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**JHPIEGO's Work in Policy:
A Comprehensive Review**

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired immune deficiency syndrome
AIDSCAP	AIDS Control and Prevention
AVSC	AVSC International
CBT	Competency-based training
CECAP	Cervical Cancer Prevention
COFP	Comprehensive family planning
CRHCS	Commonwealth Regional Health Community Secretariat
D&C	Dilation and curettage
DFH	Division of Family Health (Nepal)
ESSALUD	Social Security Institute (Peru)
FP	Family planning
GTI	Genital tract infection
HIV	Human immunodeficiency virus
IP	Infection prevention
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University/Center for Communication Programs
JK	Brand name of bleach in Kenya
MAQ	Maximizing access and quality
MNH	Maternal and Neonatal Health
MOE	Ministry of Education
MOH	Ministry of Health
MOH/CW	Ministry of Health/Child Welfare (Zimbabwe)
MVA	Manual vacuum aspiration
NCK	Nursing Council of Kenya
NCTN	National Clinical Training Network (Indonesia)
NGO	Nongovernmental organization
NHTC	National Health Training Center (Nepal)
Ob/gyn	Obstetrics/gynecology
OJT	On-the-job training
OSCE	Observed Structured Clinical Examination
PAC	Postabortion care
Pap	Papanicolaou smear
PDO	Program Development Officer

PMU	Program Management Unit
PNP	Policies, norms and protocols
REDSO	Regional Economic Development Support Office
RH	Reproductive health
Savlon®	Trademark for a preparation of chlorhexidine gluconate and centrimide. an antiseptic
SDGs	Service delivery guidelines
SDP	Service delivery point
SFPS	Santé Familiale et Prévention du SIDA
SOAG	Secretariat for the Strategic Objective Agreement (Indonesia)
STI	Sexually transmitted infection
TGWG	Technical Guidance Working Group
TRH	Training in Reproductive Health
USAID	United States Agency for International Development
VIA	Visual inspection with acetic acid
WHO	World Health Organization
ZNFPC	Zimbabwe National Family Planning Council

EXECUTIVE SUMMARY

JHPIEGO's 1998 cooperative agreement with the United States Agency for International Development, identifies "the need for sound reproductive health policies that influence and support performance improvement and lead to the development of sustainable programs." In the course of its work (both before and since the current cooperative agreement), JHPIEGO has helped to develop, implement and evaluate policy in many countries. In many cases, changes in policy are necessary to achieve program objectives and secure the success of performance improvement activities. This report explores the various ways in which JHPIEGO, primarily the Training in Reproductive Health Project, has been involved in policy-related work. The report documents several specific contributions to policy, but also provides a comprehensive picture of JHPIEGO's overall approach to policy.

JHPIEGO works within a broad definition of policy, looking not only at overarching national policies, but also at regulations and formal and informal operational procedures at the provider level. JHPIEGO's policy work can be organized according to the following traditional categories: identifying policy issues, identifying policy solutions, advocating for policy change, formulating policy, implementing policy and evaluating policy, but work is not typically carried out in a sequential series of discrete steps. JHPIEGO's work in policy can better be articulated through the elements of the Framework for Strengthening Reproductive Health Systems in National Programs. Like work based on the framework, policy work is circular and in many cases falls into more than one category.

The Framework for Strengthening Reproductive Health Systems in National Programs provides a useful model for exploring JHPIEGO's policy work because each element of the framework is affected by policy. In this report, examples of JHPIEGO's work in policy are grouped according to framework element. In some cases, the role of policy is readily evident, as in the case of service delivery guidelines development, in which JHPIEGO works with countries to develop policies based on up-to-date scientific knowledge and international standards. Other components of the framework (such as service delivery points) seem less related to policy but for programs to work, service delivery points must have operational policies that support the guidelines or standards.

To assess JHPIEGO's impact on policy, two methods of data collection were employed: an internal document review and synthesis, and key informant interviews. Documents included trip reports, technical reports and program "blurbs" as well as other JHPIEGO materials. This review helped to guide the interviews conducted with JHPIEGO program and technical staff from Baltimore, Maryland and field offices.

The interviews and document review revealed that JHPIEGO is involved in policy work at various levels of the healthcare system. They also suggest that policy concerns are an integral part of JHPIEGO's programmatic work. Throughout the interview process, it was evident that most staff considered service delivery guidelines development to be the only area in which JHPIEGO does policy work. Providing staff with a framework for thinking about the other kinds of policy-related work they do helped them to provide a more complete picture. These results should dispel the notion that JHPIEGO does not 'do policy.'

On the whole, JHPIEGO does not directly address policy. JHPIEGO has worked on policy when it was relevant to the work of developing training systems. Policy work has become an extension of the work JHPIEGO is already doing. This indirect approach is possible because, in many countries, there is no need to change law to implement changes that support the training

system. When there are no national policies that would be obstacles to the changes JHPIEGO proposes, it is often institutional (Ministry of Health, university, service delivery points) policies that need to be changed, and JHPIEGO has found that working with these institutions, rather than with legislators, has effected more dramatic results.

JHPIEGO's Work in Policy: A Comprehensive Review

INTRODUCTION

In JHPIEGO's 1998 cooperative agreement with the United States Agency for International Development (USAID), Objective 2 emphasizes "the need for sound reproductive health policies that influence and support performance improvement and lead to the development of sustainable programs." Both before and since the cooperative agreement, JHPIEGO has helped to develop, implement and evaluate policies in the countries in which it works. Changes in policy are often necessary to achieve program objectives and ensure the success of performance improvement activities. This report explores the various ways in which JHPIEGO (mainly Training in Reproductive Health [TRH], and particularly within the most recent cooperative agreement) has been involved in policy-related work. Although the report documents several of JHPIEGO's specific contributions to policy, it is not intended to be a comprehensive summary of all such work. Instead, it provides an overall picture, demonstrating that policy is an integral part of JHPIEGO's work.

BACKGROUND

Policy is often thought of as something that occurs only at the highest levels of government, and there is a notion that doing work related to policy requires special training. Though the literature on policy considers a variety of perspectives, it most often describes a process that takes place among a select group of players, generally at the national level. But this traditional approach ignores the vast amount of concrete policy work that takes place at other levels within and outside governments. A policy handbook developed by the Commonwealth Regional Health Community Secretariat (CRHCS): *East and Southern Africa and Support for Analysis and Research in Africa Project/AED* (2000) broadly defines policy as: "a framework which guides decision making in an organization or government." It goes on to name specific forms of policy including: general statements about priorities; written regulations; guidelines, procedures and standards to be achieved by practitioners; and informal (unwritten), but widely recognized practices. This report also uses a broad definition of policy, looking not only at national policies but at regulations and formal and informal operational procedures. This process is consistent with policy analysis done by others, such as the AIDS Control and Prevention (AIDSCAP) Project, in the field of international health.

JHPIEGO's work also differs from the formal policy development process defined in the literature. The formal process usually begins with the identification of policy issues and ends with evaluation of the policy once it has been implemented. JHPIEGO's work does not occur in a prescribed sequence. Although the traditional model is intuitive and does help to describe the types of policy work that take place, many authors acknowledge that rarely does this multi-stage model describe what actually happens in the world of policy. "Changes in policy and policy implementation rarely result from a linear process of generating research, laying out options, choosing between alternatives, and evaluating the implementation of the selected option. Rather, changes come about through the process of iterative interactions among three 'streams' of activity: defining the problem, suggesting solutions, and obtaining political consensus" (Porter and Hicks 2000). This iterative process more accurately describes the way in which JHPIEGO's policy work takes place. It has not, however, been used in this report because it does not allow for the clear separation of the types of work.

The Framework for Strengthening RH Systems in National Programs (see **Appendix A**) provides a useful model for exploring JHPIEGO's policy work because it is a familiar frame of reference for programmatic work. Each element of the framework, as well as the associated peri-program areas, has policies that affect it. In some cases, the role of policy is readily evident, as in the case of policy and service delivery guidelines (SDGs) where JHPIEGO works with countries to develop policies based on up-to-date scientific knowledge and international standards. Other components, such as service delivery points (SDPs), seem less related to policy but for programs to work, the SDPs must have operational policies that support the guidelines or standards.

In each of the areas outlined by the framework, JHPIEGO influences policy using a variety of mechanisms, both direct and indirect. As mentioned above, JHPIEGO is rarely involved in direct policy work insofar as it does not tend to work with policy-making bodies within national governments, especially legislative bodies. Staff members do, however, use direct approaches with other organizations involved in the policy arena including universities, nursing councils and SDPs. Some of the direct approaches include building incountry capacity to inform and influence policy, strategic advocacy and development of policies or guidelines. Indirect approaches include implementing changes in practice on a small scale as an impetus for policy change and informal contact with policymakers. JHPIEGO often works with the people responsible for implementing policy rather than focusing on those who formulate it. A recent analysis of policy formulation suggests that efforts should be made to involve the midlevel personnel responsible for translating policies into programs earlier in the process (Porter and Hicks 2000). These people are the ones who will bring a policy to life and, without their support for implementation, a policy can fall off the government's agenda. By involving them from the outset, they are involved in the development phase and are more likely to support the changes that are made.

Categories of Policy Work

The traditional staged approach, although not an accurate description, does provide useful language for discussing the ways in which JHPIEGO influences policy. As shown in **Appendix B**, JHPIEGO's policy work can be organized according to the traditional categories: identifying policy issues, identifying policy solutions, advocating for policy change, formulating policy, implementing policy and evaluating policy. Each one is outlined in **Appendix B** to provide a shared understanding of these commonly used terms. To avoid representing JHPIEGO's work as a sequenced process and to tie this work into JHPIEGO's previous programmatic thinking, this report uses the Framework for Strengthening RH Systems in National Programs to present examples of policy work. In considering the following categories it is important to keep in mind that policy work is often a circular process and, in many cases, work falls into more than one policy category.

Identify Policy Issues

In the process of working with training programs and healthcare systems, JHPIEGO staff members come across problems that impede existing programs and new initiatives. These problems are identified directly through needs assessments and indirectly when they arise during the implementation of policies or programs. Some of the obstacles to JHPIEGO programs are practical or organizational, but others are related to the policies of governments and institutions. Problems that are identified can often be translated into policy issues so that they will be relevant to the work of policymakers. Whereas a problem defines an unsatisfactory solution, an issue "focuses on the cause of the problem and suggests directions to look for a

solution” (Rau and Flanagan 1999). An example Rau and Flanagan (1999) provide to illustrate this distinction is:

Problem: Young adults do not understand the risks of unprotected sex.

Issue: Many youth are sexually active but do not have the information that is needed to practice safer sex.

JHPIEGO has taken a role in translating problems into policy issues. Raising such issues can bring them to the attention of policymakers at SDPs, training institutions and within ministries of health and education. In addition to translating problems into issues, staff members prioritize problems, deciding which policy issues need to be addressed. Finally, the provision of up-to-date information and of venues for discussion of issues helps JHPIEGO’s incountry counterparts to identify policy issues that need to be addressed.

Identify Policy Solutions

JHPIEGO also helps to provide solutions to policy issues. For example, the Cervical Cancer Prevention (CECAP) program provides an answer for policymakers who are looking for an effective way to implement policies geared toward providing cervical cancer screening for all women of reproductive age. Giving policymakers a feasible option bridges the gap between the problem and solution. Although CECAP is an example of an entirely new approach, JHPIEGO also introduces small-scale changes that help to meet policy goals. For example, when there have been too few providers available to meet policy goals, JHPIEGO has recommended the expansion of service provision to new cadres of healthcare providers (e.g., nurses).

Advocate for Policy Change

As in the identification of policy issues, JHPIEGO uses both direct and indirect approaches to advocate for policy change. Direct approaches include introducing new policy issues or solutions, providing data in support of advocacy efforts, holding meetings with policymakers to discuss policy issues and disseminating information about policies. Indirect approaches include informal conversations with policymakers and building the capacity of incountry counterparts to advocate for policy change.

Formulate Policy

Developing documents (e.g., international reference documents) that are used by countries or organizations to write policies is one way in which JHPIEGO helps to formulate policy. Organizing and facilitating meetings for the purpose of policy or standards formulation is an indirect approach. Staff members contribute directly to policy formulation by drafting policies for governments and institutions and by participating on policy-making bodies. In some cases JHPIEGO documents (e.g., a country workplan, recommendations for change) have been adopted as national policy; in other cases, technical papers have contributed to policy change.

Implement Policy

Perhaps the most important role that JHPIEGO has in policy is its implementation—helping to make changes in training or service delivery that reflect the intent of policies. This role results from JHPIEGO’s expertise in training systems development. Although implementation is not always viewed as “policy work,” without effective implementation, policies have no impact. And, working with those who are implementing policy gives further access to the policymakers. Not

only can these people directly address the successes and shortcomings of policy change, they serve as advocates for future change.

Evaluate Policy

Finally, evaluation of programs provides the data upon which to base policy decisions. By determining whether or not policies are being implemented, and by pinpointing obstacles to their implementation, JHPIEGO helps to ensure the policies' effectiveness.

METHODOLOGY

A literature review was conducted using MEDLINE® and POPLINE to explore current thinking about policy, particularly in the fields of international health and family planning (FP). Two key methods of data collection were used: an internal document review and synthesis, and key informant interviews. The document review included trip reports, technical reports and blurbs as well as other JHPIEGO materials. This review helped to guide the interview process. Twenty-four interviews were conducted with JHPIEGO program and technical staff from Baltimore, Maryland and field offices in the summer of 2000. The focus of the interviews was work under TRH but examples from the Maternal and Neonatal Health (MNH), CECAP and Santé Familiale et Prévention du SIDA (SFPS) programs were collected if they came up in the course of discussion. Initial interviews were conducted with six staff members in which they were asked to talk about their experience in policy-related work. Their responses were then reviewed and categorized. Before all subsequent interviews, the staff members were sent an e-mail outlining the topics already addressed and were encouraged to consider other types of policy work. In addition, some staff members in field offices were asked for their input via e-mail; they also received a copy of the outline. All staff members interviewed were asked for any documentation of the policies discussed. When additional information was needed, e-mail was used to follow up in the majority of cases, but a small number of additional interviews were conducted.

JHPIEGO'S POLICY WORK

As noted above, JHPIEGO's policy work takes many forms. The following examples are not an exhaustive list of the work that JHPIEGO staff members have done. Instead, it is an illustrative sample of the types of policy work with which JHPIEGO has been involved. A more complete listing of examples, by category, is provided in **Appendix B**.

Key Components of the Framework for Strengthening Reproductive Health Systems in National Programs

Needs Assessment

Generally, training sector assessments undertaken by JHPIEGO included only a limited number of questions related to policy, and these questions were general in nature and geared to the national-level policy environment for FP. JHPIEGO's *Training Sector Assessment Checklist* includes a section on policy that begins with the following: "This section of the report should synthesize the specified goals and objectives of any national policies directly relating to or affecting the reproductive health and FP rights and behavior of individuals. RH barriers or problems in terms of how national policies affect reproductive health should be identified in this section." This introduction is followed by a series of questions that should be considered both when there is and when there is not a FP policy in place. These general questions are helpful in

identifying policies that are not clear or that may serve as obstacles to training and performance improvement efforts. They may also help to guide program initiatives.

For the needs assessment conducted in Malawi in February 1999, a number of additional policy questions were incorporated (see **Appendix C**) that addressed specific policies in six areas (adolescents, sexually transmitted infections [STIs], postabortion care [PAC], preservice education, inservice training and supervision), and key stakeholders were interviewed using these questions. Because the JHPIEGO program in Malawi has a broad scope of work, a more detailed look at policies was needed to develop programs more effectively. Interviewees identified a number of policy issues that they felt needed clarification or updating. For example, to better meet the needs of service delivery sites, they suggested reviewing the criteria for deployment of preservice graduates more carefully. Identifying such policy issues early in the programming process allows them to be addressed for more effective programming and facilitates their incorporation into the program design.

Current International Resource Materials

Since the mid-1990s, a number of organizations, most notably the World Health Organization (WHO) and USAID, have convened groups of experts to develop international resource materials. These materials are evidence-based guidelines that countries can use in formulating policies, particularly for service delivery. JHPIEGO has been involved with the development and dissemination of these materials, and both of these activities are examples of direct policy work.

A number of JHPIEGO staff members were participants at the conferences where these documents were developed. In 1995, Dr. Harshad Sanghvi was one of 21 experts brought together to determine WHO's eligibility criteria for initiating and continuing contraceptive use. In March 2000, Dr. Emanuel Otolarin participated in the conference to revise these guidelines. In 1992, Dr. Noel McIntosh, Dr. Paul Blumenthal and Monica Kerrigan represented JHPIEGO at the Technical Guidance Working Group (TGWG) meetings where USAID's *Recommendations for Updating Selected Practices in Contraceptive Use* was developed. Drs. McIntosh and Blumenthal also participated in the meetings on Volume II of this document. In some cases, the participants were selected because of their position in the field of RH or because of personal (and professional) contact with meeting organizers; in others, JHPIEGO was asked to send representatives of the organization. In either case, international committees and working groups set standards that are promoted by the sponsoring organizations and are a means by which JHPIEGO has input into the policies or standards of these organizations—standards that guide policy and practice in countries throughout the world.

JHPIEGO has also been instrumental in the dissemination of these resource materials. At a global level, JHPIEGO made both volumes of the TGWG recommendations available on the Internet through its ReproLine® website. These documents are accessed regularly—between January and June 2000, there were 7,202 hits to these documents and 512 repeat users. Although the statistics do not indicate who is using the documents (the location of over 84% of the users is unknown), that they are being used in this form is clear. In addition, the WHO and TGWG documents were used by JHPIEGO for the development of prototypic SDGs, which are the model used in the guidelines development process described below. JHPIEGO staff and consultants also reference them in discussions of what should be included in guidelines, and they have been an integral part of the contraceptive technology updates that precede the guidelines development process. In Malawi, for example, the contraceptive technology update included a discussion of international standards. The dissemination of international resource materials helps to ensure that policies and guidelines are consistent with the latest scientific evidence, strengthening the standards that are set.

In West Africa, the SFPS program held a workshop to train consultants in the guidelines development process. Dr. Willibrord Shasha and co-trainer, Dr. Nagbandja Kambatibe (RH Program Director, Centre for African Family Studies), used the international resource documents, along with current scientific literature, to provide the consultants with the information needed to defend arguments for more inclusive policies. This workshop increased awareness of the international resource documents, disseminated their content and promoted their use as a tool for policy development. It was also a means of building incountry capacity to influence policy. The development of incountry consultants who can serve as advocates for policy change has occurred on an informal basis in other countries. In the Ukraine, a technical advisory group evolved through JHPIEGO's training efforts. Although this group was not an initial goal of the project, as training progressed the participants who were the most enthusiastic, influential and most likely to move things forward were given more support so that they would become further involved in non-training activities such as curricula and training materials development. As they learned more, they began to work as advocates for JHPIEGO's work. They have since been asked to help JHPIEGO in influencing policymakers. When it was time for the national SDGs to be approved, for example, these trainers were instrumental in convincing those responsible to accept the changes that had been made. In addition, they advocated for the new curricular component before the Ministry of Health (MOH).

National Policy and Service Delivery Guidelines

JHPIEGO's work in the development of national policy and SDGs is perhaps the best example of direct policy work. JHPIEGO has assisted with the development of national guidelines for FP, RH and essential maternal healthcare in almost 30 countries since 1994. JHPIEGO has worked on regional guidelines as well. For example, JHPIEGO was one of a number of organizations that contributed to the development of regional guidelines for PAC in East and Southern Africa, through the Regional Economic Development Support Office (REDSO) project. At a national level, the development process generally includes a series of meetings with key stakeholders, contraceptive technology updates for those individuals involved in the development process, dissemination of international resource documents, introduction to model SDGs and negotiation of the content. This structured process allows for more rapid development of national guidelines while reliance on generic documents (which are based on international reference documents) as a starting point for development gives greater credibility to the final product.

Though guidelines are often written as an implementing document rather than as formal policy, in some countries their use has been written into official policy. For example, in the Ukraine the draft National RH Program 2000–2005 specified that the guidelines developed with JHPIEGO's assistance are the standard for service delivery. At the time that this report is being written, it is not known if this stipulation will appear in the final program document, but it shows the attention these guidelines have received from national policymakers. In Indonesia, guidelines for basic delivery care were developed to change clinical practice through inservice training. These guidelines have since been written into national standards by the Indonesian Society of Obstetricians and Gynecologists, officially endorsed by the MOH and the professional associations, and incorporated into the preservice midwifery curriculum. In Peru, the midwifery and medical schools adopted the *Comprehensive Reproductive Health Guidelines* as a textbook, and a special university edition was printed; the guidelines have thus become a part of institutional policy.

Development is not, however, the only role that JHPIEGO has with regard to national guidelines. Perhaps more important is its role in the dissemination and implementation of these policies. As noted by the participants in a conference on guidelines, "development of policies,

norms and protocols (PNP) is not an end in itself. Implementation of PNP is the key element” (MAQ Conference 1999).

For the changes in service delivery to be realized, it is necessary that the guidelines be disseminated, service providers understand the changes in practice, essential equipment and supplies are available, and that institutional policies support the changes. JHPIEGO has played a role in ensuring that these requirements are met.

Dissemination of copies of guidelines is a key step in performance improvement because guidelines generally represent best practices. In most countries, JHPIEGO’s dissemination strategy has involved 2- to 3-day workshops—learning interventions designed to improve provider performance (with copies of the guidelines distributed as the learning materials). In the Ukraine, 3-day workshops were conducted for providers to teach them how to use the guidelines, address barriers to access and highlight what was new and progressive. In addition, the providers received training on how to negotiate with supervisors regarding changes in practice. Such an approach is consistent with the need to include those people who will actually be implementing the policy changes. “To achieve the policy goals, the physicians as implementers must (a) understand the intentions behind the changes; (b) be able to implement the changes; and (c) be willing to implement the changes” (Hanning and Spangberg 2000).

Ukrainian administrators were included in the workshops to familiarize them with the guidelines. This procedure, too, fits well with the idea of Hanning and Spangberg (2000) that “it is easier for implementers to adhere to policy if it is supported strongly by management and political decision-makers.”

Often during guidelines development, problems that are likely to affect their implementation (e.g., service delivery issues) are identified. In Brazil, for example, the guidelines development process led to the realization that there was no clear policy on who could provide what services. JHPIEGO held a series of meetings to discuss the related policy issue: to expand access to services, nonphysician healthcare providers need to provide a broader array of RH services and possible solutions. The ultimate outcome was the development of job descriptions and self-assessment tools based on the national SDGs. Job descriptions serve as policy in that they set standards for the provision of services.

Once guidelines have been implemented the process does not end; updating guidelines should be a continual process. In a number of Latin American countries, JHPIEGO stressed the importance of updating guidelines as part of the initial development process, encouraging those involved to institutionalize and standardize the process for updates. Because the policymakers have already been sensitized to the need for guidelines and consensus has been reached on the need for revision, the revision process should be much more rapid than initial development (Macias et al 1999). It is important to keep in mind that policy change is not a one time proposition; developing a culture of policy change may be more important than effecting a specific change. The development and implementation of guidelines in Ecuador is particularly noteworthy from a policy perspective and is described in the text box that follows.

Ecuador's Service Delivery Guidelines: A Unique Approach

JHPIEGO was the lead organization in the development of comprehensive RH guidelines that were developed by representatives from 50 organizations in both the public and private sectors. The guidelines included chapters on FP, gynecological cancers (cervical and breast), selected topics in maternal and perinatal health, STIs, adolescent RH, HIV/AIDS, infection prevention, menopause/infertility and domestic violence. The chapters were drafted by organizations with expertise in each field, and JHPIEGO helped them to negotiate with the MOH to gain their support and guidance. Once the draft was agreed to by all of the involved organizations, the guidelines were field-tested using a tool developed by JHPIEGO, and a report was prepared that summarized the findings. This process allowed for buy-in from most of the players in the policy process—the field-testing was particularly important because it provided a way for the implementers to provide feedback.

Although the development of the guidelines was formulation of policy, it also supported previous policy efforts. The Latin American Perinatology Center, a division of the Pan-American Health Organization, had developed three instruments (a basic perinatal history form, a clinical history form and a partogram) that had been adopted as standards. They had not, however, been implemented in Ecuador and were not being used. They were included in the guidelines as standard tools and because the guidelines are standards for the MOH and service provision nongovernmental organizations, these tools have now been implemented.

Another unique aspect of this guidelines process was the development of an implementation strategy. It was decided that implementation required not only distribution but also training. To ensure the quality of training and, therefore, the success of implementation, the responsibility for implementation was divided among four groups. JHPIEGO took on responsibility for the FP and infection prevention sections, the National Cancer Institute implements the cancer section, women's groups work on domestic violence and nongovernmental organizations are implementing the sections on adolescent RH. This multipart process is designed to maximize the impact of the guidelines.

One obstacle that slowed the implementation process was a political crisis that led to changes in MOH staff. Because the new staff was not familiar with the guidelines, additional negotiation was needed before the process could continue. Such obstacles are common in policy work and often cannot be avoided.

An important policy outcome of the process was a shift in responsibility for FP services. Whereas nongovernmental organizations have historically been responsible for FP in Ecuador, since the development of the guidelines, the MOH has taken a lead role—allocating financial resources for FP commodities and heading an interagency group that supports FP efforts. Another impact is that the way policy is formulated has changed—the participatory process used for these guidelines is being replicated by the MOH for the production of pediatric SDGs.

Preservice Education in Health Professional Schools

In the preservice arena, JHPIEGO's impact on policy has been mainly through standard curricula, licensure and certification requirements, personnel deployment, training policies and selection criteria. In some cases, JHPIEGO has also worked to shift the overall training policy from inservice to preservice. There are other examples of policy effects in preservice education that are country specific. Some of these examples are included below to illustrate the breadth of JHPIEGO's policy work in this area.

In a number of countries, JHPIEGO has been instrumental in changing the content of the curriculum for preservice medical, midwifery and nursing students. In Kenya, after minilaparotomy was introduced, it was incorporated into the medical internship as a requirement. This change was implemented by the Medical Practitioners and Dentists Board, which registers doctors for independent practice. At the same time that this change was being introduced, it was recommended that competency in a number of MNH skills be required; these changes were also incorporated into the internship requirement. Similarly, in May 2000 the MOH in the Ukraine approved a new curricular component for obstetrics/gynecology (ob/gyn) residents—a 5-day FP course that was developed by JHPIEGO in collaboration with faculty of

major medical universities who had undergone JHPIEGO training. Curricular changes are policy changes insofar as curricula are operational policies for universities and schools.

In Uganda, JHPIEGO's work on curriculum changes had broader implications for the preservice training system. More than half of all midwifery schools in Uganda did not include FP in the curriculum because they are religious affiliates. When JHPIEGO helped the Nursing Council to revise the curriculum, the changes addressed FP as well as a number of other skills including training skills, STIs and maternal health. Because the changes were comprehensive, the Nursing Council added FP to the final exams required of all nursing students. With such a requirement, the religious schools had to change their policy so their students would be prepared for the exam. Now students at those institutions receive knowledge-based FP training within the schools and are allowed to go to neighboring government institutions for training in FP clinical skills.

Changes in the way the curriculum is implemented rather than in the content itself are another type of operational policy in which JHPIEGO has had an effect. In Morocco, JHPIEGO helped to structure the 9-week ob/gyn rotation in the sixth year of medical school so that all students would acquire clinical skills. Competency-based training (CBT) was introduced, and greater demands were placed on both students and faculty in terms of the development of clinical skills. While an evaluation showed that the majority of students learned five sentinel skills in FP and maternal healthcare, after the first year of implementation of the new rotation self-reported questionnaires from both faculty and students also indicated perceptions of improvements. Another indicator that the new structure was successful was that students began to hold parties at the end of each rotation to thank the professors who had coached them.

Peru provides an example of another unique approach. JHPIEGO is working with the Social Security Institute (ESSALUD) and the MOH, the two largest employers of medical and midwifery school graduates, to institute change in preservice policy. Recognizing that the midwifery schools using a standard curriculum were making more progress than those who were not, USAID asked JHPIEGO to expand the program to other medical and midwifery schools. Because midwifery and medical schools were not coordinating their efforts, JHPIEGO approached ESSALUD and the MOH, and suggested that they develop a national agreement outlining the key characteristics required for the midwives and physicians they employ. It is hoped that such an agreement will encourage the medical and midwifery schools to consider how best to respond to the defined needs and encourage them to use the existing curriculum. This approach follows on one used in Bolivia where JHPIEGO helped to revise the medical and nursing curricula at two schools¹ so that all students graduate with the skills needed to provide the basic package of services offered through the MOH's national insurance plan. A potential strength of this approach in Peru is that it provides a mechanism for tying curricular changes to broader health policies (e.g., health sector reform-policies) that may have more significance for the MOH and ESSALUD than they do for the medical and midwifery schools.

Curricular change means not only the addition of new requirements but also the removal of unnecessary requirements. In Kenya, IUD requirements were made less intensive in the preservice nursing curriculum. After the basic preservice curriculum for nurses was revised to include FP skills, the Nursing Council of Kenya (NCK) felt that the graduates of the preservice program had the same skills as the graduates of the 6-week inservice course. "Anecdotal evidence from inservice trainers presented another picture, however. Inservice trainers felt that nursing school graduates were not competent in basic FP skills and they needed an additional 'apprenticeship' before being allowed to deliver FP services, especially IUD insertion" (Brechin,

¹ Work is ongoing at the other medical and nursing schools.

Smith and Schaefer 1997). A skills assessment conducted by JHPIEGO, the NCK and the MOH (Brechtin, Smith and Schaefer 1997) showed that students were, in fact, not graduating with these skills and it was recommended that instead of maintaining requirements that could not be met, they be removed from the curriculum. The NCK has not removed the IUD requirement altogether but it has agreed to use anatomic models instead of clients for IUD training.

Licensure/certification requirements are clearly another area in which JHPIEGO has had a policy impact. In countries where licensure/certification issues have not been considered recently, JHPIEGO has a role in bringing the issues to the attention of policymakers—just raising the issues may be the first step in policy change. Specific changes have been effected. In the ob/gyn department at the University of Nairobi in Kenya, there is now a requirement that all interns receive training in minilaparotomy and PAC prior to completing their training. At the Universidad Mayor De San Andres in La Paz, Bolivia, JHPIEGO is working with the ob/gyn department of the medical school and the maternal and child health department of the nursing school to institute a new evaluation system for students—evaluation is part of the certification process. The Observed Structured Clinical Examination (OSCE) has been instituted as the method of evaluation at the end of the 12-week rotations in these departments. Other departments within the school are in the process of adapting this approach, but their specialties are beyond JHPIEGO's scope of work.² JHPIEGO is also working with other medical and nursing schools throughout Bolivia to implement the OSCE.

The above points to one of the limitations to JHPIEGO's policy work; because of the focus on RH, JHPIEGO cannot support the broader changes that may be required for a change in overall institutional policy. Thus, though changes may be made in the ob/gyn department, these changes may be more susceptible to new leadership or other changes in the environment than a change in the policy of the institution as a whole.

Training policies are an important component of any training system. In some cases, changes in who is providing training can be an important step in increasing the effectiveness of training. Part of this may be making the training role of some staff members explicit. In Kenya, all nurses were expected to help in the clinical training of students, but there was no one person who had responsibility for their training. After the skills assessment (discussed above), the Division of Nursing, the NCK, tutors and inservice trainers recommended that preceptors be given a greater role in preservice education. JHPIEGO helped the Medical Training Colleges to institute a preceptorship in the FP rotation. Once the preceptorships had been instituted, the NCK saw their value and agreed that preceptorships should be used for all types of clinical training, thus changing its organizational policy in response to JHPIEGO's work.

Deployment policies can also affect the quality of training and of service delivery. A skills assessment done in Kenya pointed to the rotation of preceptors as a cause of reduced quality of training. It suggested that the annual rotation of staff, often into positions for which they were not specially trained, decreased the effectiveness of training. It was suggested that FP was a desirable rotation because of the limited hours, lack of emergencies and types of services provided, which made the rotation of FP preceptors quite common. Following advocacy by JHPIEGO, at a 1998 meeting of the Nursing Matrons (the officers in charge of preceptors), the NCK changed their policy, agreeing to keep preceptors in their positions rather than including them in the general rotations.

² JHPIEGO has found that the approaches it uses in FP and RH can be transferred to other fields. Content matter experts and faculty in other disciplines have been trained in CBT techniques including curriculum development at the Centre for African Family Studies in Nairobi, Kenya and at a medical school in Indonesia.

Another way in which JHPIEGO has influenced policy with regard to preservice training is by bringing policymakers together around preservice issues. In 1996, the SFPS program coordinated (with much assistance from other donors) the *Regional Forum on Education in Reproductive Health in Medical Schools and Professional Health Schools in West and Central Africa*. This forum brought together representatives from 18 francophone African countries to discuss preservice reform and to develop country action plans. Advocacy was required to encourage decision-makers to consider the issues, but by the end of the conference there was a commitment from key decision-makers to work on preservice issues. A specific outcome was the recommendation that generic FP/RH and Emergency Obstetric and Neonatal Care curriculum modules be developed for use in all of the countries. This type of collaboration is a policy intervention outlined in the JHPIEGO 1998 Cooperative Agreement, and this particular recommendation has been carried out—the FP/RH module was developed through a number of activities and was finalized in 1999. The other module is being developed, and it is expected that it will be finalized by 2001.

In Zimbabwe, JHPIEGO brought the Zimbabwe National Family Planning Council (ZNFPC) and the MOH/Child Welfare (CW) together to strengthen their relationship with regard to preservice training. ZNFPC trainers conducted training for the MOH/CW nursing faculty, which allowed the ZNFPC to share its technical expertise with the ministry and highlighted the role of the ZNFPC as a locally available resource. As a result, the MOH/CW now calls upon the ZNFPC to provide support for preservice training institutions.

Inservice Training for Practicing Health Professionals

The inservice arena also offers numerous examples of JHPIEGO's work related to policy. Some countries have, with help from JHPIEGO, instituted new methods for inservice training. Results of an evaluation of the group-based IUD/genital tract infection (GTI) course in Zimbabwe showed that on-the-job training (OJT) was a useful alternative to the standard group-based courses, which had not had great success. These results were used to advocate with the ZNFPC for the adoption of new training approaches—specifically, structured OJT. After a course was developed, the ZNFPC adopted structured OJT as an official training approach and agreed to certify using OJT. Similarly, in Kenya structured OJT for IUD services has been adopted by the Division of Primary Health Care so that adequate knowledge and competency rather than attendance at a 6-week course is the requirement for certification. In the mid-1990s, JHPIEGO worked in Uttar Pradesh, India to develop a cadre of trainers skilled in humanistic, CBT approaches. The goal was to improve the quality and effectiveness of training. Though JHPIEGO's assistance ended in 1998, an evaluation of another project in 1999 showed that CBT approaches were being used at both the preservice and inservice levels. At King George's Medical Center in Lucknow, CBT is the standard training methodology in the ob/gyn department, and other departments have asked for assistance with their teaching methods.

New training strategies are another way that JHPIEGO affects inservice training policies. JHPIEGO/Nepal has worked closely with the National Health Training Center (NHTC) to develop more effective strategies for training, particularly in FP. The Comprehensive Family Planning (COFP) course introduced in 1993 consolidated a number of training courses (e.g., FP skills and counseling) and increased the efficiency of training in terms of direct cost and time away from the health post by workers attending training. CBT, which increases training efficiency, was also introduced (Magarick et al 1997). More recently, JHPIEGO helped to bridge the gap between government policy at the NHTC and the training done by nongovernmental organizations (NGOs). First, JHPIEGO advocated for use of the government standards by the NGOs. Although initially hesitant, the NGOs came to recognize the quality of the government training and the effectiveness of CBT. JHPIEGO then worked with the government to get them

to integrate NGO trainees into the government-training schedule on an equal basis and to agree to give NGO trainees the NHTC training certificate. The compromises made by both parties resulted from JHPIEGO's influence and led to a new policy with regard to training.

JHPIEGO has also affected policy by first changing inservice training. In Nepal, the initial step toward policy change was obtaining written permission to conduct PAC training for nurses. Despite the need for more providers of PAC services and the lack of a policy limiting the provision of these services by nurses, it had been widely accepted that only physicians could perform the manual vacuum aspiration (MVA) procedure. Providing training showed decision-makers that non-physician healthcare providers could become competent in the delivery of PAC services. As a result, provision of PAC services by nurses was accepted, and a limited number of nurses began to provide these services. This indirect policy approach was used because no policy existed that was an obstacle to change and because it was less likely to draw negative attention to the suggested changes. A similar approach is being used in the Ukraine where JHPIEGO is working to obtain permission to conduct a course in IUD skills for midwives. This training is aimed at changing policy so that midwives can provide IUD services, a change that is necessary to meet the need for IUD providers in rural areas. Making this change is particularly difficult in a country traditionally focused on physicians, but articulating the problem and providing a solution may be a successful approach to implementing change.

Indonesia provides perhaps the best example of JHPIEGO's impact on inservice training policy. The National Clinical Training Network (NCTN) was developed based on JHPIEGO's framework for strengthening RH systems. This network has established policies for institutionalizing CBT, and other institutions have linked their training methodologies with that of the NCTN. The MOH, for example, decreed that all FP and safe motherhood training go through the NCTN. One example of NCTN training policy is the institutionalization of the trainer qualification process, which was adapted from JHPIEGO's Trainer Development Pathway (Sullivan et al 1998). The NCTN now requires all trainers to complete a practicum in training skills; unfortunately there is an insufficient number of advanced and master trainers to meet the demand this requirement generates. This situation is an example of the way in which policy changes have ripple effects throughout a system—effects that should be considered before policy implementation, but that cannot always be anticipated.

JHPIEGO has encouraged the integration of preservice and inservice systems in some countries; such integration has both resulted in and been the result of policy changes. In March 1999, the Bolivia MOH requested technical assistance from JHPIEGO to develop a national policy for the development of human resources for the health sector. Two long-term JHPIEGO consultants worked with the MOH to formulate a policy that integrates preservice education and inservice training. The result was a cohesive strategy for developing the knowledge and skills that healthcare workers need to provide the basic package of health services offered in the public sector. The MOH and Ministry of Education (MOE) approved this policy in September 1999. In July 2000, the national *Policy and Strategies for Human Resource Development in Health* was published. This document outlines the national human resource development policy and its implementation. With JHPIEGO's encouragement, the Kenyan inservice and preservice systems also came together so that all faculty, preceptors and other trainers attend the same courses and acquire the same knowledge and skills. This system resulted in the use of a standard approach to and content of training by both the preservice and inservice systems, which has led to more efficient use of resources and increased standardization within the healthcare system.

Service Delivery

Service provision policies can be an aid or an obstacle to the implementation of broader policies, such as SDGs. At a Maximizing Access and Quality (MAQ) Conference held in West Africa, participants cited policies regarding the referral system and lack of equipment as examples of obstacles to implementation (MAQ Conference 1999). JHPIEGO has worked both at national and local levels to improve service provision policies so that they support training efforts and implementation of guidelines.

Who can provide services according to official policy is sometimes an impediment to quality services. In Bolivia, the lack of clear job descriptions is a barrier to the provision of services by a wide range of providers. When FP services were first introduced in the public sector in the early 1990s, JHPIEGO staff considered the development of job descriptions an important area for intervention. Because FP was completely new to the country, it was felt that this issue was too much to undertake and it was tabled. Now that demand for FP exists and FP is widely accepted, it may be an appropriate time for advocacy around this issue. In Turkey, though midwives are officially allowed to provide IUD services, the SDPs to which many were posted did not include this in their job descriptions, and sites were concerned about who would be responsible if there was a complication. JHPIEGO worked with the MOH to revise job descriptions to include IUD services as well as FP counseling and postpartum and postabortion FP counseling.

Infection prevention (IP) is the area in which JHPIEGO has had the most effect in terms of changing institutional policies to improve performance. In Nepal, no IP policies or standards existed at hospitals, but JHPIEGO staff felt that they were important tools for performance improvement. After a core group of providers received IP training, infection control committees were formed at selected hospitals and policies were drafted. These were submitted to the hospital administrations and were approved in all cases. Hospital-wide IP training followed, and there have been changes in IP behaviors. Unfortunately, it is not widely accepted that policies can be a tool for daily work and evaluation. As a result, some simple activities that could promote the use of the policies (e.g., posting them in the hospitals, using them as the basis for evaluation) have not been undertaken, and this limits their broader implementation. An example of a very specific IP policy made as a result of JHPIEGO's influence is the effort in Malawi to replace the Savlon[®] with JIK as the standard solution for disinfection. After first garnering national-level support for this change, JHPIEGO and AVSC have been working with district health management teams to build support among the people responsible for budgeting and supplies. This activity in Malawi is another example of JHPIEGO's efforts to work with those responsible for the implementation of policy.

Accreditation of SDPs is seen as a tool for improving and maintaining the quality of services. The PROQUALI project in Brazil is perhaps the best example of accreditation. In the Bahia and Ceará states of Brazil, JHPIEGO, in collaboration with Johns Hopkins University/Center for Communication Programs (JHU/CCP) and Management Sciences for Health/Family Planning Management Division, helped the Secretariats of Health to develop lists of verifiable, objective criteria that could be used to assess the quality of FP services at a SDP. These tools formed the basis for the accreditation policy of the Secretariats, and numerical goals were set for accreditation. Clinics that meet those standards receive the PROQUALI logo, which is recognized by clients thanks to an associated information, education and communication campaign. As part of implementation, supervisors were trained in the criteria, how to achieve them and how to mobilize resources for their achievement. The SFPS Gold Circle campaign is another example of an accreditation policy. The SFPS program worked with JHU/CCP and the MOH in four countries to help them set standards, establish criteria and learn to assess whether criteria are being met. SDPs that meet the criteria receive a gold circle as proof of their

accreditation. This effort, like that in Brazil, relies heavily on community involvement and includes efforts to educate clients about what quality services are and about their right to them. SFPS not only helped the MOH in setting the guidelines for accreditation but is also helping clinics to implement them by providing the equipment, training and commodities needed to provide quality services.

Peri-Program Areas

Discussion of some of the peri-program areas, such as licensure/certification, deployment and qualification of trainers has been included in the preceding section, **Key Components of the Framework for Strengthening Reproductive Health Systems in National Programs**, because they are tied to the specific components. The following section focuses on topics that have not been addressed previously.

Strategic Advocacy

Strategic advocacy is more closely related to traditional policy approaches than much of the other work that JHPIEGO does. JHPIEGO uses both direct and indirect approaches to advocate for policy change.

Training courses alone can serve an advocacy role whether they are geared to service providers or policymakers. IP training is often cited by staff as a way in which training influences policy. In Bolivia, IP training in September 1998 helped to put the issue of IP on the policy map for the MOH. This training led to the development of national IP guidelines, which will be used at all service delivery sites when they are published. In the Ukraine, IP training courses were conducted at five service delivery sites. After the courses, all five sites asked the MOH for permission to be IP pilot sites to test the new methods they had learned. These requests generated interest on the part of the MOH, which has since decided to revise the Infection Control Standards for Maternity Houses—standards that have been in use for the last 45 years.

Discussions with policy- and decision-makers, both formal and informal, are another way in which staff members advocate for policy change. In 1999, JHPIEGO program staff (Jennifer Macías and Jeanne Rideout) met at the WHO to discuss the gap between the technical guidelines that WHO had developed and actual practice. They encouraged the WHO to consider the need for a more comprehensive approach to guidelines, which includes assistance with implementation as well as distribution of guidelines. In 2000, JHPIEGO and partners organized a WHO regional conference in Nepal at which they introduced a new strategy to ‘disseminate, adapt and utilize’ technical guidelines—this strategy is now called the DAU process. Although JHPIEGO cannot take credit for this change in approach, advocacy on the part of JHPIEGO staff members who had experience in guidelines implementation was likely a factor contributing to this change.

Organizing conferences also allows for advocacy. In 1998–1999, JHPIEGO organized a conference in preparation for the West African MAQ Conference held in March 1999 in Dakar, Senegal. At the preparatory conference, participants discussed the need to disseminate and apply PNP so that SDG development efforts would achieve their desired objectives—improved access to and quality of services. This meeting provided a platform for furthering the notion that guidelines development is just one step in the process of quality improvement.

Participation in policy-making bodies is another way in which JHPIEGO staff members are able to fulfill an advocacy role. The importance of such participation has been recognized: “Policy/planning co-ordination is also influenced by NGOs’ representation on government bodies

and vice versa, and by the degree of formal integration of NGOs with government services" (Gilson et al 1994). JHPIEGO staff members do participate on a number of government and nongovernmental bodies that are important to the policy process, particularly where there is a JHPIEGO incountry office. For example, in Nepal staff serves on the Non Governmental Organization Coordinating Committee, Nepal Nursing Council, Nepal Nursing Association, the boards of the Nepal Fertility Care Center, Chettrapati Family Welfare Center and Quality of Care Management Center, and the Safe Motherhood Network. A JHPIEGO staff member is also the chair of the NGO training committee. In Kenya, a JHPIEGO representative serves on the National RH Advisory Committee, one of two NGOs with such representation. And in Indonesia, one staff member will soon be spending half of his time as a Program Management Unit (PMU) Advisor—the PMU advises the government regarding FP issues. Another JHPIEGO staff member not only serves on the Secretariat for the Strategic Objective Agreement (SOAG), a group that liaises between the government and USAID on its program of support for health and FP, but also serves as an advisor to the Director General of Community Health. This type of influence most often results from long-term relationships that are based not only on JHPIEGO's technical expertise but also on the recognition of the skills of the individual staff member. Participation on policy-making bodies allows for input into the policy process and gives staff members access to policymakers, which can increase their ability for informal policy influence and lend credibility to JHPIEGO's work. One staff member noted that even when the committee is not directly relevant to JHPIEGO's mission, such participation lays the groundwork for policy efforts.

Direct policy advocacy is particularly necessary when a new intervention is being introduced. When PAC was introduced in West Africa, there were no policies or guidelines and PAC was a controversial issue. Meetings were held with policymakers early in the process so that issues could be raised that needed consideration and so that the policies that were created would allow for some flexibility. Among the issues raised were: what level of facilities could provide PAC services, how should the MVA equipment be managed and what level of provider could provide PAC services. Flexible approaches to policy included statements that trained providers could provide PAC rather than specific cadres. Although this statement might be interpreted as only including physicians at the start of a program, it leaves open the possibility for expansion to other levels of service providers. One interviewee suggested that having this type of discussion might have been possible in West Africa because there are often few policymakers in these countries and, therefore, JHPIEGO staff members are more likely to be able to draw their attention.

The introduction of visual inspection with acetic acid (VIA) and cryotherapy under the CECAP program has also required policy dialogue at the outset. In Peru, the MOH had a policy specific to referral of women with cervical cancer, and there was legislation prohibiting the provision of curative services. JHPIEGO held discussions with the MOH and Peru's National Cancer Institute to determine the best course of action in terms of changing these policies to encourage the use of VIA and cryotherapy. Working with the MOH, JHPIEGO helped to revise the national cervical cancer SDGs to include VIA as an alternative to the Papanicolaou (Pap) smear and cryotherapy as an alternative to loop electrosurgical excision procedure. More recently, the guidelines have been revised to allow VIA to be offered anywhere that Pap smears are available and to provide VIA as an alternative where Pap smears are not available. This revision is an important change in policy that will make cervical cancer screening and treatment available to more women if it is implemented. In this regard, JHPIEGO is working to train a core group of providers to offer VIA and cryotherapy.

JHPIEGO has also advocated for policy change by organizing conferences to address specific policy issues. In 1998, JHPIEGO held a regional workshop for policymakers to discuss the

future of Norplant® services in Central and West Africa. The goals were to assist the participating countries to think about the critical decisions needed regarding the future of their fledgling Norplant programs and to guide them in their decision-making around whether to continue, expand or phase out Norplant services. Country-specific recommendations resulted as well as a consensus document, *Strategy for Norplant in Central and West Africa*. Similar outcomes from a CRHCS meeting in East and Southern Africa were described in relation to policy as follows: “While not legally binding, these resolutions are statements encouraging member states to address the specific issues. In some instances, the country response is to formulate a policy” (CRHCS: East and Southern Africa and Support for Analysis and Research in Africa Project/AED 2000).

A recent meeting in Ghana helped stakeholders to consider the role of policy in IP behaviors and points to the likelihood that a performance improvement approach will lead to policy discussions. The MOH and other stakeholders had voiced frustration that IP practices fell short of desired levels in most parts of the country, despite efforts aimed at improving them. JHPIEGO facilitated a meeting at which a performance improvement approach was used to look at the reasons for the performance gap. A list of strategies was developed that included a number of items related to policy including: adapt IP protocols to cut across all service areas, strengthen supervision systems at all levels and standardize bleach used in all facilities. This process highlights the way in which the performance improvement approach can identify policies that hinder or may help performance.

In some cases SDGs serve a role in strategic advocacy; including new guidance in these documents can open a window for increased access and also for policy movement. In Jamaica, an appendix was included in the national guidelines that provides guidance regarding provision of contraception to adolescents. Though it is not a policy document, this appendix discusses the legal context for adolescent services and may encourage providers to increase access for adolescents.

Monitoring/Followup

Monitoring and followup activities relate to policy in two ways: 1) the results of monitoring activities may supply data that can be used to sway decision- or policymakers and 2) implementation of policies may be monitored. In addition, this section considers policies regarding monitoring and followup within training systems.

Under the MAQ Initiative, an evaluation of the guidelines dissemination process was conducted in Zimbabwe (Chibatamoto 1996). This evaluation was an activity geared directly to monitoring the implementation of policy. Pre- and post-dissemination questionnaires were given to a random sample of service providers, using a matched pair design to look at the difference between those who had attended dissemination workshops and those who had not. The study showed a significant difference in compliance with the guidelines suggesting that staff members who attended the workshops were not orienting other staff at their sites—a responsibility they were supposed to take on following workshop attendance. This finding showed the importance of monitoring implementation.

A similar study in Kenya evaluated the orientation package used to guide providers in orienting others to the guidelines. The study was conducted in 26 districts: 13 that had the RH update through the training center as well as materials (guidelines, *The Essentials of Contraceptive Technology*, Family Health International chart) and 13 that had the RH update plus one day of discussions on how to orient staff to the guidelines. This latter group was also given an orientation package and had a chance to practice orientation. Preliminary findings (Lynam 2000)

suggested that many providers had not had an update for 15 to 20 years and needed a basic course rather than simply an orientation to the new guidelines. These examples suggest that monitoring is a vital step in ensuring the successful implementation of policy.

Ryder (1996) discusses the fact that policy development is not a scientific but a political process. Thus, although research can influence the process, it is unlikely to be the only influence, and clear scientific results may not be the most influential factor in decision-making. JHPIEGO does not do research solely as a means of influencing policy, but the results of studies that are done can be used as evidence of the need for change. The Kenya nursing assessment discussed under *Preservice Education* is an evaluation that was used for advocacy. In Nepal, a formal evaluation of the COFP course was conducted after it had been introduced. The study showed that the COFP course was effective in improving services for clients, which led to the continuation of the policy to use COFP for training. In addition, the evaluation pointed to a number of issues that fall within the realm of policy—the need for a certification process for trainers and participants and the need for selection criteria for participants.

In terms of policies with regard to monitoring and evaluating training, JHPIEGO has helped to incorporate the Preservice Midwifery Core Competencies, developed by PRIME, into the evaluation of midwifery knowledge and skills. JHPIEGO/Indonesia finalized the curricular content units that lay the foundational skills for midwifery (normal antenatal, intrapartum, postpartum and newborn care), added the teaching component of the package and is disseminating the materials to faculty in midwifery schools. The use of the Core Competencies for evaluation has been adopted as the standard by a number of organizations including the WHO, USAID and the World Bank, which plan to take on different elements of midwifery skills evaluation.

In thinking about the monitoring of policy, it is clear that policy changes can rarely be attributed to one organization. Collaboration is often required for changes in policy and because a number of forces influence policy, attributing policy change to JHPIEGO alone would be difficult, if it is possible at all. As AIDSCAP (1999) noted in a review of their policy work: “Evaluation of policy work is complex for a number of reasons, including the difficulty in attributing policy changes to specific interventions and of quantifying changes in the policy environment. In addition, because much of policy change is incremental and attitudinal, it is often hidden from evaluation efforts.” JHPIEGO will need to consider these issues as it moves forward.

DISCUSSION

The interviews and document review show that JHPIEGO staff is involved in policy work at various levels of the healthcare system. They also suggest that policy concerns are an integral part of JHPIEGO's programmatic work. Throughout the interview process, it was evident that most staff considered SDGs the only area in which JHPIEGO does policy work. Providing staff with a framework for thinking about the other kinds of policy-related work they do, however, helped them to provide a more complete picture. These results should dispel the notion that JHPIEGO does not 'do policy.'

One limitation of this study is that the interview format and process provided information that was biased toward a limited number of country programs. The length of time the JHPIEGO Program Development Officer (PDO) had been working on that program was a major factor affecting the level of information. Those PDOs who were relatively new to a program were less aware of the policy work that had been done in the initial stages of a program, and they were

more likely to view JHPIEGO's policy work as limited to SDGs.³ Other staff members had clearly been thinking about policy work for some time prior to the interview (in fact, some had been contacted earlier in the year to collect initial information for this study); these staff members provided a more comprehensive picture. When staff was available for an interview as well as when the interview took place also affected the outcome. Many of the interviews, particularly those with field-based staff, were conducted during JHPIEGO's staff development activities. Although this time period allowed the interviewer to contact a greater number of staff in person, those who were interviewed at this time seemed busier than staff contacted at other occasions. In addition, because these interviews were the first ones to be conducted, these staff members were given little information prior to the interview and thus, were not able to respond to the answers of others. Finally, the unstructured interview format, which was useful in capturing as many types of policy work as possible, allowed for a large degree of variation in the interviews. These limitations do not, however, affect the utility of this study in providing an overall picture of the policy work that JHPIEGO has done.

Something that does not come across well in the examples discussed above, but which was apparent in the interviews, is the importance of informal connections with policymakers. Conversations over dinner and at cocktail parties and personal friendships are an important aspect of the policy process. Such meetings provide another venue for discussing policy or performance issues, often in a less threatening context. The general consensus among those who mentioned these informal connections is that such contact is more beneficial and more common where JHPIEGO has an incountry presence. One interviewee felt that Baltimore-based staff was less able to exert influence in this way because they do not have a clear sense of how much influence they have and because they are too far removed to push things along. Another staff member suggested that having staff incountry that can attend meetings regularly over a long period of time, rather than drop in occasionally, facilitates policy work.

Volunteerism was mentioned as another way to get involved in policy using an indirect approach. When JHPIEGO staff is at meetings where policy changes are being discussed and can provide assistance to the development process, offering such help can be an important entrée into the policy arena. Such collaborative efforts help to increase JHPIEGO's visibility and credibility, both of which are important to JHPIEGO's ability to influence policy. One staff member mentioned that having small amounts of money that can be quickly mobilized is another way that JHPIEGO can become involved. For example, in Nepal when NGOs requested copies of *Protocols for Essential Maternal Healthcare*, which were not available because of the small initial print run, JHPIEGO provided funds to print copies that were then purchased by the NGOs.

On the whole, JHPIEGO has not addressed policy in a direct manner—staff members have not gone into a country saying that their goal is to change the RH policy. JHPIEGO has worked on policy when it has been relevant to the work of developing training systems. Because JHPIEGO is known for its expertise in training, and because its policy work is an extension of that work, JHPIEGO is less likely to meet with resistance from organizations that have policy change as a mandate. An indirect approach is possible, in part, because in many countries there is no need to change law to implement changes that support the training system. When national policies do not exist that would be obstacles to the changes JHPIEGO proposes, it is often institutional (MOH, university, SDP) policies that need to be changed, and it is usually easier to work with these institutions than it is to work with legislators.

³ This finding points to the importance of program staff working on the same program for as long as possible. When policy work is involved, relationships are particularly important and they take time to establish and have an effect.

One argument put forward with regard to the policy work of organizations involved in international assistance is “that a crucial condition of maintaining the sustainability of policy-based approaches to international assistance will be ensuring that policy-makers and politicians feel that they own policies” (Okunzi and Macrae 1995). This reasoning is relevant to JHPIEGO’s work, especially as it moves forward, in that effective changes in policy must be driven at least in part by local counterparts. What this argument leaves out is that the buy-in of those responsible for implementation is vital to the effectiveness of any policy: without their support the goals of a new or changed policy will not be realized.

This sort of approach is also useful in considering when opportunities arise for policy change. As mentioned in the **Background**, there are times at which policy change is easier to implement, largely due to external circumstances. When JHPIEGO staff can identify such opportunities, it is more likely that they will have an effect. For example, when an orientation program was being devised for new government physicians in Nepal, JHPIEGO took advantage of the opportunity to introduce a FP component. Using these opportunities feeds into ownership by local policymakers because a small change is being made to their policy before it is implemented, and they are involved in making the change.

It is important to note that JHPIEGO’s work is influenced by broad changes in policy approach in the countries in which it works. For example, where health sector reform is instituted decentralization generally occurs and, therefore, some policy decisions are shifted to local governments who may be less well informed than MOH staff (Hardee and Smith 2000). Some changes in the policy environment may support changes JHPIEGO has been advocating and can be used to encourage change. For example, one focus of health sector reform is more efficient service provision; one way to increase efficiency is to expand service provision to lower level healthcare providers (Hardee and Smith 2000). If JHPIEGO is recommending expansion of service provision to a new cadre of workers, linking this recommendation to health sector reform may encourage its adoption. Similarly, changes made in response to the 1994 International Conference on Population and Development are likely to influence the policy process. When a government adopts an integrated RH approach, there may be greater opportunity for the introduction of new initiatives like PAC.

Other external factors that affect policy work, both in positive and negative ways, include changes in government, changes in funding priorities and changes in leadership. For example, it was not until the government in Guatemala changed, and a pro-FP government came to power, that the national SDGs could be published. In this case, JHPIEGO had already been doing work to increase the knowledge of FP in the preservice setting. When the policy window opened, JHPIEGO was able to take advantage of the opportunity and quickly publish and begin to implement the guidelines that had already been developed. This situation illustrates the belief that “politics and timing can be more decisive for the future of policy than theory and actual evaluation results” (Hanning and Spangberg 2000). It is important to note this concept because efforts to change policy are often beyond the control of those advocating for change.

At this point, it seems that what is most relevant for JHPIEGO in terms of thinking about policy is the process by which it is developed or implemented rather than the content of the policy, a distinction that has been made in the academic literature (Musick 1998). A number of staff members wanted to know more about what policy work means for them and what exactly is involved. Although some information (e.g., specific numbers of meetings required) is impossible to provide because of the large degree of variability in the policy process (depending on the issue being addressed, the people involved and the context in which the work takes place), it is hoped that the examples will provide some insight into the world of policy. It is also hoped that the examples in this report will help to make policy something that is more concrete and

understandable. It is clear from talking with staff that when guidance is provided, as in the case of SDGs, policy work can be a successful support for training systems.

That leads into questions of where JHPIEGO should focus its work in policy. The interviews suggested that JHPIEGO should use a familiar approach, focusing on those areas in which it has expertise and on those issues where it is likely to have the greatest impact. JHPIEGO is most effective when working with incountry counterparts to formulate policies for healthcare and training systems—areas most relevant to its programmatic work. To date, the majority of JHPIEGO's work has been at the institutional level. This level has been an effective area in which to work, in large part because of JHPIEGO's role in training systems. Although much of the focus of the policy community is on national-level change, other levels of policy are important to the success of the system as a whole. Without sound policies at all levels, a system is not complete. This report also suggests that implementation should not be overlooked as an area of policy work; it is through action that staff members have been most successful in changing the policy environment. Although impact in this area may be less noticeable, it is the cornerstone on which all policy change rests. Finally, JHPIEGO has also had an important role in putting policy issues on the agenda both locally and nationally—the first step in any process of change.

Responses in interviews indicated that the programmatic staff requires more guidance when undertaking policy work. There is a need for an internal programmatic policy that addresses such efforts. This internal mechanism could address such issues as what types of policy work staff should consider, particularly in the field of RH beyond FP, and how policy work can be made more visible. Staff expressed an interest in more information on the steps in creating policy change and more support when they are doing this work. Understanding what is involved, and knowing what has and has not worked in other countries can help them to be more effective. Finally, there is a need to monitor and evaluate the policy work that is done. Benchmarks and indicators that reflect this policy work are one place to start. Until now, some of the work has been captured in written documents (e.g., trip reports), but much of it has been maintained only in the memory of JHPIEGO staff. Some staff members suggested that this indicates that much of this work is not recognized or valued.

This report represents a first attempt to document JHPIEGO's policy work. It begins to articulate the variety of JHPIEGO's direct and indirect efforts to work on policy, which include identifying issues and solutions; advocating for policy change; and formulating, implementing and evaluating policy itself. The strategies and successes identified in this report should dispel the notion that JHPIEGO does not “do policy,” and the suggestions made by staff members to encourage a more concerted focus on policy point to the importance of this work to the success of JHPIEGO's programs. This report encourages staff to acknowledge JHPIEGO contributions to RH policy and demonstrates the very real results achieved in policy through JHPIEGO's programmatic efforts. JHPIEGO will continue to work within a broad definition of policy that looks not only at overarching national policies, but also at regulations and formal and informal operational procedures at the provider and institutional level. Recognizing that JHPIEGO is—and has long been—in a position to play an important role in policy development and implementation is the first step to ensuring continued appropriate and valuable contributions in the RH policy arena.

REFERENCES

AIDS Control and Prevention (AIDSCAP). 1999. *Making Prevention Work: Global Lessons Learned from the AIDS Control and Prevention (AIDSCAP) Project 1991–1997*. Family Health International, AIDSCAP Project: Arlington, Virginia.

Brechin SJG, TM Smith and L Schaefer. 1997. *Family Planning/Reproductive Health Skills Assessment of Nurses Finishing Basic Training in 12 Institutions in Kenya*. JHPIEGO Technical Report FCA-33. JHPIEGO Corporation: Baltimore, Maryland.

Chibatamoto PP. 1996. *Evaluation of the Use of the New Guidelines on Reduced Medical Barriers in Family Planning Service Delivery*. Zimbabwe National Family Planning Council: Harare: Zimbabwe.

Commonwealth Regional Health Community Secretariat (CRHCS): East and Southern Africa and Support for Analysis and Research in Africa Project/Academy for Educational Development (AED). 2000. *Policy Development, Implementation, and Monitoring for Health*. AED: Washington, D.C. Draft.

Gilson L et al. 1994. The potential of health sector non-governmental organizations: Policy options. *Health Policy and Planning* 9(10): 14–24.

Hanning M and UW Spangberg. 2000. Maximum waiting time—a threat to clinical freedom?: Implementation of a policy to reduce waiting times. *Health Policy* 52(1): 15–32.

Hardee K and J Smith. 2000. *Implementing Reproductive Health Services in an Era of Health Sector Reform*. Futures Group International: Washington, D.C.

Lynam P. 2000. *The Multiplier Effect: Dissemination of MAQ Guidelines in Kenya*. Presentation at JHPIEGO's Learning Expo. Baltimore, Maryland, 1–16 June.

Macias J et al. 1999. *Documenting the Reduction of Medical Barriers: A Desk Review in Reproductive Health Service Guidelines in Four Latin American Countries*. JHPIEGO Corporation: Baltimore, Maryland.

Magarick R et al. 1997. *Institutionalizing Competency-Based Reproductive Health Training in a National Training System*. Paper presented at The American Public Health Association Meeting. Indianapolis, Indiana, 9–13 November.

MAQ Conference. 1999. *Conference on Maximizing Access and Quality of Care (MAQ): Implementing Policies, Norms and Protocols in Reproductive Health Services*. Conference Highlights. Dakar, Senegal, 1–4 March. JHPIEGO Corporation: Baltimore, Maryland.

Musick DW. 1998. Policy analysis in medical education: A structured approach. *Medical Education Online* 3(2): <http://www.med-ed-online.org/f0000011.htm>.

Okuonzi SA and J Macrae. 1995. Whose policy is it anyway? International and national influences on health policy development in Uganda. *Health Policy and Planning* 10(2): 122–132.

Orosz E. 1994. The impact of social science research on health policy. *Social Science and Medicine* 39(9): 1287–1293.

Porter RW and I Hicks. 2000. *Knowledge Utilization and the Process of Policy Formulation: Toward a Framework for Africa*. AED: Washington, D.C.

Rau W and D Flanagan. 1999. *Policy and Advocacy in HIV/AIDS Prevention*. Family Health International, AIDSCAP Project: Arlington, Virginia.
<http://resevoir.fhi.org/en/aids/aidscap/aidspubs/handbooks/bccpol.pdf> (On-line training material.)

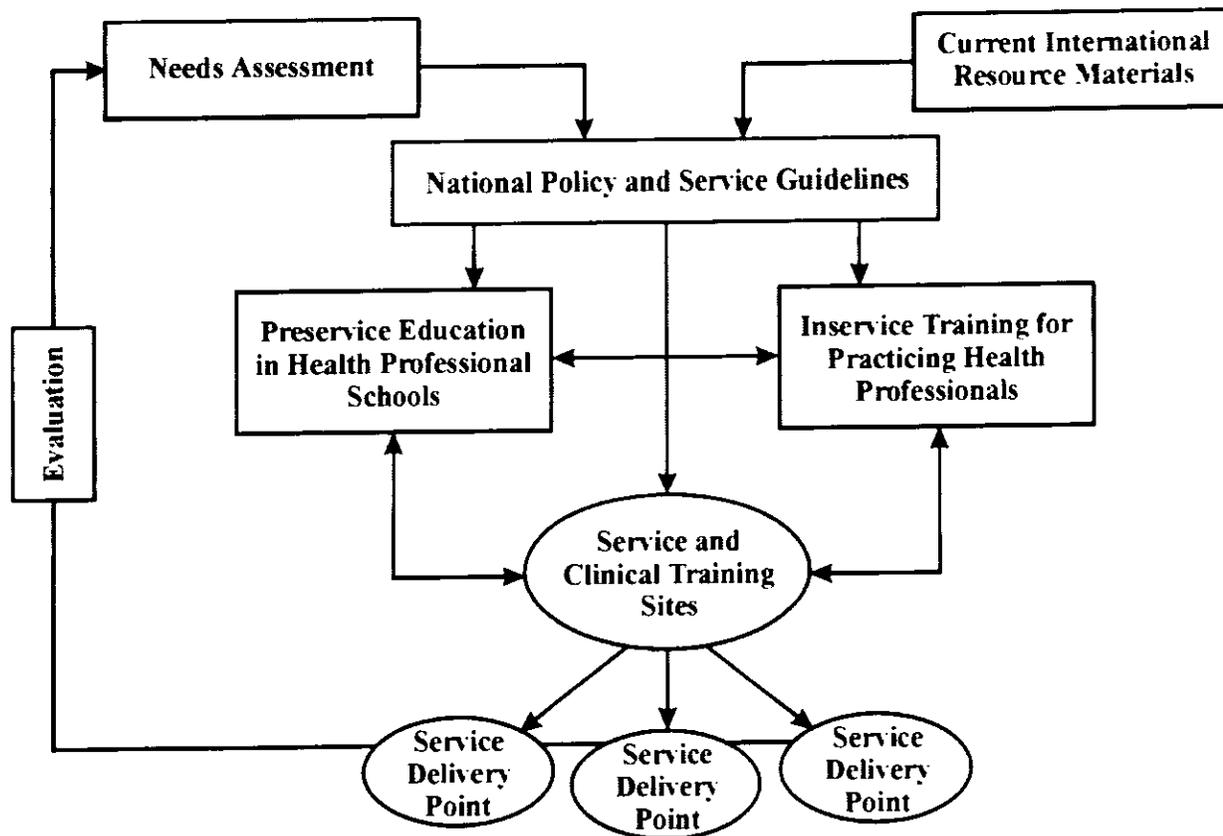
Ryder D. 1996. The analysis of policy: Understanding the process of policy development. *Addiction* 91(9): 1265–1270.

Sullivan R et al. 1998. *Clinical Training Skills for Reproductive Health Professionals*, second edition. JHPIEGO Corporation: Baltimore, Maryland.

APPENDIX A

Framework for Strengthening Reproductive Health Systems in National Programs

The framework for strengthening a country's reproductive health education and training may be seen as a network of pathways aimed at linking the national system of higher education, the healthcare system, the political system and cultural norms to strengthen reproductive health policy, training and services (see figure below). Within this framework, the educational and health systems work together to prepare a cadre of providers who can deliver standardized, high quality reproductive health services. Service delivery, preservice education and inservice clinical training follow a single set of service guidelines that reflect up-to-date national policy. Implementation of this framework in various countries has demonstrated its appropriateness and effectiveness in improving the performance of healthcare providers and the systems within which they work.



APPENDIX B

Examples of Policy Work by Category

Policy Activity	JHPIEGO Example
Identify policy issues	
Elicit policy issues through needs assessments	<ul style="list-style-type: none"> Malawi: Needs assessment
Identify policy needs through needs assessment results	<ul style="list-style-type: none"> Kenya: Preservice nursing assessment Kenya: Supervision assessment identified policy issues
Hold conferences/meetings to raise awareness and address issues	<ul style="list-style-type: none"> MAQ Conference on guidelines dissemination Strategy for Norplant in Central and West Africa Conference SFPS Regional Forum on preservice education Uganda: Performance improvement meeting on IP
Disseminate international resource documents	<ul style="list-style-type: none"> Malawi: Clinical training updates Ukraine: Used WHO criteria in guidelines development
Strategic advocacy through training courses	<ul style="list-style-type: none"> Bolivia: IP training led to national SDGs for IP Malawi: IP training led to MOH interest in IP and revision of IP guidelines Ukraine: IP training
Translate problems into policy issues	<ul style="list-style-type: none"> India: Mechanism for building confidence of trainees Brazil: Need for job descriptions Peru: Organize ESSALUD and MOH to influence curricular content
Identify policy solutions	
	<ul style="list-style-type: none"> Nepal: Advocate for nurses providing the MVA procedure Ukraine: Advocate for midwives to provide IUD services
Advocate for policy change	
Relationship with policymakers	<ul style="list-style-type: none"> Indonesia: Advisor to Director General of Community Health
Capacity-building	<ul style="list-style-type: none"> Central Asian Republics: JHPIEGO trainers as advocates for change West Africa: Policy consultants
Provide data from assessments	<ul style="list-style-type: none"> Uganda: Preservice assessment documented impact of preservice training
Introduce new policy issue	<ul style="list-style-type: none"> Peru: VIA and cryotherapy introduced West Africa: PAC introduced WHO: Policy on dissemination of guidelines
In meetings with policymakers	<ul style="list-style-type: none"> Uganda: During transfer of preservice to MOE, policy issues
Share information on policy	<ul style="list-style-type: none"> Côte d'Ivoire: Took Minister of Health to see successful Norplant program Jamaica: SDG appendix on legal status of provision of FP to adolescents
Formulate policy	
Develop international resource materials	<ul style="list-style-type: none"> Prototypic SDGs Changes to International Planned Parenthood Federation service guidelines

Policy Activity	JHPIEGO Example
Develop SDGs	<ul style="list-style-type: none"> • Almost 30 countries • REDSO PAC guidelines
Help with policy creation	<ul style="list-style-type: none"> • Guatemala: Helped to draft policy on emergency contraception • Malawi: Part of board that will develop new RH policies
<i>Participate on policy-making bodies</i>	
<ul style="list-style-type: none"> • International 	<ul style="list-style-type: none"> • WHO: Clinical guidelines for FP • Technical Guidance Working Group
<ul style="list-style-type: none"> • Regional 	<ul style="list-style-type: none"> • Attended CRHCS meeting
<ul style="list-style-type: none"> • National councils, associations, networks, task forces 	<ul style="list-style-type: none"> • Indonesia: SOAG, FP PMU • Kenya: National RH Advisory Committee • Malawi: Safe Motherhood Task Force, Human Resource Advisory Committee, RH Unit Programme Management Group • Nepal: Non Governmental Organization Coordinating Committee (chair subcommittee), Nepal Nursing Council, Nepal Nursing Association, boards of Nepal Fertility Care Center, Chetrapati Family Welfare Center and Quality of Care Management Center, Safe Motherhood Network • Uganda: Safe Motherhood Task Force
<i>Set standards</i>	
<ul style="list-style-type: none"> • Accreditation 	<ul style="list-style-type: none"> • Bolivia: Brought MOH and MOE together to develop criteria for accreditation of private schools • Brazil: PROQUALI logo for SDPs • Ghana: Standard curriculum instituted as requirement for accreditation of nursing/midwifery schools • SFPS: Gold Circle for SDPs (4 countries)
<ul style="list-style-type: none"> • Licensure/certification 	<ul style="list-style-type: none"> • Indonesia: Preservice Midwifery Core Competencies • Kenya: Minilaparotomy and PAC for interns to graduate • Nepal: Starting discussions on nursing licensure and school certification • Peru: To work on plan for inservice licensure/certification • Turkey: Process for licensing midwives to provide IUD services • Zimbabwe: Structure OJT allowed for certification
<ul style="list-style-type: none"> • Graduation/training requirements 	<ul style="list-style-type: none"> • Bolivia: OSCE for graduation • Kenya: Competency used as standard for IUD training (not type of course)
<ul style="list-style-type: none"> • Evaluation 	<ul style="list-style-type: none"> • Indonesia: Preservice Midwifery Core Competencies as standard for evaluation • Peru: OSCE used for evaluation in some medical schools
<i>Change operational policy</i>	
<ul style="list-style-type: none"> • National training strategies 	<ul style="list-style-type: none"> • Bolivia: JHPIEGO consultants helped to develop <i>Policy and Strategies for Human Resource Development in Health</i> • Indonesia: NCTN used for all MOH courses • Nepal: NHTC changed to COFP course
<ul style="list-style-type: none"> • Organization of training 	<ul style="list-style-type: none"> • Kenya: Introduced preceptors • Nepal: Developed NHTC management documents for training courses

Policy Activity	JHPIEGO Example
<ul style="list-style-type: none"> Curriculum/training content 	<ul style="list-style-type: none"> Kenya: IUD requirements removed for nursing students Nepal: Designed FP component for new orientation program for government physicians Ukraine: 5-day course in FP for ob/gyn residents Ukraine: 3-day course in FP in family practitioners' retraining Ukraine: Increased FP in midwifery curriculum
<ul style="list-style-type: none"> Curriculum implementation 	<ul style="list-style-type: none"> Morocco: CBT for 9-week ob/gyn rotation
<ul style="list-style-type: none"> Deployment 	<ul style="list-style-type: none"> Kenya: Deployment of FP preceptors Mali: Changed faculty roles at one school
<ul style="list-style-type: none"> Service delivery 	<ul style="list-style-type: none"> Bolivia: Who can provide which services Nepal: IP policies introduced at selected hospitals
<ul style="list-style-type: none"> Supervision 	<ul style="list-style-type: none"> Uganda: New support supervision tools introduced
Implement policy	
Disseminate guidelines	<ul style="list-style-type: none"> Guinea: Tools for dissemination of SDGs Kenya: SDGs dissemination plan and dissemination of malaria and pregnancy guidelines Ukraine: Dissemination workshops
Change operational policy	<ul style="list-style-type: none"> Indonesia: Peer-review used to strengthen implementation of standards Malawi: Work with district teams to change ordering practice for disinfection solution
Foster preservice/in-service coordination	<ul style="list-style-type: none"> Kenya: Systems unified, using one policy
Develop standards to support policy	<ul style="list-style-type: none"> Bolivia: Curricular changes to meet needs of new national health insurance Malawi: Developing RH guidelines to support integration of RH services Tanzania: Essential maternal healthcare standards developed as part of decentralization process
Implement change as model	<ul style="list-style-type: none"> Bolivia: JHPIEGO implemented FP services, gave message that these services were acceptable Guatemala: JHPIEGO implementing FP services at one site Nepal: PAC training for nurses Ukraine: IUD training for midwives
Evaluate policy	
Evaluate implementation	<ul style="list-style-type: none"> Kenya: Evaluation of standard orientation package for SDG dissemination Nepal: To evaluate provision of PAC services by nurses Zimbabwe: Evaluation of SDG dissemination
Other	
Develop policy-making bodies	<ul style="list-style-type: none"> Ukraine: JHPIEGO helping to establish Association of Midwives
Work cited in official policy	<ul style="list-style-type: none"> Ghana: Standard curriculum as requirement for accreditation of nursing/midwifery schools Indonesia: MNH recommendations used as MOH policy Peru: RH guidelines adopted by MOH and universities Ukraine: Draft RH plan cites guidelines as standard for service delivery

APPENDIX C

Policy-Related Questions from Malawi Needs Assessment

General FP/RH

- ◆ Are there contraceptive methods available within the country?
- ◆ Is there a long-term contraceptive method strategy?
- ◆ Who developed the SDGs? To which cadres were these targeted? How were they disseminated?
- ◆ Are there standards for staffing at FP/RH clinics?
- ◆ Are there guidelines or restrictions on who can provide what method/service?
- ◆ Is there a FP policy?
- ◆ Is FP viewed as an independent growth reduction measure or as a necessary part of a comprehensive health program?
- ◆ Are there any eligibility requirements for particular methods?
- ◆ What mechanisms are used for delivery of FP services (e.g., community-based distribution programs, mobile clinics, private sector), and what role does each play?
- ◆ Who regulates/monitors the national FP/RH policy and takes leadership for coordination of all FP/RH issues (whether government, NGO, private)?
- ◆ What is the role of the central government, regional government and district governments with regard to FP policy, service delivery and training?
- ◆ How many service delivery sites are there?
- ◆ Is there an official uniform record-keeping system at the clinic level?
- ◆ Is there a central office responsible for tabulating all FP/RH data?
- ◆ How does the government determine how many and where FP/RH service providers are needed (deployment)?
- ◆ How are contraceptives distributed?

Adolescents

- ◆ If an adolescent receives a contraceptive method, is s/he required to get any sort of consent first?
- ◆ Are there any adolescent clinics?
- ◆ Is there an age requirement for receiving a contraceptive method?

STIs

- ◆ Is STI management considered a responsibility of a provider working in a FP clinic?
- ◆ Are nurses allowed to prescribe drugs for STI treatment?
- ◆ Is syndromic diagnosis/treatment the national standard?
- ◆ Do any facilities have microscopes?
- ◆ Is there a national testing laboratory?
- ◆ What is the prevalence of STIs? What are the most common?
- ◆ Are there national STI syndromic management protocols? (If so, get a copy.)

PAC

- ◆ What is the law on abortion?
- ◆ Is MVA currently provided as a method to treat incomplete abortion?
- ◆ Are nurses or midwives, medical assistants or clinical officers allowed to perform MVA?

Preservice Education

- ◆ Under what ministry do the nursing/midwifery schools, College of Health Sciences (medical assistant and clinical officer) and medical schools fall?
- ◆ How are service providers prepared to train students?
- ◆ Is there an official designation of “clinical preceptor” or something similar for those service providers who work with students?
- ◆ Is there a requirement for tutors to continue to do some clinical practice?
- ◆ Who approves the various curricula? How often are they revised?
- ◆ How are graduates deployed?
- ◆ How are faculty supervised (by whom, how often)?
- ◆ How are preservice schools in general supervised (by whom, how often)?
- ◆ To whom are supervision reports on faculty and schools submitted, and how are they used?
- ◆ By whom (or which ministry) are tutors employed?
- ◆ How does someone become a tutor?
- ◆ Is there a continuing education requirement for tutors?

Inservice Training

- ◆ How are inservice trainers selected?
- ◆ How are inservice trainers trained?
- ◆ How is the need for inservice courses determined?
- ◆ Is postgraduate (refresher) training a requirement for doctors, nurses or midwives?

- ◆ How often is postgraduate training required?
- ◆ How many hours of postgraduate training are required?
- ◆ Are specific institutes designated as postgraduate training institutes?
- ◆ If yes, how many institutes offer postgraduate training in the country?
- ◆ Is there a single, standard curriculum that is used by each institute for all inservice training?
- ◆ If yes, who determines the content of the curriculum? How often is the curriculum revised? Through what process does the curriculum get revised?
- ◆ Are trainees allowed to select the training topic and training institute that they attend?
- ◆ Who covers the cost of training, including tuition, supplies, transportation and lodging?

Supervision

- ◆ What are the FP/RH supervision and management systems? Who is responsible?
- ◆ How are supervisors selected/trained? Is supervision their full-time job?
- ◆ To whom do supervisors report?
- ◆ How are supervision reports use?