to use funds, and lack of accountability and tracking of resource use—are common challenges. *Health systems issues* can range from lack of human resource capacity, to inequitable distribution of infrastructure (e.g., facilities, transportation, communication), to limited coordination and integration across sectors (e.g., public, private), levels (e.g., national, district, community, facility), and program areas (e.g., RH, HIV) (Example 7). Closely related to health systems issues are specific *operational barriers* encountered when

## New Strategy Seeks to Address Barriers to RH/HIV Integration

While Kenya has an overall policy to integrate RH and HIV services, many operational barriers inhibit implementation. To assist in-country partners in identifying key barriers to integration of RH and HIV services, the Health Policy Initiative organized interviews with policymakers, program managers, and service providers at the central and district levels (Okundi et al., 2009). The assessment identified numerous barriers, including the lack of service protocols and operational policy guidelines for RH/HIV integration, inadequate government funding for service integration, limited staffing levels in public health facilities, and the existence of parallel HIV and FP/RH supervision and logistics systems.

To help address these issues, the Integration Technical Working Group (ITWG), jointly chaired by the Division of Reproductive Health and the National AIDS and STD Control Program, expanded its membership to 30 public, NGO, and private agencies and donors working in RH and HIV programs. The ITWG's objective is to facilitate the scale-up of RH/HIV integration by ensuring that supportive policies and guidelines are in place, harmonizing planning, and ensuring that stockouts will not derail integration. The group is also expected to advocate for the resources and political commitment necessary to make integration a reality.

In February 2008, the ITWG formed a subcommittee to spearhead the preparation of an RH/HIV integration strategy. The Health Policy Initiative provided technical and financial assistance to the subcommittee to build members' policy development skills and coordinate stakeholder dialogue. The Ministry of Public Health and Sanitation and Ministry of Medical Services adopted the *National RH/HIV Integration Strategy* in 2009. The next steps include preparing operational policy guidelines and costing the operational plan. As a related step to support integration, the ITWG called for an assessment of the barriers HIV-positive women face in accessing RH services; plans are underway to use the findings to design training materials to reduce stigma and discrimination in public health facilities (Herstad and Okundi, 2010).

trying to put policies into practice on the ground, such as inefficient logistics systems, weak referral mechanisms across facilities, or burdensome monitoring and reporting requirements (with little understanding of how to use the information to improve services). Finally, as highlighted in Section 1, implementation takes place within a particular environment. As a result, *sociocultural, economic, and political issues* can hinder the roll out of policies and programs. Examples include gender inequalities, HIV-related stigma and discrimination, lack of political will to address health issues, and high levels of poverty.

### Tailored solutions to overcome barriers.

Proposed strategies to overcome barriers must be informed by evidence and meet stakeholder and client needs. The type of barrier will determine the type of response required. If policies conflict, policy reforms or other actions may be needed. For example, HIV policies are often hindered by laws and law enforcement practices that drive MARPs underground (Example 8). If financial gaps are an

issue, stakeholders might advocate for additional funds but also need to find ways to improve efficient allocation and use of existing resources (e.g., “more money, better spent”). If human resource capacity is an issue, countries may consider strategies such as strengthening medical training institutions, exploring task shifting options, or offering incentives for providers who serve in rural or other underserved areas.

In summary, key considerations for overcoming barriers are (1) understanding the needs of beneficiaries/clients and implementers; (2) assessing the appropriateness of the proposed solution given the barrier and the context; (3) engendering stakeholder buy-in and commitment to take action; (4) determining resources required for the proposed solution; and (5) enacting accountability mechanisms to ensure that barriers have been addressed. Ultimately, success in overcoming barriers is essential for high-quality services, integrated programs, and effective health systems.

### Multi-stakeholder Dialogue Addresses Barriers to Local Implementation of Indonesia's 100% Condom Use Policy

The Health Policy Initiative worked to empower HIV-positive women and female sex workers in Indonesia through training on advocacy, facilitation, policy dialogue, and positive prevention. The trained women went on to train others through organizations such as Ikatan Perempuan Positif Indonesia (IPPI), Bali Plus, and Yayasan Kesehatan Perempuan (YKP). Two members of IPPI trained by the project also serve as national advocacy facilitators to support efforts of the National AIDS Commission (KPAN).

Work with HIV-positive women and sex workers revealed several barriers to the 100% Condom Use Policy (CUP), a key component of the country's national effort to prevent HIV transmission through the sex industry. Sex workers did not want to carry condoms for fear of being arrested or detained by police. Law enforcement did not endorse the CUP because they felt it encouraged sex work. Policymakers and implementers feared that their support would be seen as admitting sex work exists and thereby endorsing infidelity. These factors have limited the implementation of the CUP.

In December 2009, in connection with the project's work with HIV-positive women and sex workers, the district AIDS commission in Denpasar in Bali Province requested the project's assistance to facilitate a coordination meeting among key stakeholders on implementation efforts regarding the 100% CUP. Participants included 180 brothel owners, pimps, village heads, and law enforcement officers. Several HIV-positive sex workers previously trained by the project participated in discussions and policy dialogue to describe the barriers that they have faced in implementation of the 100% CUP. The policy dialogue resulted in an agreement that law enforcement will take a "social health" approach to condom use, instead of a legal approach. Thus, although sex work is illegal, law enforcement personnel agreed to not charge female sex workers if they can show a good health record. Each female sex worker will be given a valid health card, either from a health center or YKP clinic, that shows routine health check-ups. Law enforcement will use this as a monitoring tool, thus female sex workers will no longer need to avoid carrying condoms or hide each time law enforcement officials inspect brothel facilities.

## 2.5 Leadership and Governance

Leadership and governance “involves ensuring strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design, and accountability.”<sup>4</sup>

Policy formulation and implementation are long-term processes that require sustained leadership, ownership, and oversight. The World Health Organization (WHO) identifies leadership and governance as one of the six building blocks for health systems strengthening. In the policy arena, leaders play an important role in keeping issues high on the agenda, guiding policy development and adoption, mobilizing resources, fostering participation of civil society, and coordinating involvement of different sectors and stakeholders. They are also essential for articulating the importance of policy goals and directives and ensuring implementers are accountable for achieving desired results. Strong leadership is a key ingredient for good governance. Good governance is achieved when citizens can voice their needs to leaders and service providers; leaders are responsiveness to the needs of citizens and ensure oversight of services; and providers offer high-quality services and share feedback with leaders and clients (Brinkerhoff, 2008).

Sustaining leadership and good governance, however, are key challenges to implementing policies. High-level government leadership and health positions in developing countries experience frequent turnover, hindering continuity in program support and oversight. Once a policy is adopted, leaders may divert their attention to other priorities, and responsibility for implementation may transition to a new group that may or may not have been involved in the policy’s design. In addition, as health systems continue to decentralize, local leaders and healthcare providers may not yet be adequately trained or equipped to take on new responsibilities.

Leaders for health policy implementation come from various sectors and have different roles. These could include parliamentarians and health ministry personnel, officials from the ministries of finance and planning, or district council members, medical officers, and health officials. Leaders also come from outside government, from such sources as faith-based organizations, the private sector, NGOs, and the media. Leaders could—and, in fact, should—also come from groups of intended beneficiaries of health services, including women, PLHIV (Example 9), MARPs, the poor, and underserved groups. Regardless of the individual leader or role, four common pillars of leadership and good governance are commitment, capacity, continuity, and communication.

**Commitment.** Leaders must have commitment for implementing policies, which requires regular attention and follow-through after the policies are adopted. Leaders’ commitment can come from within, based on personal interest in an issue, a sense of responsibility for the public good, or drive for excellence in job performance. Commitment can also be strengthened by networking and group dynamics, including awareness raising and advocacy by civil society, peers, and other leaders and influential groups. Commitment can also be encouraged through mechanisms to promote accountability, for example, through the electoral process in democratic societies, media scrutiny of health issues and programs, and citizens monitoring and watchdog groups.

**Capacity and continuity.** Once committed to a policy issue, leaders must have the capacity to act. Individual skills include capacity to understand

<sup>4</sup> See WHO webpage on “Health Systems Topics,” available at <http://www.who.int/healthsystems/topics/en/>.

and apply data to inform policy formulation, priority setting, action planning, and monitoring. It requires a sense of self-efficacy, which can be bolstered by strengthening programmatic skills (e.g., management, financial planning) and technical expertise (e.g., accurate understanding of RH, HIV, and maternal health issues). Leadership capacity also involves a lot of art—to navigate the Policy-to-Action process, to engage and coordinate with partners, to inspire change.

Institutional- and systems-level processes must be in place to promote leadership capacity building and continuity. Examples include training and leadership development, succession planning (to help address turnover issues), mentoring programs, South-South exchanges, performance-based evaluation systems, and networking mechanisms. For example, one way the Health Policy Initiative fostered leadership

for health policy issues is through the creation and strengthening of leadership networks, including parliamentary committees to address RH and HIV issues (e.g., Mali, Tanzania) (Example 10), HIV business councils (e.g., in Mexico, Guatemala, Jamaica) (Example 11), and religious and interfaith networks (e.g., Kenya, Mali, Tanzania). Working with leaders from many sectors and levels can help to gain a critical mass of supporters to sustain commitment for health issues.

**Communication.** Leadership and good governance require good communication. To ensure smooth functioning of policies, programs, and systems, leaders must be responsive to their citizens, able to guide and exchange feedback with program implementers, and reach out to other sectors (e.g., finance, planning, private sector) and stakeholders that can support health policy implementation.

## 9. MIDDLE EAST AND NORTH AFRICA

### People Living with HIV Emerge as Leaders

From 2005–2010, the “Investing in PLHIV Leadership in MENA” initiative strengthened the capacity of people living with HIV in the Middle East and North Africa (MENA) region through training, mentoring, and small grants (Kay and Datta, 2010). The initiative sought to build social capital of PLHIV in the region, promote greater investment in PLHIV, and foster policy dialogue and advocacy. On the path to strengthened PLHIV leadership in MENA’s HIV response, the initiative has achieved several outcomes. PLHIV are taking steps to form a regional network (MENA+); women living with HIV have emerged as leaders and are starting support groups for other women affected in the region; and national AIDS programs (NAPs) have contributed funding to support expansion of PLHIV-led activities in-country. In addition, the Health Policy Initiative assisted PLHIV to create and use four curricula (which will be available in English and Arabic) to help build the capacity of PLHIV in the region.

Key partnerships have been made to ensure sustainability of gains from the Investing in PLHIV Leadership initiative and to ensure that the path to greater PLHIV leadership continues. Among these steps are a pledge by the Jordan NAP to support the MENA+ website; resources and support provided by Ford Foundation and ICW to establish a regional women’s network; and additional funding by NAPs for country-level activities led by and for PLHIV.

By exemplifying the GIPA principle, the Investing in PLHIV Leadership in MENA initiative has supported the transformation of HIV-positive people as engaged leaders working with their peers, physicians, health officials, political leaders, and other stakeholders to improve HIV prevention, care, and treatment programs in the MENA region.



Photo credit: A. Bhuyan.

“I feel strength I didn’t have before. I feel I am able to communicate better. I was shy—I didn’t know how to speak. But after this training, I’m strong.”

—Woman living with HIV, Egypt

Further, to promote public health initiatives, strong leaders must have the courage to speak out on and communicate about sensitive issues. For example, the Health Policy Initiative has strengthened the capacity of Christian, Islamic, traditional, and community leaders in Kenya, Mali, South Africa,

Tanzania, and Indonesia to openly discuss issues such as women's inheritance rights, HIV-related stigma and discrimination, family planning and birth spacing, constructive men's engagement, and female genital cutting.

## 10. MALI

### Parliamentarians Take Action to Meet Local Health Needs

Repositioning family planning in Mali has included working with parliamentarians on legislative reform. The Parliamentarian Network on Population and Development (REMAPOD) was formed to advocate for FP/RH priorities. On June 24, 2002, REMAPOD succeeded in getting the RH law, Law No. 02-044, approved by Parliament. The network subsequently has focused its efforts on implementation of the law. To monitor implementation, REMAPOD members launched the initiative "parliamentarians on the path to health centers." Funded by the Health Policy Initiative through a small grant, this initiative involved conducting site visits to rural facilities with the aim of identifying potential barriers to implementation of the RH law. On one of the site visits, in the region of Koulikoro, the review team discovered that the rural health facility lacked a medical doctor because of insufficient resources. The network identified this as a barrier to the availability of RH services and lobbied the MOH to cover the salary of a medical doctor for the facility. The MOH agreed to do so in February 2008. As a result of the parliamentarians' advocacy efforts, one of the poorest communities in Mali has a chief medical doctor who can provide FP services. The experience provides a model for how leaders can make a difference in health service provision in their communities.

## 11. PRIVATE SECTOR

### Business Councils Foster Leadership and Accountability for Private Sector HIV Initiatives

National HIV business councils serve as a platform for leadership in the HIV response and can hold member companies accountable for commitments in HIV workplace policies, financial resources, and community investments. The Health Policy Initiative has supported the formation and capacity development of national HIV business councils, especially as individual companies designed HIV workplace policies and formalized their commitment to HIV. The project supported the formation of business councils in Mexico, Guatemala, and Jamaica and has provided technical assistance to business councils and unions in Mozambique and Tanzania.

For example, since its founding in 2004, the National HIV/AIDS Business Council (CONAES) in Mexico has grown into a strong advocate for a private sector role in the national HIV response. The council has 26 member organizations, reaching about 150,000 employees. Members have adopted HIV and anti-discrimination workplace policies. In recognition of its important role, in October 2009, CONAES was invited to become a voting member of the National AIDS Council Governing Body. The inclusion of CONAES will help to ensure that the business community has an active voice in the HIV response. This step marks another milestone in CONAES's strengthened HIV capacity and leadership role in Mexico.

In Mozambique, the Health Policy Initiative partnered with EcoSIDA (Business Forum Against AIDS, Malaria, and Tuberculosis) to launch the Private Sector Task Force for Monitoring and Evaluation (PSTF). Composed of representatives from EcoSIDA, the National AIDS Council, International Labor Organization, UNAIDS, Health Policy Initiative, and Population Services International, the PSTF aims to coordinate the private sector's response to HIV and strengthen multisectoral collaboration by creating a private sector monitoring and evaluation (M&E) subsystem in alignment with the national HIV reporting system. The M&E subsystem encompasses program monitoring, program effectiveness and efficiency, impact evaluation, and allocation of financial resources. PSTF will use the new subsystem to monitor the workplace response to HIV and harmonize indicators for inclusion in the country's national M&E database. The subsystem will help PSTF increase efficient use of resources and reduce duplication of effort in the private sector HIV response. PSTF began piloting the M&E subsystem in early 2010 by collecting data from EcoSIDA members in five provinces.

## 2.6 Action Planning

Action planning is an evidence-based collaborative and cyclical process of determining *what, how, who, when, and where* resources and efforts are required to put the broad policy or strategy into practice.

Once a policy has been adopted, it needs a plan. While the policy sets priorities and gives broad guidance on strategies to achieve goals, the action plan includes the details for interventions, such as the resources required and the people or institutions responsible for carrying them out. A possible stumbling block at this stage is that “difficult decisions that were avoided when the policies were drafted” must be resolved as plans and operational guidelines are developed (Stover and Johnston, 1999, p. 23). When activities are too general, it may not be clear who needs to do what. Then, no one is accountable. Further, without the participation and buy-in of those responsible for mobilizing the human and financial resources, implementation may be severely hampered. In particular, to implement national strategic plans on the ground, stakeholders at local and functional levels must be involved in the decisionmaking process and have capacity to carry out strategies.

**Devising action plans.** As in the case of policy and strategy development, action planning is concerned with both content and process. In terms of content, action plans outline specific activities, resources available and needed, the timeline for carrying out activities, responsible groups, and monitoring indicators and data sources (Box 6 and Example 12). Planners need to translate broad policy goals into specific, measurable, appropriate/achievable, realistic, and time-bound (SMART) objectives—the gold standard for goal setting (Doran, 1981; INFO Project, 2008). Action planning also requires assessing strategic options and considering availability of adequate resources for the implementation of the different strategic interventions in all priority areas, including ways of making judicious or better use of existing resources. Techniques such as rapid situation analysis can

### Box 6. Action Planning Steps

Evidence-based dialogue and planning meetings are needed to

- Build consensus on goals
- Set priorities
- Develop strategic options
- List activities and map actions
- Assign roles and responsibilities
- Identify available and needed resources
- Determine sources of funding
- Develop timelines
- Assess feasibility of proposed interventions
- Set milestones and performance indicators
- Identify capacity-building needs
- Make revisions based on stakeholder feedback
- Draft detailed action plans

help planners to understand issues, challenges, and opportunities in the local environment.

**Bringing policymakers and implementers to the table.** In terms of the process, action planning may be seen as the art of facilitating interaction among planners, implementers, service providers, financial decisionmakers, beneficiaries, and other key stakeholders to enable a locally-determined response. This may involve conducting or updating stakeholder analyses to identify and engage key stakeholders at national and local levels to develop feasible and implementable action plans. Policy dialogue and planning meetings provide a platform to collaboratively draft detailed plans that can guide the conversion of policy and strategic directions into concrete actions.

**Linking local and national plans.** Ultimately, policy and program implementation takes place at the local level. Local action plans must be linked to the national-level policy and financing frameworks

## Operationalizing the National Population Strategy

Jordan has undertaken a number of steps to put the *National Population Strategy 2000* into practice. These steps include design and implementation of the Reproductive Health Action Plan (RHAP) Phase I (2003–2007), *Contraceptive Security Strategy*, and RHAP Phase II (2008–2012), which includes a detailed M&E plan. Key factors contributing to the design and roll out of these plans and strategies include evidence-informed advocacy and decisionmaking, multisectoral engagement, and strong leadership by the Higher Population Council (HPC).

**RHAP II.** Launched in November 2008, RHAP II is designed to promote a multisectoral response to improve the quality of and access to FP/RH services. The plan was developed by a multisectoral RH Planning Task Force comprising the HPC, MOH, Ministry of Planning, Ministry of Finance, Ministry of Education, Ministry of Youth, Jordanian Association for Family Planning and Protection, United Nations Relief and Works Agency, and commercial sector representatives. A number of background studies and analyses—including market segmentation, national health accounts, operational barriers, the procurement system, and detailed situation analysis—informed the development of the plan. The task force used DemProj and FamPlan of the Spectrum System of Policy Models to set realistic goals and determine resource requirements for achieving goals. The Health Policy Initiative facilitated this planning process by building task force members' capacity in strategic planning, advocacy, costing, and budgeting techniques and assisting to organize policy dialogue and planning meetings to identify priority issues and actions. The project also helped several youth become policy champions advocating for youth-related issues and promoting the inclusion of youth-specific objectives and activities in RHAP II. As a result, for the first time, youth participated in designing a national-level health policy.

**Resources.** These high-level commitments have been operationalized through the approval and funding of several significant policy documents and plans of action. For example, in June 2005, the Prime Minister approved and, in 2006, the Ministry of Finance funded the first year of the national *Contraceptive Security Strategy*. This funding has continued annually since that time, based on projections from the MOH's logistics system. Further, in late 2006, the government of Jordan signed—and is continuing to fulfill—its commitments outlined in a memorandum of understanding with USAID to transfer the responsibility for purchasing contraceptive commodities to Jordan. In addition, in June 2008, the Ministry of Planning and International Cooperation allocated approximately US\$800,000 to RHAP II for the first 18 months of the plan's implementation. The funds represent a significant increase over RHAP I, whose budget was US\$819,000 over four years. In particular, early and consistent involvement of finance and planning officials in the task force was an important factor in Jordan's ability to ensure funding.

**M&E.** RHAP II includes a detailed M&E plan that outlines indicators and methodologies for data collection and use. The Health Policy Initiative assisted HPC to draft the M&E plan for RHAP II (a component missing from the original RHAP). Subsequently, HPC established and staffed an M&E unit to carry out the plan and is building the unit's capacity in key M&E competencies.

**Capacity.** Throughout these planning and implementation processes, the HPC has shown considerable leadership and increased its organizational capacity. Over time, the government has increased funding of HPC activities and donor support from USAID through the Health Policy Initiative is focused on technical assistance to strengthen policy-related institutional capacity.

to ensure smooth flow of financial resources and effective monitoring and feedback. When action is devolved to local or provincial levels, challenges are greater. In decentralized settings, national policymakers and planners must train and orient local-level decisionmakers to establish links among national goals, policies, strategies, budgeting, and local actions. Implementers must understand how their short-term activities and objectives relate back to overall national strategy and policy goals. To aid this process, demographic projection, planning, and other health models, such as DemProj, FamPlan, and the AIDS Impact Model,<sup>5</sup> can provide useful information to translate overall policy and strategy goals into SMART objectives for the decentralized level units (Example 13).

In addition, development of financial plans requires hands-on training for decentralized-level planning team members to identify inputs and estimate costs for each activity in consultation with Ministry of Finance officials. This often requires several rounds of planning meetings to come up with good cost estimates and going back and forth (planning-

budgeting) and revising a number of activities to ensure financial feasibility. Low-cost and high-impact activities must be selected for immediate implementation, keeping in mind the limited availability of resources. The action plan must also identify appropriate financing mechanisms to ensure timely access to and disbursement of the allocated funds.

To roll out local planning efforts, collaborative methods for designing local action plans may be initiated in selected areas, followed by designing a framework for replication in other districts. For example, the Health Policy Initiative facilitated a local planning process in Uttar Pradesh, India, leading to adoption of HIV district action plans in five districts. The project also assisted in setting up the District AIDS Prevention and Control Units responsible for executing the plans. Establishing “twinning” relationships to share lessons learned from local action plans and innovative approaches with additional districts can strengthen local capacity and expedite the process of replication.

## 13. TANZANIA

### Costed Implementation Plan and Advocacy Help Reposition Family Planning

In early 2009, the President of Tanzania set a goal of reaching 60 percent modern method contraceptive prevalence by 2015 as part of the *National Road Map Strategic Plan to Accelerate Reduction of Maternal and Newborn Deaths in Tanzania (One Plan)*. In response to this ambitious plan, the Ministry of Health and Social Welfare (MOHSW) initiated work to design a *National FP Costed Implementation Plan (NFPCIP)*. Several organizations contributed to the action planning process, including the MOHSW, Private Nurses Midwives Association of Tanzania, and other in-country and international partners (Lasway and Hiza, 2009). The Health Policy Initiative coordinated the development of the Policy and Advocacy Strategic Action section and assisted in projecting the contraceptive commodities and acceptors that would be needed to meet the 60 percent CPR target. The latter required tailoring a FamPlan application (a component of the Spectrum System) to accommodate regional differences in FP use, fertility intentions, and capacity to deliver goods and services—which was essential in designing a more accurate costed implementation plan.

In April 2010, the government launched the NFPCIP in a well-publicized media event. To promote policy dialogue and advocacy, the Health Policy Initiative assisted the Tanzania Parliamentary Association on Population and Development (TPAPD) to convene 25 parliamentarians who had previously demonstrated commitment to FP issues. Subsequently, they embarked on a series of meetings with key decisionmakers, including parliamentary groups and committees, such as the Finance Committee and Committee on Population and Development. Advocacy efforts culminated in a meeting on June 27, 2010—the day before the Minister of Health was due to present the proposed budget to Parliament. Eighty parliamentarians, nearly one-third of Parliament, attended, along with the Minister of Health. The next day, at the budget session, parliamentarians pledged to increase government funding for family planning to carry out the NFPCIP. With this commitment made, now there is a need for ongoing advocacy and policy dialogue to ensure that the Government of Tanzania allocates and releases funds.

<sup>5</sup> Available online at <http://www.healthpolicyinitiative.com/index.cfm?id=software>.

## 2.7 Resource Mobilization

Stewardship of health resources involves ensuring optimal use of limited resources (human, financial, material) to achieve desired goals.

“Resources” include the array of financial, human, material, and other resources needed to carry out plans and programs. Few, if any, countries have all the resources they need to meet their citizens’ health needs. Thus, there are always choices to be made about what must be done and what can realistically be done. For example, the situational analysis phase in policy and strategy development should include an assessment of human, institutional, and financial gaps and resources needed to meet policy goals. Setting priorities and making hard choices about how to allocate resources and efforts is an unavoidable feature of policymaking and strategy development. The policy process is geared to guiding decisionmakers in making the choices that will result in the best possible use of valuable human, financial, and material resources.

When resources are scarce or limited, policymakers, planners, and program implementers must seek to maximize available resources through a variety of means, such as mobilizing new resources, efficiently and equitably allocating existing resources, and tracking expenditures to enhance flow of resources and reduce waste. Resource maximization is an ongoing, iterative, and interdependent process of analyzing, planning, mobilizing, allocating, using, tracking, and monitoring resources effectively, efficiently, and equitably. Before resources are acquired and allocated for the implementation phase, policymakers and planners must know what resources are needed and who will provide them. This requires a good understanding of (a) financing trends and current sources of funding (e.g., donors, government, NGOs, private enterprise, households) and respective funding mechanisms; (b) key

financial decisionmaking processes and actors; and (c) financing issues, needs, and gaps.

**Mobilization of new resources.** Mobilizing new resources requires evidence-based advocacy and multisectoral dialogue with key stakeholders who have control over resources to get them committed, allocated, and authorized. Involvement of key stakeholders in action plan formulation is a major step toward mobilizing financial and human resources from different partners. Involving influential stakeholders, such as the Ministry of Finance and Ministry of Planning, in health budgeting helps mobilize resources for policy implementation by using evidence to demonstrate the magnitude of the health issue, the consequences of inaction and benefits of action, the level of resources required, and the cost-effectiveness of proposed strategies.

**Costed strategic plans** provide a framework and timeline for implementation and bolster advocacy to mobilize and secure long-term funding. They help to set priorities and allocate resources effectively to reach goals and target populations or beneficiaries. Costed action plans have higher chances of approval as they provide clear understanding of the required investment to financial decisionmakers.

There are sound tools, methodologies, and approaches available to cost plans, interventions, and scale-up models. The Health Policy Initiative has helped in-country partners use computer-based models—such as the Resource Needs Model (RNM), Goals, FamPlan, ALLOCATE, Safe Motherhood, and other models<sup>6</sup>—to inform, influence, and improve strategic planning and

<sup>6</sup> Computer models can be downloaded at <http://www.healthpolicyinitiative.com/index.cfm?id=software>.

resource allocation decisions in various countries (Box 7 and Example 14). These models help estimate resource requirements, assess feasibility of achieving the stated goals, and analyze alternative resource allocation scenarios to inform decisions.

**Efficiency.** Governments can maximize the use of existing resources through improved donor coordination, human resource planning and task shifting, integration of programs where appropriate, and partnerships with other sectors. For example, enhancing donor coordination can avoid duplication of effort and ensure that priority, cost-effective interventions are funded. “Contracting out” service provision to NGOs or the private sector can promote access, extend health service coverage into remote areas, introduce alternative approaches to service delivery, and reduce government long-term recurrent costs. National Health Accounts, public expenditure tracking systems, and mid-term budgetary reviews are useful tools/processes to promote efficiency and fiscal accountability. Attention to the flow of funds is also important—mechanisms should be in place to systematically identify and remove barriers to effective disbursement and expenditure of funds, especially at the decentralized level.

**Equity.** When equity is an important consideration, pro-poor financing interventions introduce fairness in resource allocation and use (Box 8). This may involve (a) designing equity-based formulae for resource allocation and applying gender budgeting approaches; (b) promoting transparency and involving underserved groups in national and local planning/budgeting forums; (c) designing and assessing impact of alternative resource allocation scenarios by geographic area, target population, and health area; (d) developing appropriate strategies, such as public-private partnerships to reach the poor; and (e) implementing pro-poor financing schemes such as vouchers, conditional cash transfers, fee exemptions, and social insurance.

#### **Responding to changing funding levels.**

Finally, action plans must be developed in such a way that implementation can respond to varying and changing funding levels. Carrying out a

plan includes the generation and allocation of resources as proposed as well as managing and monitoring resource use. As priorities change, resource allocation needs to change. During the implementation phase, information regarding what is working, what is not working, and why ultimately serves to inform planners and donors about resource allocation decisions to maximize the returns on the investment.

#### **Box 7. Male Circumcision Decision Makers’ Program Planning Tool**

The Health Policy Initiative designed 44 new models, curricula, manuals, guidelines, frameworks, and other tools to aid policy work. The project also continues to update and refine existing computer models, such as the Spectrum Suite.

One new tool designed under the Health Policy Initiative—with the project’s implementing partner, the Futures Institute—is the Male Circumcision (MC) Decision Makers’ Program Planning Tool (DMPPT). This tool estimates the cost and impact of scaling up male circumcision as an HIV prevention strategy, which helps policymakers and planners understand resources needed for scale-up. With UNAIDS and WHO, the Health Policy Initiative is estimating the cost and impact of MC scale-up in a number of sub-Saharan African countries, including Kenya, South Africa, Uganda, Zambia, and Zimbabwe.

**Learn more:** [www.malecircumcision.org/programs/DMPPT.html](http://www.malecircumcision.org/programs/DMPPT.html)

#### **Box 8. The EQUITY Framework**

The Health Policy Initiative’s EQUITY Framework (Health Policy Initiative, 2010b) calls for

- **Engaging and empowering the poor;**
- **Quantifying inequalities in health service access and health status;**
- **Understanding barriers to access;**
- **Integrating equity goals, approaches, and indicators into policies, plans, and development agendas;**
- **Targeting resources and efforts to the poor; and**
- **Yielding public-private partnerships for equity.**

The project has successfully applied the approach in a number of countries, including Guatemala, Kenya, India, and Peru, to increase access to FP/RH services among the poor, indigenous, and other underserved groups.

### Increased National and Provincial Budgets for HIV Action Plans

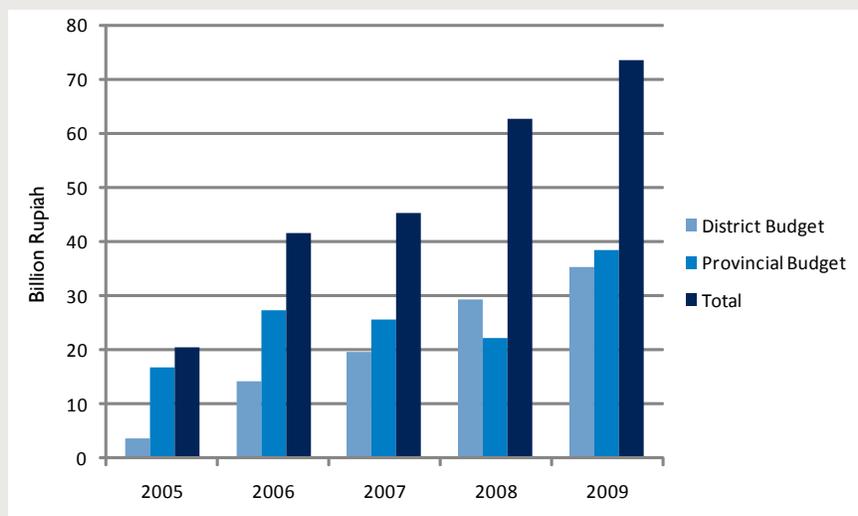
Indonesia's National AIDS Commission (KPAN) is responsible for the development and implementation of the country's national HIV strategy (2007–2010). In 2006, KPAN requested the Health Policy Initiative's assistance to develop a national costed action plan to implement the strategy. The project supported KPAN to form a national costing team, including staff from KPAN and the Center for Health Research at the University of Indonesia, and to cost the national action plan using the Resource Needs Model (RNM). RNM is a software program that estimates resources needed and cost implications of national strategic plans (Health Policy Initiative, 2010e). KPAN shared the draft costed action plan at workshops with decisionmakers. Based on feedback, the plan was finalized and endorsed in May 2007. The costed action plan is a powerful tool that has helped KPAN advocate for increased resources for HIV programs.

At the end of 2007, Jakarta Province sought the project's technical expertise to use the RNM with the Goals Model, which estimates the impact of alternative resource allocation patterns on achievement of HIV program goals, and link these with the Asia Epidemic Model, developed by the East-West Center. KPAN presented findings from the linked models at a national meeting in March 2008. The Ministry of Planning embraced this approach as a national planning methodology for costing and planning HIV programs in Indonesia and, as a result, Presidential Instrument No. 3/2010 has integrated HIV planning into the national development planning process.

To roll out the approach at the provincial level, KPAN established two national facilitator teams: one team to build capacity for modeling and creating costed provincial HIV action plans and another team to build capacity of provincial stakeholders to advocate for budget allocations and adopt local regulations on HIV prevention, treatment, and care. The Health Policy Initiative and partners developed guidelines and training materials on planning, resource allocation, and advocacy. The project also trained the costing team and the advocacy team, which includes PLHIV, men who have sex with men (MSM), transgenders, and other MARPs. KPAN financed and organized a series of eight trainings for 157 provincial stakeholders from all 33 provinces, and the Health Policy Initiative observed and provided technical support.

This strategic planning process has helped to increase the national budget allocation for HIV from US\$11.4 million in 2006 to US\$77.7 million in 2010 (Mboi, 2010). Provincial and district HIV budgets have also increased.

**Provincial and District HIV Budget Allocations (in Billion Rupiah)**



Source: Nafsiah Mboi, National AIDS Commission, Indonesia, "Update: Toward Universal Access and MDG." Presented at the XVIII International AIDS Conference, Vienna, Austria, July 18–23, 2010.

## 2.8 Implementation of Strategies

Policy implementation is the set of actions needed to create conditions to facilitate effective service delivery in pursuit of policy goals.

With policies and plans in place, it is time to get to the actual “doing” of policy implementation. Most, if not all, policies will call for the implementation of new or improved services. Policy implementation involves accomplishing “policy objectives through the planning and programming of operations and projects so that agreed upon outcomes and desired impacts are achieved” (Brynard, 2005, p. 9). The art in implementing strategies is understanding the specific actions needed to put policies into practice on the ground, which will vary considerably depending on the specific context and policy. In general, implementation of policies and strategies involves organizing, budgeting, motivating, collaborating, training, supervising, monitoring, and leading to “make the strategy work.” Full implementation of the strategy, such as integrating two vertical health programs, may require a redefinition of operational tasks and responsibilities in light of the proposed approach. This is often the most crucial and expensive part of creating conditions for effective implementation. The greater the difference between the current approach and the proposed new approach, the more difficult the implementation because more changes in the operative behavior of the system are needed. As illustrated in this section, pilot demonstrations and operations research can help assess what is or is not working and producing intended results and why. Pilot testing can help to explore the feasibility of implementing an innovative strategy before it is carried out on a large scale (WHO, 2009) (Examples 15 and 16).

Implementation of strategies involves coordinating and mobilizing **people** (e.g., manpower planning, human resource gap analysis, task shifting, capacity building, performance-based evaluation), **resources**

(e.g., allocating, ensuring flow of resources, using, and managing), and **actions** (e.g., policy, systems, community levels) with the aim of achieving policy goals. The implementation stage may involve the following:

- Disseminating the policy/strategy and raising awareness of its provisions among implementers and intended beneficiaries
- Building system, institutional, and individual capacity to carry out the strategy successfully
- Allocating sufficient resources to implement the strategic interventions
- Adopting associated supportive policies, such as guidelines on new treatment protocols, confidentiality, or gender-sensitive and culturally-appropriate services
- Removing barriers to implementation
- Carrying out pilot tests to inform plans to go to scale
- Assessing and integrating best practices and programs into policies for continuous improvement
- Installing support systems, including training programs and monitoring and information systems
- Tying incentives to achievement of results
- Creating a strategy-supportive culture (for example, if the strategy is proposing a decentralized system, stakeholders at the district level should be involved in decisionmaking)
- Exercising strategic leadership to keep implementation on track.

## Implementation of MARP GBV Screening Pilot Program Encourages Policy and Institutional Change

Gender-based violence (GBV) is not only an issue for women. Emotional, physical, and sexual violence is often perpetrated against MSM, transgendered persons, and male sex workers as a form of discrimination against their gender identities. Such violence increases their risk for HIV. However, healthcare providers have been slow to address the issue of GBV among MSM and transgenders—being either unaware of their vulnerability to violence or reluctant to delve into these sensitive issues.

The Health Policy Initiative designed a GBV Screening Tool in collaboration with health sector and community-based partners in Mexico and Thailand—two countries with concentrated HIV epidemics among MARPs, including MSM and transgenders (Egremy et al., 2009; Betron, 2010). Partners actively engaged in designing the tool and received training on GBV and use of the screening tool, as well as related issues, such as stigma and discrimination. When piloted through integration into HIV services for MSM and transgenders, the GBV Screening Tool revealed high levels of violence among these groups. Ensuring the availability of appropriate GBV services designed specifically for MSM and transgenders who experience violence was a key need identified during the pilot test. Despite this challenge, the pilot led to myriad positive changes in access to services for MSM and transgenders:

- **Increasing awareness among health providers:** pilot activities have increased awareness on GBV, sexual orientation, gender identity, and HIV vulnerability.
- **Replicating the approach:** in both countries, the approach has opened the doors for replicating the training and screening in other parts of the countries.
- **Linking providers and community groups:** improved collaboration has led to increased service uptake and cooperation in other areas besides GBV.
- **Achieving policy-level change:** in both countries, policy and institutional changes have included addressing GBV for MSM and transgenders in services originally designed for women only; expanding training on sexuality, gender, and violence; addressing issues of post-exposure prophylaxis; and ensuring safe spaces for survivors of GBV.

## Implementing the Voucher Scheme in Uttarakhand

In Uttarakhand, public-private partnerships (PPPs) have been a key mechanism for achieving the goals contained in the state's *Health and Population Policy*. The POLICY Project assisted in the design of the original policy in 2002, and the Health Policy Initiative (2010c) provided assistance to formulate the updated policy, adopted in 2010. The steps below describe the process of implementing a voucher scheme, based on a PPP model, to expand access to affordable and high-quality FP services among the poor. The voucher scheme pilot was designed and tested with support from the USAID-funded Innovations in Family Planning Services II Technical Assistance Project (ITAP). With the vouchers, beneficiaries can obtain family planning and reproductive and child health services from a cadre of qualified private sector providers. Based on the successful pilot test, the government decided to scale up the approach across the state and fully integrate the PPP approach into the 2010 state *Health and Population Policy*.

### Design Phase

- Public-private dialogue and consultations to reach consensus on how to design, test, evaluate, and scale up the voucher scheme in Uttarakhand
- Selection of the pilot districts based on health and poverty indicators and available private sector providers
- Selection of the target population: below poverty line populations in rural areas
- Baseline survey to understand the current use of reproductive, maternal, and child health services, needs, and choice of providers

### Implementation Systems

- Establishment of a multisectoral Voucher Management Unit (VMU) to manage and monitor the voucher scheme activities
- Mapping and identification of private service providers
- Contractual agreement with private nursing homes (PNHs)
- Development of monitoring records and reports
- Design of referral slips and other formats
- Design of monitoring systems
- Design and installation of management information systems for NGOs and VMU

### Quality Assurance Mechanisms

- Training of VMU staff
- Preparation of quality standards/guidelines for PNHs and development of accreditation guidelines
- Assessment and accreditation of PNHs
- Training and supervision of accredited social health activists (ASHAs) by the NGOs managing block-level activities and technical inputs from ITAP
- Client verification
- Medical audit of PNHs
- Client satisfaction survey

### Demand Creation at the Community Level

- Design and printing of vouchers
- Information, education, and communication materials for clients
- Materials for PNHs
- Development of a marketing and communication strategy

### Evaluation and Scale-up

- Comparison of baseline and endline survey results
- Costing of the pilot test and projecting costs of scaling up
- Advocacy and dialogue to get government's approval for funding and scale-up

## 2.9 Monitoring, Evaluation, and Accountability

To move from policy to action, monitoring efforts should not only consider the delivery of services and impact on health outcomes, but also the nature of the policy implementation process itself—to better understand what is and is not working on the ground.

Despite the best intentions, policies may languish—due to lack of political commitment, human and financial resources, or other crucial inputs. Policy implementation takes time and may occur sporadically, not reaching all areas or beneficiaries equitably or as intended. Monitoring and evaluation (M&E) systems are needed to regularly evaluate performance to assess how implementation is going, inform mid-course corrections, and ensure that stakeholders are accountable for achieving policy goals. However, many of the challenges to effective data analysis and use (Section 2.1) can also hinder M&E and need to be addressed, including limited capacity to gather and analyze data; weak linkages between data use and practice; and inadequate feedback to program implementers.

To move from policy to action, policies and strategies should include M&E plans with clear indicators of progress, as well as outline systems to track service delivery and health outcomes. Understanding the “why?” behind quantitative results may require additional analyses, such as expenditure tracking to see how resources are being spent and policy implementation assessments to identify barriers to putting policies into practice. Further, M&E systems must be linked with efforts to engage government leaders, civil society advocates, and other stakeholders in monitoring. Such mechanisms help to promote accountability, transparency, and ownership of policy initiatives.

**M&E plans and systems.** Policies should be measureable and measured. Thus, consideration for M&E must begin at the policy and strategy

development stage, with specific, measurable, time-bound goals. National M&E frameworks and indicators are needed to track implementation of services outlined in policy instruments, as well as assess impact on health indicators. At the national level, the Health Policy Initiative has assisted stakeholders in countries such as Guatemala, Kenya, and Jordan to design RH and HIV M&E plans. This work has involved bringing multiple partners together, determining policy goals and measures, and gaining consensus among stakeholders on M&E plans. Because implementation takes place at provincial, district, and local levels, so too must M&E plans, systems, and capacity be devolved and decentralized. In decentralized settings, the project has helped to incorporate M&E into district HIV action plans in Uttar Pradesh, India; simplify reporting requirements and formats for HIV-related community-based groups in Kenya; and establish oblast-level M&E units in Ukraine (Example 17).

**Policy monitoring.** Tracking the policy environment and, specifically, assessing the process of policy implementation are a necessary complement to M&E efforts that monitor service delivery and health outcomes. USAID-supported policy projects have created and applied a number of tools to gauge the extent of supportive health policy environments, including the FP Effort Index (for example, see Ross and Smith, 2010) and FP Policy Environment Score. Beyond assessing the environment, there is a need to gauge whether and how policies are being put into practice. The Health Policy Initiative designed the Policy Implementation

### Strengthening M&E Capacity at the Local Level

Local officials need capacity to gather and use strategic information to monitor health programs and ensure they are contributing to national goals and meeting the needs of their communities. In Ukraine, the Health Policy Initiative assisted HIV coordinating councils in eight oblasts (regions) to form M&E working groups and centers. Support included hiring M&E specialists to build capacity of the centers and designing the centers' operational procedures. The project also engaged stakeholders in the oblasts to build consensus on indicators, data sources, and collection procedures, resulting in a set of more than 40 standard indicators and additional optional indicators. This consensus is vital because it will enhance the credibility of future M&E findings. The indicators were piloted in the eight oblasts in 2007, and findings were used to design the new regional annual HIV plans. The M&E centers and indicators are important steps toward sustaining monitoring of HIV policy and program implementation and can serve as a model for replication in other regions.

Assessment Tool to help stakeholders monitor policy implementation and identify barriers and facilitators for effective implementation (Bhuyan et al., 2010).<sup>7</sup> With this information, they can better understand policy implementation dynamics, engage in policy dialogue, and identify recommendations for translating health policies into action. Applications of the tool in Guatemala, El Salvador, and Uttarakhand, India (Health Policy Initiative, 2009a, 2010c), by in-country teams have inspired policy action and renewed commitment to FP/RH and HIV policies.

**Fostering good governance through accountability.** Good governance occurs when systems and the stakeholders who operate in them strive to be “efficient, effective, open, transparent, accountable, responsive, and inclusive” (Brinkerhoff, 2008, p. 3). To support strong health systems and effective policy implementation, policy implementation assessment and M&E should be a concern for stakeholders at all levels of the health system—from policymakers to

program managers and practitioners to civil society, community groups, and individuals. Government leaders have a key role to play in fostering good governance and accountability—by guiding policy and program implementation, harnessing resources, and answering to their citizens for pledged commitments. Civil society must be involved, by serving as a watchdog to monitor how policies are actually rolling out and affecting communities. Strong civil society networks, with the capacity and relationships that enable an ability to influence policymaking and implementation, are a key component of accountability. Civil society organizations and networks are increasingly taking up this challenge through a variety of mechanisms—such as the creation of grievance resolution centers at the facility level in Peru, through citizen monitoring of HIV-related stigma and discrimination in Mali and Vietnam, and through social watch activities to ensure accountability for maternal health policies (Example 18).

<sup>7</sup> The Policy Implementation Assessment Tool and associated materials are available online at <http://www.healthpolicyinitiative.com/policyimplementation>.



Photo credit: Courtesy of WRA-Orissa.

### “Social Watch” Helps Hold Governments Accountable for Improved Maternal Health

The global White Ribbon Alliance (WRA) for Safe Motherhood is an implementing partner of the Health Policy Initiative and works to build capacity of national- and state-level WRAs around the world. These alliances engage members from various sectors, including civil society, healthcare providers, government leaders, and the media, to promote maternal health. A key approach of the WRAs is “social watch,” a people-centered strategy that mobilizes civil society to hold governments accountable for their commitments (WRA, 2010).

For example, in 2005, WRA-Tanzania conducted a survey of the number of skilled personnel available at facilities in two districts and compared the findings against the health ministry’s staffing level guidelines. The survey uncovered wide disparities between the sanctioned and actual number of staff in place. The alliance used this information as part of a national advocacy campaign in 2006. As a result, the President’s office issued a letter of permission to hire all graduates from health institutions. In 2007, the Ministry of Health and Social Welfare was instructed to hire 3,890 workers and deploy them to areas with critical shortages. This translated into a 33 percent increase in staffing levels eight months later at the 24 facilities surveyed by the WRA-Tanzania.

In India, WRA-Orissa designed and used checklists to monitor implementation of policies, such as the provision of support to pregnant women for institutional deliveries and commitments to upgrade health centers and units to comply with Indian Public Health Standards. The alliance also carried out “verbal autopsies” of maternal deaths in 12 districts. This methodology gathers feedback from families, community members, and health workers to determine causes of maternal deaths and provide lessons learned for the future. In addition, WRA-Orissa organized more than 25 public hearings to provide women a chance to interact with government and health officials. Each hearing has been attended by 500–1,300 women—resulting in more than 30,000 women, mainly from rural and underserved areas, participating in the meetings. Through this engagement, women have learned about their rights and shared their grievances directly with government authorities.

As a result, the Government of Orissa has started to provide payments through checks rather than cash, to avoid misappropriation of funds intended for pregnant women. The state health department issued instructions to health facilities to ensure the presence of auxiliary nurse midwives. Steps are being taken to upgrade facilities; follow-up surveys have shown a rise in the availability of basic medical equipment at facilities. The Chief Minister of Orissa also declared that women’s self-help groups will be involved in monitoring maternal health services.

## 2.10 Scale-up and Sustainability

Policies and plans are essential for supporting program scale-up and sustainability—by setting standards, outlining roles and responsibilities, establishing coordination and monitoring mechanisms, guiding resource decisionmaking, and fostering continuity.

Scaling up and sustaining what works is the ultimate goal of any policy or pilot program, yet is likely to be the most challenging aspect of implementation. At the scale-up stage, all of the elements in the Policy-to-Action Framework must come together. Too often, however, promising pilot programs remain isolated in a few sites and are not integrated at the national policy level. Or new national initiatives are not effectively devolved to the local level, where implementation matters most. Mobilizing and maintaining adequate resources remains a persistent challenge. Eventually, political and public attention, along with financial resources

and human capacity, may be diverted to new priorities.

Scale-up and sustainability are achieved when the goals, principles, and operational guidelines contained in policy directives are normalized and consistently supported as part of the everyday practice of health service planning and provision. By establishing operational guidelines, reliable funding, and human rights principles, effective scale-up of policies and plans helps to lay the foundation so that services are not provided in an ad hoc, arbitrary, or inconsistent manner. Scale-up

### Country-led Process Places HIV Issues High on the Policy Agenda

Phase 2 of the President's Emergency Plan for AIDS Relief (PEPFAR) emphasizes the transition from an emergency to a sustained response. A central component of this transition is to encourage greater country ownership and leadership for national HIV responses. The Partnership Frameworks and Implementation Plans, agreed on by host-country governments and PEPFAR teams, aim to solidify partnerships and country-driven initiatives to address HIV.

In late 2009, the Health Policy Initiative worked with Côte d'Ivoire's MOH, the Ministry for the Fight Against AIDS (MLS), and the PEPFAR team to support the development of the Partnership Framework. The methodology focused on developing and setting priorities for Côte d'Ivoire's HIV policy agenda under the leadership of the Ivorian government and in consultation with in-country stakeholders. Key activities included a baseline policy assessment, interviews with stakeholders from 28 institutions across sectors, and analysis of policy and program barriers and gaps. These activities culminated in a three-day national-level workshop with 70 stakeholders to share and validate the policy assessment and to design an HIV policy agenda that is in concert with the *National HIV/AIDS Strategy* of Côte d'Ivoire.

During the workshop, participants adopted the HIV policy agenda and endorsed 10 policy areas for action: (1) policy commitment; (2) stigma and discrimination; (3) gender issues; (4) strengthening the multisectoral response and relationships with other health and development programs; (5) international standards; (6) human resources for health; (7) issues affecting children; (8) counseling and testing; (9) access to high-quality, low-cost medications; and (10) laboratories. In each policy area, participants identified priority policy issues and potential interventions using the following criteria: anticipated impact, effectiveness, efficiency, ownership, feasibility, and resources available. Leadership shown by the MOH and MLS, as well as active participation by Ivorian institutions and a wide range of civil society organizations, will help ensure the relevance of the national HIV policy agenda and the country's commitment to the priorities and responses.

requires knowing about and doing more of what works; doing the most possible with the resources available; and sustaining support—from human capacity to funding to political will—over the long term.

Going to scale is a complex process that differs significantly depending on the policy or program at hand. Here are a few overarching points to consider:

- Policies and programs have a better chance of success if they are country owned. **Country ownership** means that policies and programs are nationally initiated and driven, developed through participatory processes, reflect in-country perspectives and priorities, and rely primarily on in-country expertise and capacities to implement (UNDP, n.d.). When policies and programs are country-owned, in-country stakeholders are more invested in the success of the initiatives and feel greater responsibility for carrying out actions needed to bring about such success. Thus, participatory policy processes, with widespread stakeholder engagement and informed by country-specific information, are crucial (Example 19).
- Regardless of the specific health policy or intervention, successful implementation depends on a **strong health system**, including clear policies and guidelines, human capacity, resources, facilities, procurement and distribution of supplies, monitoring mechanisms, and so on. Scale-up and sustainability will be facilitated when new policies and interventions build on and can strengthen existing capacities and systems (Example 20).
- **Good governance and accountability**, discussed in Section 2.9, are essential for scale-up and sustainability. Systems, institutions, and individuals must be committed to operating efficiently, proactively identifying and addressing challenges, and being responsive to clients' and citizens' needs.
- Finally, scale-up and sustainability require both **vigilance and flexibility**. Scale-up must be continually informed by evidence of what is and is not working, with corrective measures taken as needs arise. Strategies also need a degree of flexibility so that promising approaches are adapted to different contexts while still maintaining quality standards and working toward common goals and priorities.



Photo credit: S. Sharma.

### Pro-poor FP/RH Strategies Go to Scale

Peru is a geographically and culturally diverse country. More than half of the population lives in poverty, with significant disparities in health service access between urban and rural areas and for indigenous and non-indigenous groups. Beginning in 2006, the Health Policy Initiative assisted the MOH and civil society groups to design, test, and scale up guidelines, financing mechanisms, and strategies to increase access to FP/RH among the poor, especially indigenous populations (Menotti et al., 2008). These efforts began with a focus on Junín Region, which has traditionally underserved Sierra and Jungle areas. To select appropriate policy and finance strategies to help increase FP/RH access among the poor and indigenous populations in Junín, the project and partners considered

- Relevant issues at the local, regional, and national levels;
- Involvement of regional authorities and the local community;
- Local capacity of organizations and individuals;
- Existing mechanisms and current work being done to reach the poor; and
- Financial sustainability and replicability of strategies.

The project worked with in-country partners to assess barriers to access, raise awareness of the needs of the poor and indigenous populations, and examine opportunities, challenges, and requirements for the implementation of appropriate responses. The multi-pronged approach achieved significant results, including reforms not only for the region but also scaled up into nationwide programs:

- \$1.8 million in social investment funds mobilized for pro-poor interventions in Junín via the National System of Public Investment
- FP/RH component of the JUNTOS conditional cash transfer program strengthened by the adoption of national guidelines on culturally-appropriate counseling, which are to be used by all facilities in areas with substantial indigenous populations
- Counseling and family planning included in the list of health interventions covered by the National Social Insurance Scheme for the poor (adopted by a Supreme Decree in March 2007)
- FP/RH counseling added as a preventive intervention under the national CRECER (“Grow”) initiative

Key ingredients that helped to bring about these changes included involving the poor to identify barriers and possible solutions, engaging multiple stakeholders in policy dialogue, understanding the dynamic policy environment, and building on existing national and regional capacities and programs to expand the reach of pilot programs.



## SECTION 3

# COUNTRY CASE STUDIES

This section presents three country case studies to illustrate how various elements from the Policy-to-Action Framework have come together to facilitate policy change and implementation. In Malawi, a key policy change has set the stage for scaling up community-based distribution of injectable contraceptives.

In Vietnam, HIV legal clinics are ensuring that the country's HIV Law is put into practice and monitored so that people living with HIV can take advantage of their rights. In Guatemala, multisectoral monitoring boards are promoting accountability for implementation of FP/RH policies and laws.

# Malawi: Increasing Access to Injectable Contraceptives

Efforts to expand community-based distribution (CBD) of injectable contraceptives in Malawi are a prime example of how a country's decisionmakers and FP stakeholders capitalized on a policy window. Aspects of the policy process that were crucial to the course of events include Data Analysis and Use, Addressing Barriers, Policy Dialogue and Advocacy, Action Planning, and Implementation of Strategies that opened the door to the option for Scale Up of CBD in Malawi. To understand how these policy elements worked together, it is important to know more about the policy environment for injectables in Malawi.

Malawi is a predominantly Christian country whose population and government have been committed to increasing family planning and contraceptive use since the late-1990s. The 2004 Malawi Demographic and Health Survey (DHS) reported that 28 percent of Malawian married women ages 15–49 were using a modern method of contraception—a slight increase from the 26 percent modern method use found in the 2000 DHS (National Statistical Office and ORC Macro, 2005). Throughout Africa and in Malawi in particular, the demand for injectable contraceptives has increased over the past decade. According to the 2004 Malawi DHS, about two-thirds (64%) of currently married women who were using modern contraceptives had chosen injectable contraceptives. Injectable contraceptives are popular with women because they protect against pregnancy for up to three months, making them a preferable option to daily pills that are easy to forget and a convenient option for women in rural areas who must travel long distances to reach health centers. Many women also prefer the confidentiality that the injectable method allows. Most rural women depend solely on community-level health centers for their healthcare and FP services; however, because Malawi suffers

from a severe shortage of health professionals, these health centers are often understaffed.

Malawi's understaffed health centers are due, in part, to the fact that the country has historically lacked opportunities for medical training. Many Malawians leave the country to complete their medical education to become doctors or nurses, and upon completion of their studies, do not return. To mitigate this drain on human resources for health, the Malawian government employs a group of civil servants, health surveillance assistants (HSAs), who receive 10 weeks of healthcare training to provide basic healthcare services at the community level. HSAs can be either male or female and are the lowest level of civil servant in the public health system. They are paid employees of the MOH and are based at the community level; they work in mobile or outreach clinics, village clinics, or health posts in rural areas. Although some HSAs were trained to provide vaccination injections, the MOH did not initially authorize them to provide injectable contraceptives to patients.

The combination of the demand for injectable contraceptives along with the inability to obtain these methods from nurses or doctors at many clinics meant that over the years, women began to ask their local HSAs for injectables to be administered outside of the health centers. Several districts in Malawi are known to have allowed HSAs to administer injectable contraceptives outside of the health center on an informal level and, for years, the MOH debated whether to allow HSAs or community-based workers to administer injectables. Yet, while some district health officials recognized the need for community-based provision of injectables, the national medical and nursing councils were against such a policy. The regulatory councils voiced concerns about the inability to



Photo credit: © 2007 Virginia Lamprecht, Courtesy of Photoshare.

*Villagers laugh as they watch a group of actors perform a play about the benefits of family planning near Blantyre, Malawi. The festivities are part of a larger effort of the Adventist Health Service in Malawi to promote community-based family planning.*

provide adequate supervision of the practice at the community level, potential health risks associated with administering injectable contraceptives outside of the health centers, and the possibility of overloading HSAs with too many tasks.

A number of key pieces of evidence and advocacy efforts combined to help make the case for CBD of injectables. In 2007, USAID commissioned the Health Policy Initiative to conduct a study in Malawi to analyze the feasibility and acceptability of paraprofessionals—whether HSAs or other community-based workers—to provide injectable contraceptives at the community level. The results of the analysis clearly demonstrated that most providers and community members believed that HSAs should be allowed to provide these injectables outside of the health facility setting (Richardson et al., 2009). To design and implement the study, the Health Policy Initiative worked closely with the director of the MOH’s Reproductive Health Unit (RHU), a medical doctor who was a high-level advocate for CBD of injectables. The RHU director had been a champion of family planning for years, had seen the successes of CBD of injectables in other countries, and played a key

role in communicating to decisionmakers about how CBD of injectables would benefit Malawi. The Sexual and Reproductive Health Working Group, which includes all RH stakeholders working in Malawi, and the group’s Family Planning Subcommittee also carried out advocacy targeted to the senior management of the health ministry.

In addition, prior to the March 2008 MOH Senior Management Committee meeting, extensive planning had been underway in Malawi for a study tour to Madagascar whose goal was to learn from the country’s CBD of injectables program. Lessons learned gleaned during the planning of the eventual study tour helped move the debate forward regarding the feasibility of CBD of injectables. During the March 2008 MOH meeting, the RHU director presented data from the Malawian feasibility study; explained the demand for injectable contraceptives and the health ministry’s policy to offer women their preferred FP method; and presented evidence that injectable contraceptives have been safely administered by paraprofessionals in many countries, including Uganda and Madagascar. Another facilitating factor was that two opponents to CBD of injectables

had recently left the MOH Senior Management Committee. Thus, on March 14, 2008, the MOH Senior Management Committee met and agreed by consensus to allow HSAs to administer injectable contraceptives at the community level. It was agreed that the MOH would first implement a pilot program in eight districts prior to full scale-up of the approach.

In July 2008, the RHU held a dissemination meeting with FP stakeholders to share lessons that had been learned during the study tour to Madagascar and disseminate the results of the CBD of injectables feasibility study. This dissemination meeting, “The Way Forward: Malawi’s Road to Community-Based Distribution of Depot Medroxyprogesterone Acetate (DMPA),” considered how to implement the CBD of injectables policy in regard to training, service delivery, supervision, and logistics management, focusing on areas that had been barriers to the program’s success in Madagascar. Shortly after this meeting, the RHU began work with the USAID-funded Community-based Family Planning and HIV/AIDS Services project, implemented by Management Sciences for Health and its partners, Futures Group and Population Services International, to draft program guidelines for HSA provision of injectables at the community level. The MOH officially approved the operational guidelines in December 2008.

The Community-based Family Planning and HIV/AIDS Services project distributed the program guidelines to appropriate providers and worked with the RHU to prepare manuals to train HSAs in the provision of injectable contraceptives. In August 2010, the pilot program completed more than a year of implementation. A draft evaluation

of the first year of the program, supported by USAID/Malawi and conducted by Family Health International, indicates that the community perception of the program has been positive, that HSA provision of DMPA is safe, and that women are able to more easily obtain DMPA.

To summarize, Malawi’s case exhibits how key elements came together to facilitate moving from policy to action. **Data Analysis and Use** provided evidence to national decisionmakers of the needs on the ground and feasibility of a CBD program using paraprofessionals. Moreover, **Policy Dialogue and Advocacy** by the RHU director and other stakeholders in Malawi, such as the Sexual and Reproductive Health Working Group, encouraged passage of the policy change. The development of operational program and training guidelines for CBD of injectables illustrates that **Action Planning** aided **Implementing Strategies** and **Addressing Barriers** identified during the July 2008 dissemination meeting. The policy change, guidelines, and pilot testing are opening the door to allow for the possibility of eventual program **Scale-up**.

The case in Malawi also highlights the importance of maintaining a high level of awareness of the in-country policy environment. If key stakeholders had not recognized and been ready to take advantage of a policy window when it opened, the policy decision might not have been made. Given that the policy proposed was one that had widespread support at the community level the government had a trained cadre of HSAs in place in communities, evidence showed the feasibility of the approach, and key policy opponents had left the MOH, the environment was ripe for policy action.



Launch of the HIV Legal Clinic in Quang Ninh.

## Vietnam: Policies Open Doors to Provision of HIV Services

Vietnam has notably improved its HIV policy and legal framework in recent years (Turnball, 2006; Health Policy Initiative, 2009c). To strengthen the HIV response, the government adopted a new strategy—the *National Strategy for HIV/AIDS Control until 2010 with a Vision until 2020* (2004)—as well as the *Law on Prevention and Control of HIV/AIDS* (2006), implementation guidelines for the HIV Law (2007), and guidelines on antiretroviral treatment (ART) and treatment of opportunistic infections (2005), palliative care (2006), and medication-assisted therapy (MAT) (2007). Several factors account for these changes, including leadership by the Vietnamese government to address HIV, advocacy by civil society and PLHIV, new resources from PEPFAR and other donors, and expanded diplomatic and economic relationships with other countries, opening up Vietnam to international best practices. It is not possible to explore all of these factors here, thus we focus on a few key examples that illustrate elements of the Policy-to-Action continuum.

The Vietnamese government has demonstrated leadership at various stages in the policy process. For example, in 2004, the MOH requested

assistance from the USAID-funded POLICY Project to update the *1995 Ordinance on Prevention and Control of HIV/AIDS*. The existing ordinance did not provide comprehensive legal guidelines to direct and support the HIV response as envisioned by the new national strategy, in particular, regarding provision of ART and MAT. The ordinance also focused primarily on the health sector and did not consider broader development and multisectoral implications. Furthermore, an ordinance is approved by the Standing Bureau of the National Assembly; as such ordinances can be overridden by laws approved by the full assembly. Ultimately, the policy formulation process culminated in the Standing Bureau deciding to elevate the HIV ordinance to the status of a law, submitting the new *Law on Prevention and Control of HIV/AIDS* for approval by the full National Assembly in 2006, which received about 80 percent of the deputies' votes. Thus, the HIV Law carries equal weight with other national laws and lays the foundation to bring treatment, prevention, and care programs to scale.

Formulation of the law was not without challenges. Two initial barriers in the process involved convincing policymakers of the need to adopt

a human rights-based approach and to include civil society and PLHIV in drafting the new law. POLICY had contracted the Vietnamese Research Center for Human Rights at the Ho Chi Minh National Political Academy and CARE International/Vietnam to conduct a legislative audit of the HIV policy environment. The audit helped to demonstrate to policymakers that the Vietnamese government was already committed to nearly all of the international human rights-related covenants and declarations, including the International Covenant on Economic, Social and Cultural Rights and United Nations General Assembly Special Session (UNGASS) Declaration of Commitment on HIV/AIDS. Due to the limited involvement of non-government actors in policymaking processes and the still nascent nature of HIV-related civil society groups at the time, POLICY also advocated for the participation of PLHIV and civil society as an essential element of the process, with which the government eventually agreed.

Over the three-year process to draft the law and implementation guidelines, POLICY and, later, the Health Policy Initiative, provided technical and financial assistance and coordinated participation from various stakeholders. The process of policy dialogue and debate that led to the approval of the law involved many stakeholders. This dialogue was crucial in addressing issues related to stigma and discrimination and ensuring that the views of HIV-positive people were included. For example, in May 2006, the Health Policy Initiative and United Nations Development Program (UNDP) arranged a consultation with about 40 HIV-positive people to seek their views on the draft law. Recommendations from the consultation were submitted to the National Assembly Committee for Social Affairs to ensure that the law would be responsive to the needs of those most affected by the epidemic.

The new law and its implementation guidelines provide important guidance to support and promote equitable and affordable access to high-quality HIV services. They outline an extensive set of legal measures, including the protection of

confidentiality, guarantees of the rights of people living with and affected by HIV to goods and services, measures designed to reduce stigma and discrimination, support for the implementation of MAT, and free access to ART for children.

To help implement strategies in the law and monitor accountability for enacting its provisions, the Health Policy Initiative supported in-country partners to design and launch five HIV legal clinics, mobile legal teams, and a national HIV hotline (Health Policy Initiative, 2009b). The clinics are located in Ho Chi Minh City, Hanoi, Quang Ninh, An Giang, and Hai Phong provinces. Key partners include provincial AIDS committees, the Center for Consulting on Law and Policy in Health and HIV/AIDS, Vietnam Lawyers Association, and PLHIV networks.

The clinics and hotline provide a variety of services. The staff advise on the law, help clients to prepare applications and draft letters, submit documentation to authorities, and offer referrals. A significant number of cases brought to the legal clinics have dealt with assistance in seeking treatment and care. For example, Vietnam relies on mandatory, closed rehabilitation centers for drug users and sex workers, who are also among the populations most-at-risk for HIV in the country. Individuals from these groups might also be sent to prisons. ART and treatment for opportunistic infections is extremely limited in these settings. The HIV Law allows for deferment of sentences in order to seek HIV treatment in the community; however, the process can be complicated and families wishing to seek deferments often face roadblocks from law enforcement officials.

Other common cases involve children living with or affected by HIV being prevented from attending school; HIV-positive women seeking custody of children or access to inheritance; people seeking access to free treatment or social pensions; and clients facing discrimination in their places of work. In such cases, the lawyers or peer counselors often intervene, including going with clients to resolve conflicts in schools, hospitals, workplaces, and

“The Health Policy Initiative connected us with healthcare providers, government officials, and donors so that we could discuss issues on the ground and raise the voice of people living with HIV.”

—Tung,  
Bright Futures

families. Through September 2008,<sup>8</sup> the clinics had conducted about 1,100 face-to-face consultations, and the hotline offered advice to more than 2,700 callers from all 64 provinces.

The engagement of PLHIV in policy advocacy, formulation, and implementation has been essential in encouraging rights-based, public health approaches to HIV in Vietnam. PLHIV provided comments on the national HIV/AIDS strategic plan, HIV Law, and guidelines on treatment, palliative care, and MAT. They serve on advisory boards of the legal clinics with local officials and as peer counselors in the clinics and hotline. Alongside lawyers, PLHIV play an active role in ensuring that fellow PLHIV can take advantage of the law by providing counseling to people who visit the clinics and by assisting in legal outreach and community awareness-raising activities through PLHIV support groups. Strong PLHIV networks, such as Bright Futures in the north and the Southern Positive Network, have also facilitated rollout of treatment and prevention policies by developing and providing training on treatment literacy and positive prevention (Health Policy Initiative, 2009d).

The emerging policy environment in Vietnam is striking because it

- Is based on international standards and best practices, in a country that had been reluctant to accept outside influence;

- Introduces a human rights-based approach to HIV, which had previously been a sensitive issue;
- Involved PLHIV in the policymaking process, in a country where civil society and NGO involvement in government policymaking had been rare; and
- Sets the stage for a new approach to HIV prevention among injecting drug users and sex workers by adopting programs such as MAT and condom distribution, in a country that has relied on mandatory rehabilitation centers to control so-called “social evils.”

Challenges persist in harmonizing laws across sectors, combating stigma and discrimination, and ensuring efficient implementation. However, **Policy and Strategy Development**, in the form of the new strategy, law, and guidelines, provides the policy and legal framework for improved access to services, including expanded ART coverage and a pilot methadone program in six treatment sites in Hai Phong and Ho Chi Minh City. **Data Analysis and Use** in the form of the legal audit raised awareness of Vietnam’s existing human rights’ commitments. **Leadership** by the government and **Policy Dialogue and Advocacy**, including involvement of PLHIV, also encouraged the integration of human rights and international best practices into Vietnam’s HIV response. The HIV legal clinics and hotlines are supporting the **Implementation of Strategies** contained in the law and operational guidelines, as well as fostering **Accountability** by monitoring and providing a mechanism to redress grievances. Together, these elements have proved vital in moving policies to action in Vietnam.

<sup>8</sup> Task Order 1 of the Health Policy Initiative supported the legal clinics and hotline from December 2006–September 2008. Support continues under the follow-on phase of the Health Policy Initiative in Vietnam (2008–2012).

# Guatemala: Keeping Watch on FP/RH Policy Implementation

Guatemala's FP/RH policy and legal environment has improved significantly over the past decade with the approval of the *Social Development Law*, *Social Development and Population Policy* (SDPP), *Law on Universal Access to Family Planning*, and the 15 percent tax on alcoholic beverages to finance RH activities, among others. Despite these efforts, Guatemala experiences the highest maternal mortality rate in Central America and inequalities in FP/RH service access and use persist, especially between the indigenous and non-indigenous populations. Implementation has stalled due to a variety of barriers, ranging from legal challenges by FP opponents to lack of culturally-appropriate health services to limited M&E mechanisms.

Diverse elements are coming together in Guatemala to help address these barriers—including improved use of strategic information; increased capacity of and advocacy by civil society; and strong alliances between government leaders and citizens. These efforts have culminated in a unique approach to ensure accountability for implementation of FP/RH laws and policies. In March 2008, the Congress in Guatemala established the national RH Observatory (OSAR) in collaboration with NGOs, universities, and other partners. The national multisectoral monitoring board is designed to oversee implementation of the *Social Development Law* and laws and policies pertaining to FP/RH, HIV, and maternal health. Recognizing the value of this approach, various *departamentos* (states) have established their own OSARs with support from the Health Policy Initiative and the United Nations Population Fund (UNFPA).

In 2007, prior to the formation of the national OSAR, representatives of the General Secretary for Planning (SEGEPLAN), Ministry of Public Health

and Social Assistance (MSPAS) RH Program, and Guatemalan Association of Women Physicians (AGMM) formed an in-country core team to carry out an assessment of the implementation of the RH portion of the SDPP. The Health Policy Initiative assisted the team to apply the Policy Implementation Assessment Tool (Bhuyan et al., 2010). The tool was used to gather feedback from policymakers and implementers on barriers and facilitators for putting the SDPP into practice. Issues that emerged included a lack of clarity about leadership and responsibilities for implementation; lack of clear implementation and M&E plans; insufficient dissemination and capacity building to support the policy; and difficulties accessing funds, especially by NGOs. The core team organized a multi-stakeholder dialogue to review the findings, created an advocacy brief (MSPAS et al., 2008), and carried out extensive advocacy along with other key FP champions, prompting Congress to create the national OSAR as a mechanism for monitoring FP/RH policy implementation.

Since the OSAR's formation, the Health Policy Initiative provided technical and capacity-building assistance, including helping members craft a five-year strategic plan. Adopted in 2009, the plan encompasses four components: a sustainability plan, internal regulations, an M&E plan, and an annual workplan. The strategic plan calls for forging alliances with other civil society organizations, as well as international cooperating agencies, which has resulted in additional funding and served to strengthen the organization. With increased capacity, the national OSAR has engaged in numerous advocacy activities related to commodity procurement, budget cuts, service provision, regulations related to the FP law, and other issues. Civil society advocates, especially those representing

indigenous populations, have played a key role in decentralizing the OSAR approach. Nearly two in five (38%) Guatemalans are from indigenous groups, including the Mayan, Xinkan, and Garifunan. Most indigenous populations live in rural areas, and significant inequalities exist between indigenous and non-indigenous populations. Three in four (75%) indigenous people are poor, compared with slightly more than one-third (37%) of the non-indigenous population (Guatemala National Statistics Institute, 2006). A recent study found that indigenous populations face a number of barriers to accessing FP/RH services, including lack of culturally-appropriate informational materials, provider bias, unsuitable conditions in facilities (e.g., lack of privacy), and restrictive social and familial environments (Netzer and Mallas, 2008).



To help address inequalities in access to FP/RH, in 2007, the Health Policy Initiative assisted indigenous women to form the National Alliance of Indigenous Women's Organizations for Reproductive Health. The alliance has a presence in six *departamentos* and has more than 65 organizational members. Members of the alliance advocated for replication of the OSAR approach, resulting in *departamento* OSARs being established in collaboration with local development councils and municipalities. The Health Policy Initiative provided assistance to launch the OSARs in Alta Verapaz, Chimaltenango, Escuintla, Quetzaltenango, Quiché,

and Sololá, while UNFPA replicated the approach by funding *Organización Instancia Salud/Mujer* to establish OSARs in Chiquimula, Izabal, Jalapa, Jutiapa, Petén Central, and Petén Sur Oriente. In September 2010, the USAID | Program for Strengthening the Central American Response to HIV/AIDS (PASCA) supported the launch of additional OSARs in Baja Verapaz and Zacapa. Capacity building by the Health Policy Initiative has focused on action planning, advocacy, citizen surveillance techniques, and M&E.

The OSARs have expanded and demonstrated strengthened institutional and advocacy capacity. The observatories have designed and carried out citizen surveillance and monitoring plans that include crosscutting issues, such as gender and multiculturalism. The observatories have also gained prestige and recognition, which have attracted new organizations to become members, such as the Sololá Association of Attorneys and Notaries and Catholic Ministry of Women's Affairs in Quiché. The OSARs have applied their growing capacity as advocates—organizing public forums to raise awareness about RH, indigenous, and women's issues and holding press conferences to place FP/RH and maternal and child health issues on local agendas. The OSARs have also launched a website, [www.osarguate.org](http://www.osarguate.org), to promote activities, exchange information, and share lessons learned.

Illustrative highlights of the national and *departamento* OSAR achievements include:

- In July 2008, the Guatemalan Congress issued Resolution Number 17-2008, declaring maternal health to be a national priority, and urged the MSPAS to design an effective surveillance system. In March 2009, the MSPAS took steps to implement this resolution by signing an agreement with the national OSAR. The agreement stipulates that the MSPAS will improve the maternal and child surveillance system by designing an M&E system and periodically providing information on maternal deaths and deaths among women of reproductive age to Congress and the OSAR for analysis and monitoring.

- In August 2009, the Chimaltenango development council created a Health Commission to advocate for better health, increased funding for local RH policies and programs, and compliance with RH laws and policies at the local level. The Health Commission was established as a result of advocacy efforts by the *departamento* OSAR, which increased policymakers' awareness of maternal mortality and disparities in health services among indigenous and non-indigenous populations. Shortly after its creation, the Health Commission conducted a situational analysis of FP/RH and maternal and child health issues in Chimaltenango.
- In November 2009, as a result of advocacy by the National Alliance and *departamento* OSARs, MSPAS approved ministerial accord 1632-2009 calling for the creation of an intercultural

healthcare unit within the governmental structure. The Intercultural Healthcare Unit for Indigenous Populations, which will report directly to the Minister of Health, will help improve the health of indigenous populations by making public health services more accessible to them, improving the quality and cultural appropriateness of those services, and integrating indigenous health practices and methods into public services.

The OSARs are emerging as effective mechanisms to build and sustain policy advocacy and monitoring capacity in Guatemala and increase **Accountability** for FP/RH policy implementation at national and *departamento* levels. **Leadership** by SEGEPLAN, MSPAS, the Congress, healthcare providers, and civil society partners catalyzed creation of the national OSAR to improve M&E for FP/RH policies. Civil society **Advocacy** facilitated replication of the national approach at the *departamento* level. **Data Analysis and Use**, to identify and **Address Barriers** and raise awareness of inequalities, have strengthened advocacy efforts. By fostering alliances between citizens and government, as well as monitoring implementation and accountability, the OSARs are playing a key role in enhancing **Governance** of Guatemala's FP/RH programs, especially at decentralized levels where implementation matters most.

“What has been lacking in Guatemala is an active public ... The OSARs are giving the public the knowledge and tools it needs to demand better RH services.”

—Myrna Ponce,  
OSAR Coordinator



## SECTION 4

# CONCLUDING REFLECTIONS

As this paper illustrates, there is no one set way to put a policy into practice. A multitude of variables must be considered—hence the art of moving from policy to action. And the various elements outlined along the Policy-to-Action Framework must come together in response to the given context to ensure effective flow from problem identification, through policy formulation, to policy implementation and monitoring.

Another clear message is that policy work is never totally complete. In fact, the framework presented in this paper may be thought of as a process of moving from “policy to action, and back.” This is because facilitating effective policy implementation will be an ongoing process that involves

- Educating healthcare providers, civil society groups, beneficiaries, law enforcement officials, and other stakeholders on new provisions in policies;
- Building capacity—especially at the decentralized level—to plan, fund, implement, and monitor policy and program implementation;
- Fostering engagement beyond the health sector;

- Resolving conflicts among laws and policies;
- Continuing to strengthen capacity of non-government actors to engage in the policy process; and
- Revising and updating policy instruments to reflect changing dynamics of health issues, international best practices, and the broader policy environment.

Finally, in thinking about implications for the way forward, it is important to consider what is needed to sustain policy implementation and success, as well as how policy implementation contributes to strong, sustainable health systems more broadly. Key considerations include the need for

- Sustained capacity at individual, institutional, and systems levels;
- Efficient, equitable, and sustainable mobilization and allocation of resources;
- Linkages between policy work and health systems strengthening initiatives, with clear indicators of the impact of policies on health systems; and
- Efforts to strengthen country ownership, leadership, governance, and accountability.

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Health Policy Initiative, Task Order I  
Futures Group  
One Thomas Circle, NW, Suite 200  
Washington, DC 20005 USA  
Tel: (202) 775-9680  
Fax: (202) 775-9694  
Email: [policyinfo@futuresgroup.com](mailto:policyinfo@futuresgroup.com)  
<http://ghiqc.usaid.gov>  
<http://www.healthpolicyinitiative.com>