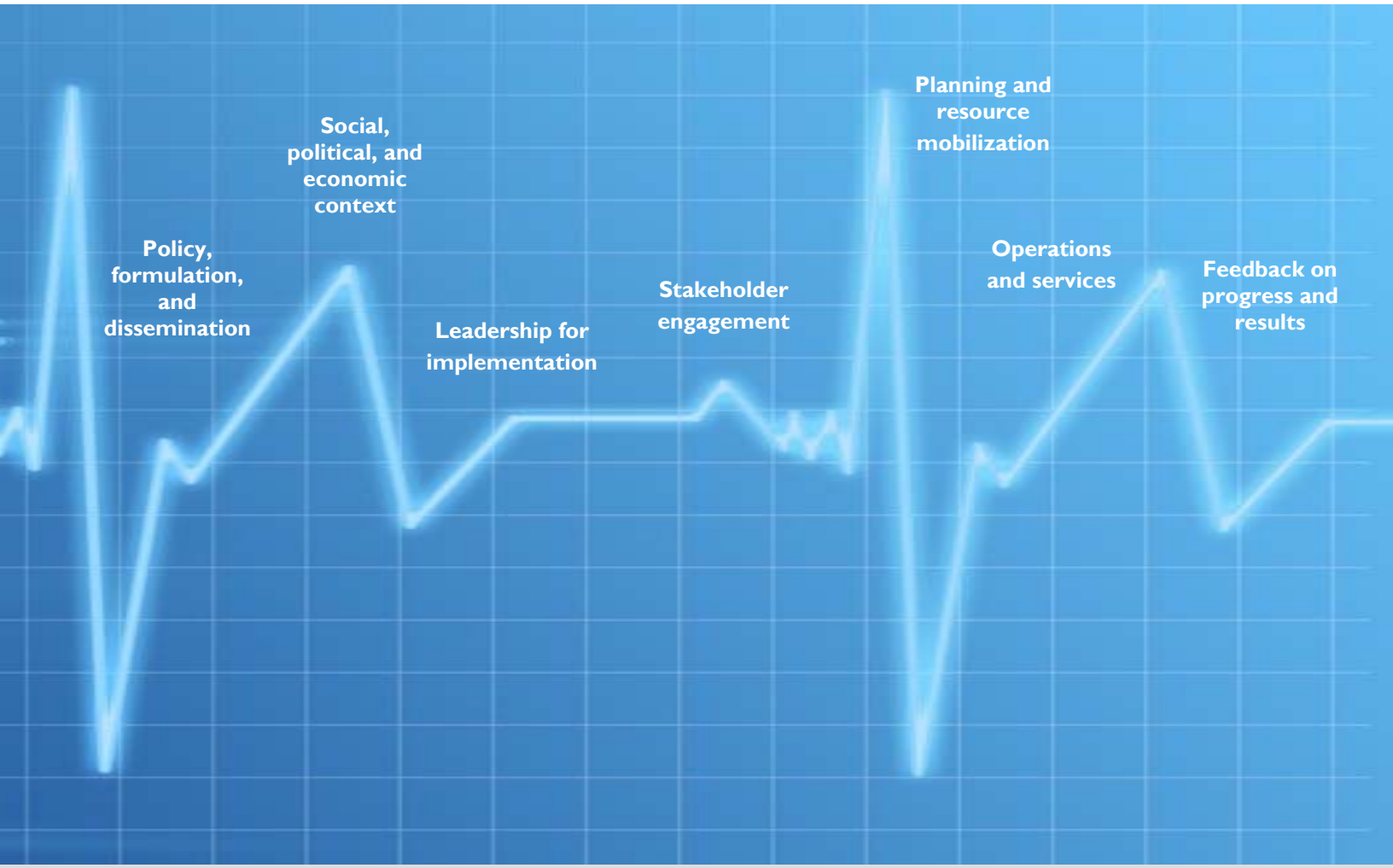
USAID FROM THE AMERICAN PEOPLE | HEALTH POLICY INITIATIVE

TAKING THE PULSE OF POLICY:
THE POLICY IMPLEMENTATION ASSESSMENT TOOL



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ABBREVIATIONS

AGMM	Guatemalan Association of Women Physicians
AIDS	acquired immune deficiency syndrome
APROFAM	Asociación Pro-Bienestar de la Familia
ASHA	accredited social health activist
CEDPA	Centre for Development and Population Activities
CONASIDA	National AIDS Commission
DoHFW	Directorate of Health and Family Welfare
FGD	focus group discussion
FP	family planning
HIV	human immunodeficiency virus
ITAP	Innovations in Family Planning Services II Technical Assistance Project
MS	Microsoft
MSPAS	Ministry of Public Health (Guatemala)
NGO	nongovernmental organization
NRHM	National Rural Health Mission
PASCA	Program for Strengthening the Central American Response to HIV/AIDS
RH	reproductive health
SDPP	Social Development and Population Policy
SEGEPLAN	General Secretary for Planning
STI	sexually transmitted infection
USAID	U.S. Agency for International Development

I. INTRODUCTION

"Policy implementation" refers to the mechanisms, resources, and relationships that link health policies to program action. Understanding the nature of policy implementation is important because international experience shows that policies, once adopted, are not always implemented as envisioned and do not necessarily achieve intended results.[1] Moreover, some services are provided with little attention as to how such activities fit into or contribute to broader policy goals. Policymakers and program implementers also often have limited understanding of how broader policies might help overcome service delivery obstacles. Too often, policy and program assessments emphasize outputs (e.g., number of people trained) or outcomes (e.g., increased knowledge among trainees) but neglect the policy implementation *process*—which could shed light on barriers or facilitators of more effective implementation. Assessing the policy implementation process "opens up the 'black box' to provide greater understanding of why programs work or do not work and the factors that contribute to program success."[2]

Assessing policy implementation is essential because it:

Promotes Accountability	By holding policymakers and implementers accountable for achieving stated goals and by reinvigorating commitment
Enhances Effectiveness	Because understanding and addressing barriers to policy implementation can improve program delivery
Fosters Equity and Quality	Because effective policy implementation can establish minimum standards for quality and promote access, reducing inconsistencies among service providers and regions

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

Key Terms

The **"tool"** refers to the two interview guides used to gather information from policymakers and implementers/other stakeholders.

The **"approach"** refers to the eight-step process for applying the tool, which is led by an in-country core team.

This document provides guidance to help readers adapt the tool to different policies and contexts in their own countries. While the tool emerged out of the desire to assess national family planning (FP) and RH policy implementation, as country teams have shown, the assessment questions are flexible enough to allow for quick adaptation to other policy areas (e.g., HIV) and different levels (e.g., national, state, district). This paper briefly reviews the theoretical underpinnings of the tool, outlines steps for applying the tool, and describes key processes and findings from the tool's four applications to date. Additional materials, listed in Appendix A, are available on CD-ROM and online (see Box 1).

Box 1. Tools You Can Use

The interview guides for policymakers and implementers/other stakeholders are included in the enclosed CD-ROM. The CD also includes Microsoft Excel templates to facilitate data collection and analysis, as well as example FGD guides and dissemination and advocacy materials from the country applications. The tools and related materials are also available online at www.healthpolicyinitiative.com/policyimplementation

Understanding Policy Implementation

Over the last 30 years, researchers have proposed several theories and frameworks to illuminate policy implementation and the factors that contribute to success or failure, including the different levels, processes, and stakeholders involved in implementing a policy.[3] Presenting the complete review of the literature, however, is beyond the scope of this paper. Put simply, "implementation" is the process of carrying out and accomplishing a policy.[4] This sounds fairly straightforward, yet policy implementation can be quite complex. More specifically, policy implementation is the set of activities and operations undertaken by various stakeholders toward the achievement of goals and objectives defined in an authorized policy.[5]

Various factors influence policy implementation, including the content of the policy, the nature of the policy process, the actors involved in the process, and the context in which the policy is designed and must be implemented.[6] Implementation is an ongoing process of decisionmaking by key actors who work in complex policy and institutional contexts and face pressures from interested as well as opposing parties.[7] As such, the motivation, flow of information, and balance of power and resources among stakeholders influences policy implementation processes.[8]

Moreover, different stakeholders may have differing perspectives on what constitutes successful policy implementation.[9] A top-down approach emphasizes the faithfulness with which implementation adheres to the policymakers' intentions.[10] Conversely, a bottom-up approach argues for local implementers to adapt policy strategies to meet local needs and concerns.[11] These two perspectives can result in very different strategies and outcomes. Increasingly, democratic policy systems support moving away from top-down or bottom-up dichotomies to a centrist approach emphasizing how actors from different institutional contexts influence what gets implemented.[12] Definitions of what constitutes implementation can also vary depending on where actors are along the continuum of policy implementation—such as complying with policy directives, reaching intermediate performance indicators or benchmarks, or achieving long-term policy goals and objectives.[13]

Thus, while policies seek to codify a set of goals and actions, the manner in which a policy is implemented is not linear and may change over time for a variety of reasons—only some of which are controlled by policymakers. Policies are often redefined and interpreted throughout the implementation process as they confront the realities of implementation on the ground.[14] Key elements along the policy-to-action continuum,[15] such as leadership, stakeholder engagement, the context, resources, and

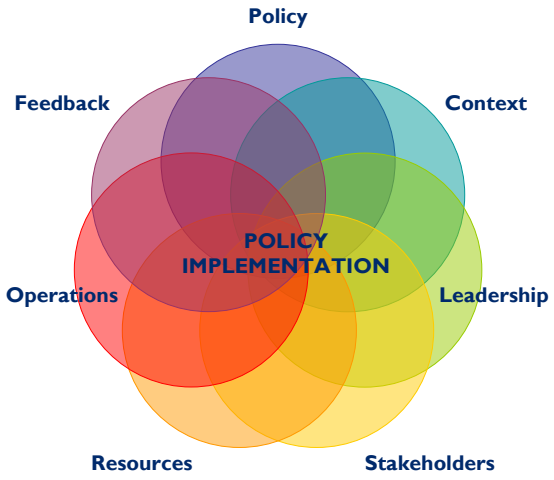
operational issues, shape decisions and actions at various levels. It takes time for some outcomes to materialize; hence, it is a good idea to assess progress along the way to ascertain what is or is not being achieved and why. Consequently, a practical way to think about policy implementation is to consider the extent and form in which activities have been carried out and the nature of issues arising during implementation.[16]

About the Policy Implementation Assessment Tool and Approach

The goal of the tool and approach presented in this paper is not to prescribe a "right" or "wrong" way to implement a policy or to define success. Rather, it is to enable in-country stakeholders to gather information about a dynamic and multifaceted process in a systematic, user-friendly manner. With this evidence, they can better understand what is and is not working in terms of policy implementation, discuss and further define root causes, and begin to devise potential solutions to identified obstacles.

About the tool. Building on the review of the literature and project experiences, the assessment tool is organized around seven dimensions that influence policy implementation (see Figure 1). The seven dimensions are discussed in Section 2.

Figure 1. Dimensions of Policy Implementation

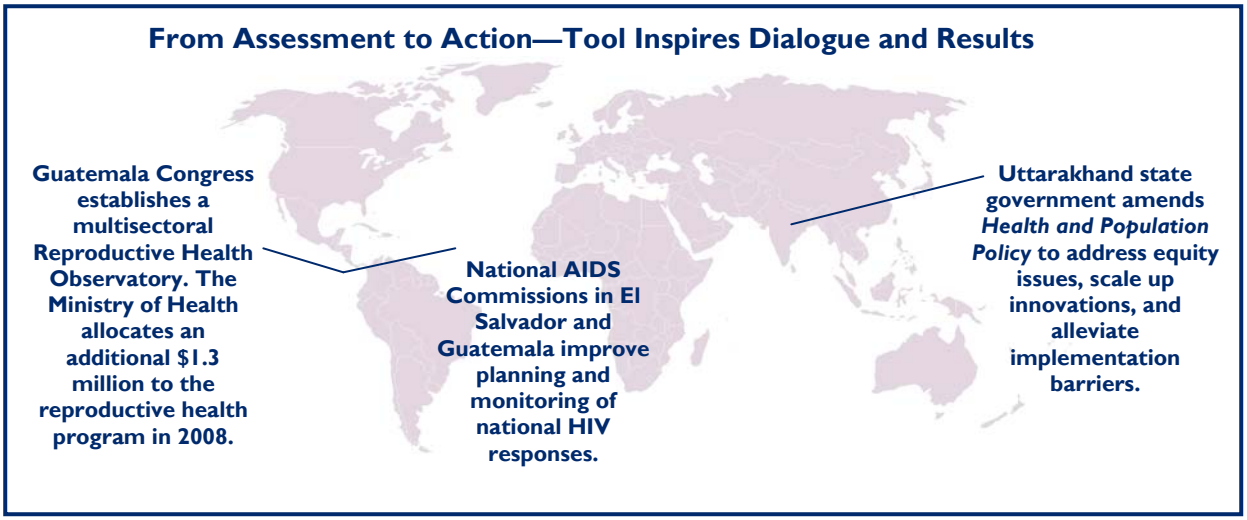


The Policy Implementation Assessment Tool comprises two interview guides: one for policymakers and one for implementers and other stakeholders. "Policymakers" refers to individuals, usually in high-level government positions, who are responsible for setting policy priorities, formulating policies and program directives, and coordinating overall policy implementation. "Implementers and other stakeholders" refers to the groups engaged in carrying out activities outlined in policies and strategies. They also include groups, such as civil society organizations, that are involved in advocating for policy issues and monitoring program accountability. The tool's interview guides use the same or similar question items to enable comparisons of perspectives between the two groups—though the implementers' version delves deeper into the dimensions, particularly regarding on-the-ground service delivery issues. Where appropriate, the questions in the interview guides can also be used to inform the development of FGD guides to gather feedback at the community level.

Uses of the tool. The interview guides gather quantitative rankings of specific aspects of implementation using Likert-like scales, as well as qualitative information based on the interviewees' experiences. The rankings help compile standardized information that can be tracked over time and can be used to compare the perspectives of policymakers and implementers and other stakeholders on the same topic. The qualitative information sheds light on perceptions and experiences with various aspects of implementation to reveal the nature and form in which a specific policy is being implemented. Collating the interviewees' practical insights and informed suggestions helps identify challenges and opportunities

for more effective implementation. As the focus of the assessment is on implementation of the selected policy in a particular context, the tool is not intended for providing data for cross-country comparisons or for a rigorous assessment of program impact. Microsoft Excel data collection spreadsheets are available on the CD-ROM or can be downloaded online to facilitate organizing and analyzing the findings.

Step-by-step approach for tool application. The tool is designed to be applied through an eight-step process, described further in Section 3. It is envisioned that a small, in-country core team will manage the assessment, including identifying interviewees and/or FGD participants and carrying out or guiding the data analysis. The core team is encouraged to review and adapt the interview guides to highlight the specific issues and topics relevant for the country context and selected policy. Moreover, the core team should engage other stakeholders in discussions about the assessment findings and possible next steps. The entire process, from selecting the policy to assessing implementation to disseminating findings, will take approximately 4–6 months. As illustrated in Section 4, the four country applications of the tool to date have shown that the tool is a user-friendly, effective mechanism for understanding dynamic policy environments and inspiring policy dialogue, renewed commitment, and tangible change.



Even the best policies can encounter implementation challenges. Thus, policies should be viewed as "living documents." They need leadership, resources, monitoring, and other inputs to thrive and achieve their goals. The tool, approach, and lessons learned introduced in this paper will assist government, civil society advocates, and others to "take the pulse" of policies in their countries and assess the extent and nature of implementation. With this information, they will be better able to understand policy dynamics and identify recommendations for translating health policies into action.

II. SEVEN DIMENSIONS OF POLICY IMPLEMENTATION

Several theories and perspectives exist on the key components of policy implementation and the ways in which to judge successful implementation. The Health Policy Initiative has organized themes, influential factors, and components into a practical framework to help policymakers, program managers, and other stakeholders translate policies into action. The framework outlines seven dimensions that influence policy implementation (see Table 1):

1. The policy, its formulation, and dissemination
2. Social, political, and economic context
3. Leadership for policy implementation
4. Stakeholder involvement in policy implementation
5. Implementation planning and resource mobilization
6. Operations and services
7. Feedback on progress and results

By laying out the assessment process in terms of seven discrete dimensions of implementation, the Policy Implementation Assessment Tool captures information about a dynamic, multifaceted process in a systematic way.

The Policy, Its Formulation, and Dissemination

The starting point for a policy implementation assessment is, naturally, the policy itself. The policy's content, formulation process, and extent of its dissemination influence whether the necessary groundwork is in place to support effective implementation. Policy content should clearly frame the underlying problem area, the policy's goals and objectives, and the population to be benefited, along with the broad actions and strategies to address the problem.[17] Other crucial elements include time horizons, rationale, and language used. Unclear or confusing policy objectives or actions may be one reason why some policies are not implemented.[18]

The formulation process also matters. A policy designed without meaningful stakeholder engagement may be more difficult to implement because it does not consider the needs of nor engender buy-in and ownership from those who will implement or "benefit" from the policy.[19] Moreover, policies that result in new programs, services, or operational guidelines need to be disseminated to and understood by those people responsible for implementing and using them.[20] If the public is going to access services or benefits brought about by a new policy, it must also be made aware of any new provisions and programs.

Thus, for a policy to support effective implementation, it should address the underlying problem through appropriate policy action; be based on strong stakeholder involvement; and be followed by dissemination to key audiences. **Section A** of the interview guides addresses how the following issues affect implementation:

- Relevance and adequacy of the policy content.
- Experiences in formulating the policy.
- Dissemination among implementers and program managers, service providers and outreach workers, and the general public.

Table 1. Seven Dimensions of Policy Implementation	
The Policy, Its Formulation, and Dissemination	Refers to the policy content, the nature of the formulation process, and the degree of dissemination. Are the policy's goals, objectives, and strategies clear and appropriate given the issues to be addressed by the policy? Do key stakeholders agree on the goals and strategies? Has the policy been disseminated to and understood by those responsible for implementation?
Social, Political, and Economic Context	Refers to the various social, political, and economic factors outside of the policy process that can either enhance or hinder effective implementation. Depending on the nature and scope of the policy, social norms such as gender inequality and governing processes such as decentralization and other factors can affect policy implementation. What are the effects and consequences of these factors?
Leadership for Policy Implementation	Recognizes that strong leadership and commitment are essential to ensure the follow through, resources, and accountability needed for putting policies into practice—however, the leaders responsible for policy formulation might find their attention diverted elsewhere once the policy is adopted or the responsibility for leading implementation might shift to new individuals and groups. How effective is the leadership for implementation?
Stakeholder Involvement in Policy Implementation	Recognizes that policy formulation is increasingly a multisectoral endeavor, yet this engagement might not continue during the policy implementation stage—thus, it is crucial to consider the extent of stakeholder involvement in policy implementation and the nature of the relationships and collaboration among different stakeholders.
Planning for Implementation and Resource Mobilization	Considers the planning, resources, and capacity needed to facilitate policy implementation. Does an implementation plan exist? Do organizations need new skills and training in order to implement the new policy? How will funding for new initiatives be ensured? How reliable is the resource flow?
Operations and Services	Refers to the coordination mechanisms, operational systems, and capacity of individuals and organizations charged with delivering services outlined in the policy. What are the positive changes as a result of putting the policy into practice on the ground? What are the challenges?
Feedback on Progress and Results	Recognizes the importance of regularly gathering, disseminating, and using feedback to assess progress toward achieving results. Who is and is not receiving information about implementation? How is the information used? Are the perspectives of beneficiaries or clients considered?

Social, Political, and Economic Context

Policy formulation and implementation cannot be removed from the context in which they take place. The social, political, and economic contexts influence what policies are developed and whether and how those policies are put into practice.[21] Contextual and environmental factors can provide both opportunities and constraints for effective policy implementation.[22] These forces exist at multiple levels (e.g., international, national, local) and change over time. For example, policies are often formulated within a multi-year timeframe. Thus, achieving policy goals means that implementation must proceed through inevitable changes in political regimes, governmental structures, economic conditions, and social environments. As the political economy changes, the health context also changes, in turn affecting which actors are

involved, which policy decisions are made, and what processes take place at various levels, including the operational and service delivery levels.[23]

With regard to the context, **Section B** of the interview guide assesses the following:

- How political factors at local and national levels—such as alignment of the policy with other relevant national and local policies, changes in government, and divergent priorities at national and local levels—affect policy implementation.
- How social factors at local and national levels, such as gender norms and cultural beliefs, affect policy implementation.
- How economic factors at local and national levels, such as poverty and global assistance mechanisms, affect policy implementation.

Leadership for Policy Implementation

Leadership is essential for effective policy implementation.[24] High-level actors and influential leaders can communicate about the policy's goals, rationale, and mechanisms, and champion the policy to ensure implementation, which requires coordination and cooperation.[25] The level of consensus among leaders and other policy stakeholders on the content of a policy and its need for implementation will affect the degree and timing of its roll-out.[26] However, the individuals or groups that led policy formulation might not follow up on its implementation, or different groups might be responsible for carrying out policy directives.[27] For example, formulating national policies is in the domain of national government officials, but implementation will likely be the responsibility of local administrators and organizations, particularly in the context of decentralization.[28]

To better understand how leadership affects implementation, **Section C** of the interview guide asks about the following factors:

- The impact of opinion leaders and institutions that support or oppose policy implementation.
- The clarity and perceived effectiveness of leadership for implementing the policy.
- The degree to which leaders engage others in decisionmaking.

Stakeholder Involvement in Policy Implementation

Policy "stakeholders" include groups or individuals responsible for implementation, people who may be positively or negatively affected by the policy's implementation (or lack of implementation), and officials and professionals accountable for achieving policy goals.[29] Participation of stakeholders in policy implementation is influenced by a range of factors, including the context; the policy content; and stakeholders' needs and resources, level of knowledge of the policy, and their relative power and influence.[30] Involvement of stakeholders in implementation can be challenging because it often requires "joint actions" in response to new partnerships that did not exist previously.[31] In some cases, stakeholder groups and organizations that may be unrelated, or are not always committed to the same outcomes, must reach agreement to support implementation. Stakeholders may also enter the fray in ways not planned by the policy. As policy implementation unfolds, additional stakeholders may find themselves being affected by the changes and may seek to also insert themselves in the process.

The successful engagement of different groups within the public, civil society, and private sectors is crucial to implementation, because each sector contributes unique perspectives, skills, and resources.[32]

For example, civil society groups are well-suited to help adapt policy strategies to reach underserved populations, such as the poor, marginalized groups, and rural populations. They can also play a role in monitoring implementation and advocating for specific strategies to improve implementation—serving as watchdogs to ensure that sufficient funding is allocated and appropriate activities are carried out. The private sector's involvement can catalyze improved quality of care and efficient logistics systems, as well as complement public sector services.

By engaging a broad array of stakeholders, particularly those most affected by the policy, implementation strategies can better respond to local needs. **Section D** focuses on the following:

- How different sectors—both inside and outside the public sector—are engaged in implementation and to what effect.
- How groups are involved in advocating for and monitoring implementation.
- The level of involvement of groups most affected by the policy in implementation.

Planning for Implementation and Resource Mobilization

Effective implementation requires planning and mobilization of sufficient resources. The "difficult decisions that were avoided when policies were drafted" must be resolved as plans and guidelines are developed.[33] Strong strategic action plans, workplans, budgets, and operational directives are often the missing link between policy formulation and actual implementation. International experiences illustrate that guidance for implementation "can range from precise blueprints to rather vague exhortations."[34] Implementation is a challenging process, even when written guidelines on goals, strategies, roles and responsibilities, and monitoring frameworks are provided; it is even more challenging in the absence of written guidance and clear action plans.

Once strategies are determined, implementing organizations need to estimate and mobilize the financial, human, and material resources required to effectively implement the policy. Because new policies often involve new strategies, organizations may be required to modify or even abandon old practices and undertake new activities. In many cases, this requires implementers to be trained in the content of the policy and required skills. For example, if a policy calls for expanding the pool of healthcare providers who can perform family planning services, such as insertion of intrauterine devices, then nurses or other personnel will need appropriate training if the policy is to achieve its goal. The degree of change that organizations must face and their readiness for change can vary greatly. Adapting to such change may be challenging for some implementing organizations, and implementation planning may or may not take this into account.[35] Longstanding norms and sociocultural factors may affect the capacity of governments and organizations to act; thus, it is crucial to address these factors when planning for policy implementation.[36]

Section E investigates different facets of planning and resource mobilization for implementation:

- New roles and responsibilities arising from the policy.
- The degree to which organizations must change, and their preparedness for change.
- The adequacy of capacity building received for implementing the policy.
- The usefulness of guidance provided for implementation (or, in the absence of an implementation plan, what is guiding the implementation process).
- The process of identifying funding sources and estimating the level of funding needed to implement organization-specific activities.
- The quality and quantity of resources (e.g., human, infrastructure, equipment, information) available for implementation.

Operations and Services

Ultimately, delivering new, improved, or differently conceived services on the ground is at the core of health policy implementation. The process of implementing a new policy, particularly those policies that require significant training, learning, and changes within or between organizations, can be time-consuming and expensive. Delays and costs can affect operations and services.[37] Policy implementation at the operational and service levels also involves coordination with other organizations—including those that may have no previous experience working together, which may have both positive and negative effects on service delivery.[38]

In addition, a "one-size fits all" approach to implementation will not likely meet the varied needs of different target populations and clients of services in the country. Thus, the degree of flexibility to adapt policy strategies affects the ability of service providers and other stakeholders to respond to local needs or specific subgroups of the population covered by the policy.[39] Implementation, therefore, involves "adapting the ideal plan to local conditions, organizational dynamics, and programmatic uncertainties. This process is often bumpy and, in the end, actual programs and services often look different from original plans."[40]

Unforeseen operational barriers arising from implementing a policy may also pose challenges that have to be overcome before the policy can lead to the intended improvements in access and quality of service delivery.[41]

To assess the nature of policy implementation at the operational and service levels, **Section F** focuses on the following:

- Appropriateness of current strategies and interventions to reach the policy objectives, given available resources.
- Positive changes in service delivery arising from the policy.
- Challenges in providing services, and how these challenges are addressed.
- Coordination with other organizations in implementing the policy.
- Degree of flexibility in adapting strategies to respond to diverse local needs.

Feedback on Progress and Results

Policies typically include monitoring and reporting requirements, which vary in terms of clarity and quality. Some policies also designate an entity to be responsible for monitoring, often a government agency or an official body comprising government and/or nongovernmental representatives. Other groups—from civil society, the private sector, media, or public sector—may also be involved, either officially or due to their own initiative, in monitoring the policy implementation process. In any case, an agreed-on set of indicators and feedback system to track progress toward achievement of results facilitates a comprehensive and measurable process. It is also important to consider the perspectives of beneficiaries or clients of services covered by the policy. By receiving feedback and using information on how policy implementation is rolling out, policymakers and implementers will be better able to assess interim achievements, make necessary course corrections, and see themselves as part of a larger effort.[42]

In **Section G**, the interview guides ask stakeholders to discuss the following:

- The policy's requirements regarding monitoring and reporting on progress, and any positive or negative consequences.
- The entities officially charged with monitoring policy implementation, other groups involved in monitoring, and their methods and systems for monitoring implementation.
- The information that the stakeholders receive as part of implementation monitoring, how they use the information, and any additional information they would like to receive.

Overall Assessment

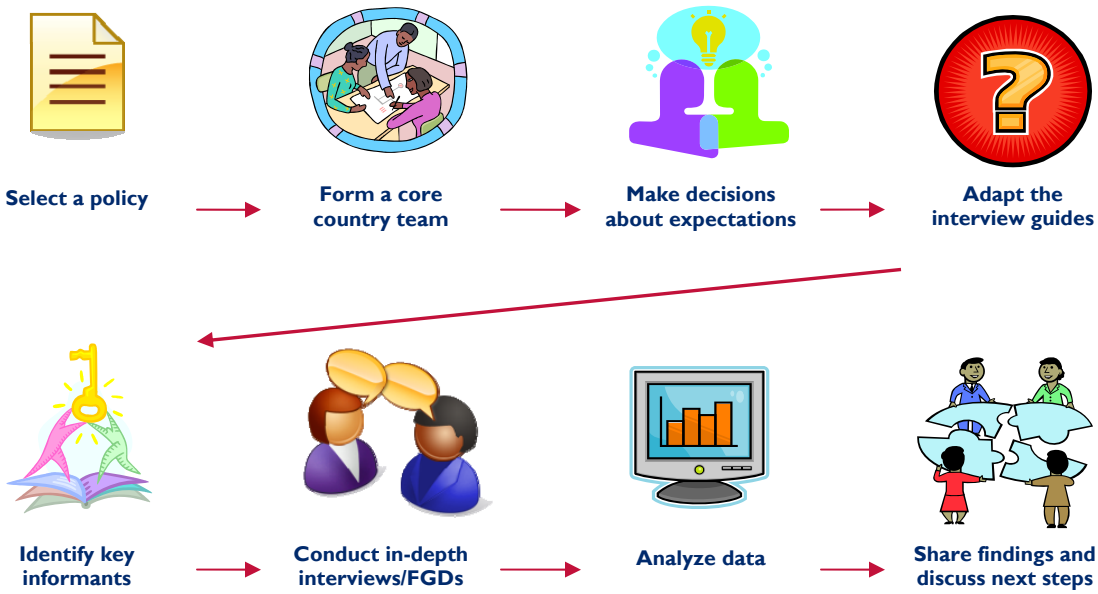
Section H of the interview guides ends by asking policymakers and implementers/other stakeholders to provide an overall assessment of the policy's implementation and whether positive changes are emerging as a result of the policy. It also asks respondents to consider what additional policy action may be needed to overcome barriers to effective implementation.

III. USING THE POLICY IMPLEMENTATION ASSESSMENT TOOL

The Health Policy Initiative designed the Policy Implementation Assessment Tool to help in-country stakeholders explore how well a specific policy is being implemented. The focus is not on the *impact* of the policy, but, rather, the *process, extent, and nature* of its implementation—because it is unlikely that policy goals will be achieved in the absence of effective implementation. The approach outlined below (and summarized on pp. 18–19) uses in-depth interviews and focus group discussions with an array of stakeholders to provide insight into factors that hinder and facilitate effective policy implementation. The findings can then be used to promote dialogue on how to resolve roadblocks to effective implementation or how to revise existing policies.

Conducting this assessment is straightforward, but it does require a level of commitment by a small group of organizers. The approach involves a series of steps that occur over 4–6 months, engages different groups of people, and requires consensus among organizers at several stages. Thus, while hopefully not onerous, the approach is by definition dynamic and iterative. Those leading the assessment should be committed to following up on the results and understand the time and resources needed before launching the assessment. The steps (see Figure 2) and considerations offered below will assist in planning and estimating resource needs for carrying out the assessment.

Figure 2. Policy Implementation Assessment: Step-by-Step Approach



Select the Policy

The first step is to select the policy to assess. One might select a policy for many reasons. For instance, health indicators may suggest inadequacies at the service delivery level; or a policy may be rolling out slowly, but the reasons for the shortcomings and delays are not well understood. Alternatively, when policy implementation is moving along effectively, policy champions may be interested in documenting and sharing lessons learned about what works. The key is to choose a policy that a core group of stakeholders is interested in so that they will be committed to assessing the policy and using the findings to try to catalyze further action. The flexibility of the tool enables selecting a policy of national scope or a subnational policy that is of interest for a particular state or district. The tool can also be easily adapted to a variety of health topics or issues in other sectors.

Form a Country-based Team

The formation of a core country team helps build credibility and buy-in for the activity, which is especially beneficial given that participants do not know beforehand what the results will be. By working with a multisectoral country team and local interviewers, the assessment takes on the form of an internal study aimed at engendering positive change and addressing local needs, as opposed to an external critique. Positioning the assessment in this way enables candid viewpoints and concerns to surface and helps to ensure that results are fully "owned" by the government and other organizations responsible for implementing the policy.

Forming the core team is a crucial step because it involves bringing together the right combination of people, institutional commitment, research skills, and a willingness to respond to the findings of the assessment. The core team manages the main tasks associated with the activity: adapting the interview guides and/or FGD guides; identifying key informants and FGD participants; reviewing the data analysis; and facilitating the dissemination of results and follow-on efforts. It is likely that an individual or small group within the core team will be charged with keeping the process moving forward, while the full core group will be engaged to provide strategic direction and guidance along the way. Members of the core team should have, or be able to mobilize, individuals with knowledge of the policy issue and the expertise needed to complete the assessment, including facilitating interviews and FGDs, conducting qualitative and some quantitative data analysis, and carrying out advocacy and policy dialogue. The interview guides are user-friendly and straightforward and have been used by a range of in-country teams, including those described in Section 4 and beyond. Capacity to carry out the assessment can be gained by reading this paper and the materials contained on the CD-ROM, through the collaborative core team process and skills of the team members, and by partnering with local research organizations, as needed.

It is not possible to state the "right" size and composition of the core team, as these will be determined by the particulars of the policy, context, and key issues being assessed. However, it is well known that multisectoral engagement is a necessary ingredient of effective health policies. Thus, the team should reflect the multisectoral nature of the policy issue, yet not be too large or unwieldy to be manageable (e.g., about 8–12 members should be sufficient in most cases). For instance, when assessing a national RH policy, the core team would ideally comprise a senior Ministry of Health official (particularly from the RH program or division in charge of monitoring and evaluation), planning and finance officials, representatives of civil society groups (including women's groups), the private sector, the lead interviewer(s), lead data analyst, and, when applicable, representatives of the organization supporting the research. Inclusion of various stakeholders will help ensure that the policy implementation assessment considers and reflects the viewpoints of different sectors. If assessing a sectoral operational policy, the

scope and size of the team might be more limited but should still represent different perspectives. Government representatives on the team need not be the senior-most officials in their ministries or departments, though they should have a level of authority that enables them to influence policies and resources as well as obtain endorsement from top leaders to conduct the assessment, stand by the findings, and carry out recommendations.

Determine the Parameters and Expectations

The core team should understand that this assessment approach is designed as a multi-stage process, including interview guide adaptation, data collection and analysis, presentation of findings, and dialogue on possible solutions. Because this assessment requires concerted effort for data collection and analysis, the team may decide to hire a consultant or consultants to undertake the interviews, analyze the results, and draft the report. Whether an original core team member or a consultant, the individual or lead representative of the institution in charge of data collection and analysis should be brought into the core team. The more complex and far reaching the policy, the more the organizers will need to plan for the time and logistics required to collect and analyze the data. Based on experience to date, the time period for completing the assessment and presenting the findings is about 4–6 months.

Remember that the data collected are intended to identify barriers and facilitators regarding *implementation* of a particular policy. Although some of the responses can be categorized and presented in quantitative form (e.g., using Likert-like scales), the assessment does not provide quantitative data on the *impact* of implementation or the coverage of services. If service delivery statistics or other quantitative impact indicators are available through other sources, cross-referencing the findings from this qualitative assessment with the available service statistics or reliable health surveys can offer insights to underlying factors, concerns, and suggestions for improved implementation. Ultimately, the usefulness of this approach is that it illuminates key barriers and brings together stakeholders to continue addressing the concerns that motivated the policy's development and adoption in the first place.

Adapt the Interview Guides

The assessment tool comprises interview guides for policymakers and implementers/other stakeholders (see Appendix A, items 3 and 4). These "master" interview guides are designed to be flexible and should be adapted to the particular policy and country context. The more the core team tailors the questions to fit the policy and crucial issues that need to be understood, the greater the likelihood that the information will be useful. The core team may also choose to use the individual interview guides to inform the development of FGD guides to gather perspectives from community-level workers, local representatives, and clients. To adapt the interview guides, the below recommendations are offered.

Conduct a policy text analysis. To help adapt the individual interview guides or create FGD guides, the core team should first do a text analysis of the policy to

Box 2. Elements of Effective Policies

Written policy documents should include the following:

- Rationale (including a statement of the problem and justification for the policy)
- Goals and objectives (what the policy will achieve, by when)
- Program measures (broad categories of activities)
- Implementation and institutional arrangements (including organizations and ministries involved)
- Funding and other resources (levels and sources, human resources)
- Indicators of success
- Monitoring and evaluation plan

Source: Hardee, et al., 2004.

examine its structure, comparing the document's content with the elements experts identify as being essential for a well-developed policy (see Box 2). The team could consider: Are objectives clear? Have specific strategies or actions been outlined? Are responsible parties and funding mechanisms identified? Is a monitoring framework included? Answering these types of questions can assist the team in identifying gaps and aspects of the policy implementation process that could benefit from more rigorous assessment through individual data collection and FGDs. Appendix B presents additional text analysis guiding questions to help assess gaps related to special topics, such as poverty and equity, gender, and client perspectives.

Consider the policy and country context. Based on the policy text analysis and the core team's knowledge of the policy environment and implementation issues, the core team should tailor the interview guide content and language as appropriate for the policy and country context. The team may choose to augment certain sections for a particular line of inquiry. For example, a new government administration may emphasize other development priorities that could affect implementation of the policy being assessed. In such a case, the team may decide to add questions about the priorities of the new government. If funding mechanisms are generally perceived as causing delays, the team may choose to include more questions about government and donor funding systems and cycles. If implementation planning is lacking or the policy is particularly complicated, the team might focus carefully on these issues to identify ways to improve implementation guidance. It is also crucial to consider the extent to which other policies support or hinder implementation of the policy to be examined.

Keep the length of the individual interview guide/FGD guide manageable. Based on field experiences in applying the tool, the number and types of questions in the master interview guides have been reduced based on the usefulness of the responses, instances when too much detailed information was requested (and difficult to summarize), and instances when respondents often did not know the answer. Other questions were rephrased to reduce the scope of the response. When adapting questions in the guides, the core team should balance its desire for information with the time constraints, both for conducting the interviews and analyzing the data. Box 3 shares tips for creating FGD guides.

Structure questions in a way that ensures consistency for data entry and analysis. When tailoring the interview guides, the team should understand and try to replicate the style of the questions in the master interview guides so that the datasets are consistent. For instance, some questions ask respondents to assess items based on categories ranked on a scale from 1 to 4, while other questions are open-ended. Also remember that, where relevant, the

Box 3. Creating FGD Guides

This tool does not provide a master FGD guide, due to the highly tailored nature of focus group discussions. However, country core teams are encouraged to use their adapted interview guides to create FGD guides to gather perspectives from other key stakeholders, especially community-level representatives (e.g., health workers and volunteers, elected officials and village leaders, and clients).

When designing the FGDs, be mindful that clients and other community members will not likely know the ins and outs of policy details. They can, however, shed light on the on-the-ground implementation and access barriers confronting programs covered in the policy.

For example, illustrative questions to pose to clients could include:

- Please explain what you know about the policy.
- What new services since [date of the policy's adoption] have you noticed?
- Have you used those services? What was your experience?
- What would improve health services in your community?

The CD-ROM includes FGD guides from the application of the tool in Uttarakhand. These guides provide additional illustrative questions for clients, community health workers, and elected officials.

interview guides seek to ask policymakers and implementers the same or similar questions—to enable comparing perspectives of the two groups. Thus, the core team should ensure that both interview guides are revised accordingly whenever a change to the text is made. It is also a good idea to preserve the question numbering system so it is easy to compare different perspectives on the same question, which could require skipping numbers in one interview guide if new items are added to the other interview guide.

Revise the data collection spreadsheets to correspond with the adapted interview guides. Separate Microsoft Excel files for policymaker and implementer/other stakeholder data are available on the CD-ROM to assist with data entry and analysis (see Appendix A, items 5 and 6). The Excel files should be updated accordingly to match the revised interview guides.

Field test the revised interview guides. Once the interview guides have been adapted, it would be a good idea to conduct a few interviews with a small number of people known to the core team. This can help assess how well the questions are understood by respondents, determine if any questions seem unnecessary, and identify potential gaps.

Follow ethical research protocols. Be sure to understand and follow ethical procedures and guidelines related to human subject research, including seeking approval from an institutional review board as appropriate. Most research on policy implementation and involving policymakers and implementers would not require such review and approval. However, review would be needed if core teams wish to interview certain populations (such as children) or cover sensitive topics (such as behaviors that could put respondents at risk if they become known). All applications of the tool described in this paper followed guidelines for ethical human subject research.

Select the Key Informants

This assessment approach calls for a relatively small number of interviews; however, the core team must determine the number and type of informants that will adequately reflect policymaking and implementation processes in the country. Informants should include representatives from all appropriate levels and sectors. Along with time and budget considerations, the team may also consider questions such as: How many interviews or FGDs should be conducted at the national/central level and regional/local levels? What array of administrative, technical, and service delivery personnel and policy experts will give a balanced view of the process? Which civil society and private sector groups are involved in implementing the policy? Which clients and community-level stakeholders should be involved? The core team can conduct a brief stakeholder mapping exercise (see Appendix C, also available on the CD) to ensure that selection of informants is done systematically and there is proper representation of all stakeholder groups.

In selecting policymakers as key informants, it may turn out that only a handful of individuals played a major role in a policy's development or are responsible for the overall management of the program. Conversely, many more people and organizations are involved in the policy's implementation—thus requiring more interviews among implementers to capture the diversity of their experiences. The four applications of the tool supported by the Health Policy Initiative to date have included interviews with 30–40 respondents. More interviews may offer more information, but the core team must be prepared to collect, analyze, and present increasing volumes of data. In Uttarakhand, the team also adapted and simplified the interview guides to use as FGD guides to gather feedback at the community level. Thus, in addition to in-depth interviews, the assessment involved 32 FGDs with clients, community-level health workers, and local elected officials.

Conduct the Interviews/FGDs

Once the key informants and/or FGD participants have been selected and appointments have been scheduled, the interviewer(s) and FGD facilitator(s) should explain the purpose of the assessment and obtain consent from the key informants and participants before proceeding. Because many questions are open-ended or ask the respondents to explain their answers, the interviewer/facilitator must have experience in qualitative research techniques, be able to put the respondents at ease, and be comfortable probing for additional information. They should also be comfortable interacting with high-level policymakers as well as other respondents at all levels. Ideally, the interviewer/facilitator will have a policy background and/or be familiar with the particular policy being assessed. With the attached master interview guides, interviews should typically take about one hour for policymakers and 1.5 hours for implementers and other stakeholders. Similarly, the FGDs should be kept to a manageable time, allotting about an hour for each discussion.

Organize and Analyze the Data

The team will need to have some expertise with qualitative and quantitative data analysis. This expertise may reside with core team members who will undertake the analysis or through an external consultant or research organization. The analysis should consider the status of policy implementation at various levels to highlight what and where the major obstacles and facilitating factors are, as well as to identify promising local initiatives, lessons learned, and recommendations. As with any study, it is important to let the themes come from the data and not impose a pre-conceived structure. Because the two interview guides ask the same or similar questions, the team can compare the responses of policymakers and implementers on key issues. The quantitative data, based on the questions with numbered response categories, can be presented in graphs, while the qualitative information on implementation experiences can be presented as themes and through use of quotes. The analysis may reveal issues requiring additional investigation to discover root causes, which may be beyond the scope of this assessment.

Once the analysis is complete, the core team should meet to review and confirm the findings, explore the themes and issues that arise from the analysis, and discuss dissemination steps (for examples of analyses and presentations of findings, see Appendix A, items 8–11 and 13–15).

Microsoft Excel files are available on CD-ROM (see Appendix A, items 5 and 6) or can be downloaded online to assist with data collection and analysis. These files should be updated to match the revised interview guides. Appendix D provides tips on using the data collection sheets.

Disseminate and Discuss the Findings

The core team is responsible for organizing forums to present and discuss the assessment results with key stakeholders. Bringing stakeholders together to discuss the findings can re-focus attention on the selected policy and rekindle the interest that initially led to formulation and adoption of the policy.

Deciding which stakeholders to involve in such a forum and how to present the findings will depend on the policy and local context. The team may invite all those in a position to rally further action, or the team may decide to introduce the findings through small roundtables or groups first, followed by a larger forum. When presenting the results, ample time should be left for questions and comments. The benefit of

disseminating findings through various mechanisms is that it provides opportunities to re-engage key stakeholders and re-focus attention on the policy issue and how to best address it—thus fostering discussion and renewed commitment to action.

To start the discussions, the core team can draft some proposed initial recommendations based on findings from the assessment, but the team must also engage stakeholders in developing recommendations and encouraging their buy-in for next steps. Based on the outcomes of the dissemination and advocacy, the core team and other stakeholders can identify and set priorities for further action. Follow-up could include sharing the findings as a part of a broader advocacy strategy; conducting further in-depth analysis of specific barriers, such as financial resources or service delivery among rural populations; or convening a multisectoral group to design concrete recommendations to alleviate policy implementation barriers or formulate new policies.

The Policy Implementation Assessment Tool can also be applied periodically to determine the extent to which proposed recommendations are having the desired effect on policy implementation. Thus, the core team may wish to use lessons learned from conducting the interviews and analyzing the data to update the interview guides so that they can be used in future assessments and monitoring activities.

The following pages provide a summary of steps and tips for applying the Policy Implementation Assessment Tool.

Summary and Tips for Using the Policy Implementation Assessment Tool

Select the Policy

Illustrative criteria for selecting a policy for assessment:

- There is a need to understand why policy implementation is not effective or not achieving intended results.
- Conversely, implementation may be going smoothly or exceeding expectations, and there is interest in identifying and sharing best practices.
- The policy is crucial for the health and well-being of the general public or specific groups.
- The policy has been in effect for a sufficient length of time to elicit useful information on implementation experiences.

Form a Country-Based Team

- The core team is responsible for leading each stage in the assessment process. Team members must be committed to sharing and using the assessment's findings.
- The nature of the policy (e.g., national, operational) will affect the scope and size of the core team.
- The team composition should reflect the multisectoral nature of the policy issue, which will also bolster the legitimacy of the assessment findings.
- Government members on the team should have a sufficient level of authority so that they can influence policy change and resources and get endorsement for the assessment and its findings from the top-most leaders.

Determine Parameters and Expectations

- The assessment tool collects data, which are intended to identify barriers and facilitators to *implementation*. It does not provide data on the *impact* of the policy or the coverage of services.
- The assessment findings can be cross-referenced with other available quantitative data sources (e.g., health indicators, service statistics), which may shed light on why health indicators are or are not being met.
- The assessment is a multi-stage process. If time is limited, the team may wish to consider hiring consultants to provide assistance in data collection and analysis.
- Based on previous experience, the time period for completing the assessment and presenting the findings is about 4–6 months.
- It is important to understand and follow ethical procedures and guidelines related to human subject research, including seeking approval from an institutional review board, as appropriate.

Adapt Interview Guides

- Modifications to the interview guides will be driven by the country context. Conduct a policy text analysis of the policy to help adapt the interview guides to the local context and policy.
- When adapting or adding questions, follow the general format of items used in the master interview guides to ensure consistency for data entry and analysis.
- If appropriate, use the adapted interview guides to inform the development of FGD guides to gather perspectives of other key stakeholders.
- Field test the interview and/or FGD guides with a few informed individuals to ensure the items are understood and elicit appropriate information from respondents. Have in mind that the adapted or additional questions should not add excessively to the time needed for conducting the interviews.

Select Key Informants

- The number of key informants varies; 30–40 interviewees should be a sufficient number to elicit useful data.
- Informants should include policymakers and implementing agencies/other stakeholders familiar with the policy. Be sure that the number of interviewees selected is sufficient to capture the diversity of experiences in policymaking and implementation.
- Based on the selected policy, informants should be drawn from all relevant levels (e.g., national, regional, district) and sectors (e.g., public, private, civil society).
- If conducting FGDs, participants could include community health workers, local officials, and clients, among others.

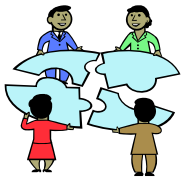
Conduct Interviews/FGDs

- Many of the questions are open-ended. Interviewers and FGD facilitators should be experienced in qualitative research, with an ability to put key informants and FGD participants at ease, keep them centered on the key issues to be addressed, and probe for additional information as needed.
- It is a plus if the research team is familiar with the policy or policy issue.
- Interviews typically take about one hour for policymakers and 1.5 hours for implementers. Similarly, keep the length of the FGDs manageable, allotting about an hour for each discussion.

Organize and Analyze the Data

- Ensure the core team has qualitative and some quantitative data analysis expertise, either through the team members or external consultants.
- Adapt the Excel data collection spreadsheets to match the adapted interview guides. When analyzing data, allow key themes to emerge from the data and avoid establishing a pre-conceived structure.
- Consider policy implementation at various levels and from different perspectives to determine barriers and facilitators. Where possible, identify promising local initiatives and lessons learned.
- Findings may illuminate the need for additional research to identify root causes and to begin to develop solutions.
- Review and discuss the findings and key issues emerging from the analysis within the core team prior to broader dissemination.

Disseminate and Discuss the Findings



- Synthesis and presentation of the study's findings provides an opportunity to re-engage stakeholders interested in the policy's implementation and outcomes.
- Whether in small groups or large discussion forums, the findings should be shared with a range of stakeholders responsible for implementation and monitoring, beneficiaries, and those who can advocate for further action.
- To start the discussions, the core team could draft some initial recommendations based on data from the assessment, but the team must also engage other stakeholders in developing recommendations and encouraging buy-in for next steps.
- Based on the outcomes of the dissemination forum(s), the core team and other stakeholders can identify and set priorities for further action.
- Apply the tool periodically to "take the pulse" of the policy and assess whether improvements in implementation have been made.

IV. COUNTRY EXAMPLES

To date, the Health Policy Initiative has collaborated with in-country core teams to carry out four applications of the Policy Implementation Assessment Tool. These applications have assessed national RH and HIV policies in Guatemala, the state *Health and Population Policy* in Uttarakhand (India), and the national HIV/AIDS strategic plan in El Salvador. This section reviews the key findings and outcomes from these applications. The original pilot-test of the tool took place in Guatemala to assess the RH section of the *Social Development and Population Policy* (SDPP), while the validation and expansion of the tool (to gather feedback at the community level) took place in Uttarakhand. Thus, greater details are provided for these two applications to provide readers with examples of how to form a core team, carry out the assessment, and use the findings in policy dialogue. Importantly, each country application has renewed commitment and catalyzed action for strengthening health policy implementation.

Guatemala: Reproductive Health Section of the Social Development and Population Policy

Policy. Guatemala's SDPP, adopted in 2001, is a broad policy that encompasses five aspects of social development: health, education, social communication, labor and migration, and emergency preparedness. The health component of the policy includes both RH and HIV. The pilot application of the Policy Implementation Assessment Tool focused on the RH component, which is designed to reduce maternal mortality by 15 percent and infant mortality by 10 percent. Specific activities include expanding access to RH services, increasing the number of qualified staff to offer services, and raising public awareness of RH issues.

A woman and her daughters waiting at the Health Center in Chichicastenango, Quiche, Guatemala. Photo by Elizabeth Mallas.

While recognizing the policy had played a role in improving the country's FP/RH policy environment, in-country partners expressed an interest in exploring the dynamics of how the policy was being put into practice. The research team conducted a text analysis of the SDPP, comparing the policy's content with elements considered essential for a well-developed policy.[43] This analysis revealed that the SDPP has only brief guidance on implementation. Moreover, the RH section of the policy includes only two general objectives (on maternal and infant mortality) and specifies many activities, making it difficult to link the individual activities to their expected contributions toward achieving the objectives. It was also not clear how interim progress toward results would be measured.

Core Team. In late 2006, the Health Policy Initiative formed a core team with representatives of the Ministry of Public Health (MSPAS) Reproductive Health Program, the General Secretary for Planning (SEGEPLAN), and the Guatemalan Association of Women Physicians (AGMM). MSPAS has an obvious interest in the findings, as does AGMM—which, in addition to being an NGO that focuses on health services and advocacy, was asked to represent civil society. As outlined in the SDPP, SEGEPLAN has responsibility for coordinating the implementation of the policy and for submitting an annual report to the President.

Study Parameters. The study phase ran from November 2006 to February 2007, which included 36 interviews—seven with policymakers and 29 with implementers. When deciding on *policymaker*s, the team focused on those who had been involved in the formulation of the SDPP, as well as individuals who represent important perspectives for implementation. Members of Congress and high-level officials in MSPAS and SEGEPLAN were included on the list, as were church leaders who were not necessarily supportive of all aspects of the policy. When selecting *implementers and other stakeholders*, the team included not only department-level officials (e.g., MSPAS and SEGEPLAN) and NGOs with direct roles in service delivery but also representatives from the central level, such as the finance division of MSPAS, APROFAM (a family planning association), the President's Secretary for Women's Affairs, and donor organizations that support implementation. The team also decided on how many respondents to include from the central level and Guatemala's departments, given the timeframe and budget available. Ultimately, two departments were selected: Alta Verapaz, which has the highest maternal mortality rate, and Sacatepequez, which has the lowest rate in Guatemala. Because the RH portion of the SDPP calls for reducing maternal and infant mortality, the team was interested in examining how policy implementation might differ in the two areas.

Key Findings. Respondents believed that the policy is being implemented and addresses the key FP/RH issues; however, implementers expressed relatively less confidence that the goals could be achieved within the timeframe set out in the policy. Responsibility for implementing the policy is shared among various institutions and, in some cases, lacks clearly defined roles. Political issues—such as decentralization and the legal framework on which the policy is based—were seen as facilitating implementation. Gender roles, ethnic diversity, religious beliefs, and turnover among public sector authorities were seen as impeding implementation. Most implementers reported that involvement of the beneficiary groups in policy implementation is weak or in nascent stages. The policy lacks a costed action plan and identified sources of funding to implement the policy. Despite difficulties and lack of clarity in implementation guidelines, respondents attributed positive changes to the SDPP, such as improved access to a variety of FP methods and information. While it has been difficult to implement the policy in an equitable way, respondents also indicated that there have been improvements in maternal and child health service delivery. Efforts to track the policy's implementation were seen as limited due to the lack of an implementation plan that includes a framework for monitoring and evaluation.

> "This study draws attention to the idea that in Guatemala now, health is a comprehensive problem that involves many groups and not just a health sector issue."
>
> *—Rossana Cervantes, SEGEPLAN*

Dissemination and Advocacy. The core team convened a dissemination meeting in early May 2007 to present key findings and discuss potential recommendations for the way forward. Participants included nearly 50 representatives from several civil society groups, department-level authorities from several sectors, donors, and universities, among others. Among the participants were the Vice Minister and representatives of SEGEPLAN, demonstrating high-level commitment to the activity. While presentation of the findings was an important part of the meeting, the team designed the agenda to ensure time for participants to engage with the core team about the issues and other suggestions to advance the implementation process. Following the meeting, the team prepared an advocacy brief and engaged partners in advocacy with NGOs, members of Congress, Departmental Development Councils, and MSPAS and SEGEPLAN at central and decentralized levels (see Appendix A, item 9).

Outcomes. The study findings, the process of applying the tool and promoting dialogue, and extensive advocacy have resulted in several positive developments.

Congressional Action In early March 2008, the Congress in Guatemala signed a Memorandum of Understanding with civil society (NGOs, universities, others) to form a national Reproductive Health Observatory. The multisectoral board has oversight on implementation of the SDPP; the *Social Development Law*; the *Law on Universal and Equitable Access to Family Planning*; the *Law on Combating HIV and AIDS*; and all related international agreements. The board is also charged with mobilizing and monitoring resources for implementation.

Better Indicators Development of a monitoring and evaluation plan for the RH portion of the SDPP—one key barrier to effective implementation identified by stakeholders and discussed rigorously at the dissemination forum—has begun. With USAID/Guatemala support, the Health Policy Initiative is providing technical assistance to the in-country committee drafting the plan and is using the results of the assessment in this effort. The findings of the assessment also informed SEGEPLAN's 2009 annual report to the President on the status of the SDPP.

More Resources MSPAS allotted an additional US$1.3 million to the RH program's 2008 budget—a result of advocacy by civil society and government policy champions as well as increased vigilance in complying with the country's RH framework.

Regional Action Twelve regions have established their own RH observatories, which will help improve implementation of the country's FP/RH legal framework at the regional and local levels.

Finally, the assessment proved valuable enough to RH stakeholders that interest in adapting the approach for use in the HIV field was generated. As a result, the tool has been applied to HIV policies and plans in Guatemala and El Salvador (see Box 4).

Uttarakhand: State Health and Population Policy

Policy. In 2002, Uttarakhand became the first state in India to adopt an integrated *Health and Population Policy*. The text analysis of the policy revealed that the policy is well-written, with clear, time-bound goals and strategies. The central government has also recommended it as a model policy for other states to adapt. The goals of the *Health and Population Policy* are to improve the health status and quality of life of the people of Uttarakhand; alleviate inequalities in healthcare access; address current and emerging health issues; and help stabilize population growth. To achieve these and other goals, the policy outlines policy and programmatic interventions that address organizational issues, planning, finance, training, service delivery, quality, drug availability, empowerment of women, equity, the private sector, and other concerns. Since its adoption, the government has worked to put the policy into practice, including expanding services under the Reproductive and Child Health Program and the National Rural Health Mission (NRHM). Further, districts have created District Action Plans to improve local health services. With two years remaining to achieve the state policy goals (2010) and four years for the NRHM (2012), stakeholders recognized the benefits of assessing the state policy's implementation.

Core Team. The Health Policy Initiative supported the Uttarakhand Directorate of Health and Family Welfare (DoHFW) and other stakeholders to assess the policy's implementation. The core team comprised representatives from the DoHFW, State Health Resource Center, and selected NGOs. The Rural Development Institute of the Himalaya Institute Hospital Trust assisted with data collection and analysis.

An ASHA—Accredited Social Health Activist—in Uttarakhand, India. Photo by Suneeta Sharma.

Study Parameters. The study ran from April–September 2008. The core team adapted the master interview guides to the state's context and used them to aid in designing FGD guides to explore the perspectives of clients and community-level functionaries. The study included more than 400 respondents:

- 36 interviews with policymakers (5) and implementers at the state (10) and district (21) levels;
- 16 FGDs with 179 community-level functionaries, including auxiliary nurse midwives, anganwadi workers, accredited social health activists (ASHAs), and representatives of panchayati raj institutions (local government bodies); and
- 16 FGDs with 208 clients, including women and men from rural and urban areas and from scheduled castes. (For FGD guide examples, see Appendix A, item 12.)

The team selected Almora, Haridwar, Udham Singh Nagar, and Uttarkashi Districts to represent the state's demographic profile and geographic composition (hills and plains).

Key Findings. Respondents identified several factors as facilitating policy implementation in the state, including high-level commitment, innovative pilot programs, convergence between some programs (such as health and water and sanitation), the decentralization taking place under the NRHM, and mobilization of new cadres, such as the ASHAs. Further, respondents believed that the participatory approach used to formulate the policy enhanced its development and buy-in.

> "I welcome forums of such nature, where those of us involved in policy and practices of health service delivery can talk to each other and take stock."
>
> —Mr. Keshav Desiraju, Principal Secretary, Medical Health and Family Welfare

According to key informants and FGD participants, dissemination of the policy beyond state-level actors was limited. They identified frequent transfers in key positions and lack of state- and district-level leadership continuity as barriers to implementation. In terms of resources, most respondents and participants felt that the biggest financial constraint in the state is the difficulty in accessing, disbursing, and expending already-sanctioned funds at different levels. Challenges include delays, lack of authorized banks in rural areas, and lengthy procedures. Human resource shortages were also severe, leading to fatigue among health workers and compromising quality of care. Clients identified out-of-pocket expenses and provider attitudes as major constraints. For people belonging to scheduled castes and tribes and living below the poverty line, travel costs and fees for services (e.g., medicines, supplies, lab tests) are unaffordable. Lack of transportation and distance to facilities were also cited as challenges, especially in hilly areas. In addition, respondents reported that monitoring mechanisms were often time-consuming and cumbersome, with limited use in decisionmaking and planning processes. (For the full report, see Appendix A, item 10.)

Dissemination and Advocacy. On November 19, 2008, the Government of Uttarakhand—in collaboration with the Health Policy Initiative, USAID/India, and the USAID-funded ITAP[44] Project—

organized a high-level policy dialogue event in Dehradun. More than 50 participants attended the workshop on "Policy, Innovations, and Experiences in Uttarakhand," including seven past and present health ministers, other government officials, NGOs supervising the ASHA projects, donors, and civil society and private sector partners. The workshop provided an opportunity to review the state's health indicators; learn from innovative programs in the state; present and discuss the key findings and recommendations emerging from the policy implementation assessment; and renew commitment to health sector reforms and innovations.

Outcomes. Based on the study findings and discussions, the state government is updating the policy and taking steps to remove operational barriers. The Uttarakhand Health and Family Welfare Society has been tasked with leading a multisectoral Policy Revision Coordination Committee to prepare an addendum to the policy. With assistance from the Health Policy Initiative, the committee drafted the addendum, which specifically looks to enhance evidence-based planning and devise tailored strategies for the groups and regions most in need (see Appendix A, item 11). The proposed addendum includes equity-based goals and strategies, including activities for hard-to-reach hilly areas, underserved areas in the plains, and urban slums. The addendum is currently with the Principal Secretary and Cabinet for final approval and will be incorporated into the state's program implementation plans.

Box 4. Assessing National HIV Policies and Plans in Central America

In 2008, the Health Policy Initiative formed in-country, multisectoral teams to adapt the Policy Implementation Assessment Tool to explore the implementation of Guatemala's *Public Policy 638-2005: On the Prevention of STIs and Response to the AIDS Epidemic* and El Salvador's *National Strategic Plan on STIs, HIV, and AIDS, 2005–2010*. The Guatemala study involved in-depth interviews with 6 policymakers and 26 implementers, while the El Salvador study included 12 policymakers and 21 implementers. Members of the core country teams carrying out the assessments were drawn from civil society groups, ministries of health and other key ministries, national AIDS programs, USAID, and others.

The assessments identified a number of barriers to policy implementation that hinder effective HIV program scale-up (see Appendix A, item 13). Some of the common findings included the following:

- Policy goals and implementation plans that were unclear or unrealistic given the timeframe
- Limited involvement of and attention to the needs of the most at-risk populations
- Limited multisectoral engagement in implementation, which became dominated by national AIDS control programs in the health ministries, rather than the multisectoral National AIDS Commissions (CONASIDAs)—as a result HIV was seen primarily as a health issue and not an issue to be addressed by businesses, schools, and other sectors
- The need for improved planning, leadership capacity, and integration of HIV issues at decentralized levels
- Insufficient funding, dependence on international donors, and limited absorptive capacity of NGOs, making it difficult for them to access and use available funding

In late 2008, the country core teams initiated dissemination and multisectoral policy dialogue and advocacy and are continuing to foster consensus on the way forward (for advocacy briefs, see Appendix A, items 14 and 15). For example, Guatemala's CONASIDA disseminated the findings on World AIDS Day and is using the study to help enhance its role in monitoring the HIV response. In El Salvador, findings are informing development of the next five-year HIV strategic plan, and members of the Global Fund Country Coordinating Mechanism are using the study findings to facilitate better implementation of the current plan.

Through USAID | PASCA (Program for Strengthening the Central American Response to HIV/AIDS), plans are also underway to use the tool to assess additional HIV policies and plans in the region, including in Costa Rica and Panama.

VI. CONCLUDING THOUGHTS

A supportive policy environment is the foundation on which to scale up effective, sustainable health programs. Policies help determine guidelines, systems, and relationships that govern service delivery. Yet, even the best policies can encounter implementation challenges. Moreover, operational barriers to programs can often be alleviated with appropriate policy solutions and reforms. Attention to policy issues should not end with the creation of the policy, which is, in fact, only the beginning of the policy-to-action continuum.

Thus, policies are "living documents." They require various inputs to help them fulfill their goals. These inputs include clear guidelines and implementation plans, strong leadership, multisectoral stakeholder involvement, adequate and accessible resources, and effective feedback and monitoring systems. The Policy Implementation Assessment Tool is a user-friendly, participatory approach that helps to "take the pulse" of the policy and diagnose barriers to effective implementation. Experiences from the country applications to date have shown that respondents are eager to share their viewpoints and welcome the opportunity to provide recommendations on policy implementation in their countries. Through regular check-ups and renewed commitment, policies can keep on track toward achieving policy goals.

APPENDIX A: LIST OF MATERIALS AVAILABLE ON CD-ROM AND ONLINE

The following materials are available on the enclosed CD-ROM and online at www.healthpolicyinitiative.com/policyimplementation.

Policy Implementation Assessment Tool

1. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool* (Guide)
2. *Taking the Pulse of Policy: The Policy Implementation Assessment Tool* (Summary)
3. Interview Guide for Policymakers (MS Word)
4. Interview Guide for Implementers and Other Stakeholders (MS Word)
5. Database for Policymaker Responses (MS Excel)
6. Database for Implementer and Other Stakeholder Responses (MS Excel)
7. Sample Stakeholder Mapping Form (MS Word)
8. Presentation on "Taking the Pulse of Policy: A Participatory Approach to Assessing Policy Implementation" presented at the Global Health Mini University in Washington, DC, October 9, 2009

Materials from Country Applications of the Tool

Guatemala—Reproductive Health

9. Advocacy Brief: *Guatemala: La Política de Desarrollo Social y Población en Materia de Salud: Avances y Retos en su Implementación* (Spanish)

Uttarakhand—Health and Population

10. *The Health and Population Policy of Uttarakhand: A Review: Application of the Policy Implementation Assessment Tool*
11. "Informing Health Policy Reform: Policy Implementation Assessment Inspires Action in Uttarakhand, India"

12. Focus group discussion guides
    - Accredited social health activists (ASHAs)
    - Anganwadi workers
    - Auxiliary nurse midwives
    - Clients
    - Panchayati raj institutions (local elected officials)

Guatemala and El Salvador—HIV

13. Presentation on "Assessments of National HIV Policy Implementation in Guatemala and El Salvador Help Identify Approaches for Overcoming Barriers to Implementation" presented at the HIV Implementers Meeting, held in Windhoek, Namibia, June 10–14, 2009

14. Advocacy Brief: *Guatemala: Política Pública 638-2005: Respecto de la Prevención a las Infecciones de Transmisión Sexual—ITS—y a la Respuesta a la Epidemia del Síndrome de Inmunodeficiencia Adquirida—SIDA: Avances y Retos en su Implementación* (Spanish)

15. Advocacy Brief: *El Salvador: Plan Estratégico Nacional en ITS, VIH y SIDA, 2005–2010: Avances y Retos en su Implementación* (Spanish)

Selected Project Readings on Policy Implementation

- Bhuyan, A. 2005. *Commitment for Action: Assessing Leadership for Confronting the HIV/AIDS Epidemic—Lessons Learned from Pilot Studies in Bangladesh, India, Nepal, and Vietnam*. Washington, DC: Futures Group, POLICY Project.

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- Hardee, K., I. Feranil, J. Boezwinkle, and B. Clark. 2004. "The Policy Circle: A Framework for Analyzing the Components of Family Planning, Reproductive Health, Maternal Health, and HIV/AIDS Policies." *POLICY Working Paper Series* No. 11. Washington DC: Futures Group, POLICY Project.

- Health Policy Initiative and DELIVER Project. 2008. *Analysis of the Operational Policy Barriers to Financing and Procuring Contraceptives in Malawi*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1; and Arlington, VA: DELIVER Project, John Snow, Inc.

- Menotti, E., S. Sharma, and G. Subiria. 2008. *Increasing Access to Family Planning among the Poor in Peru: Building On and Strengthening Financing Mechanisms for the Poor*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

- POLICY Project. 1999. *Networking for Policy Change Advocacy Training Manual*. Washington, DC: Futures Group, POLICY Project.

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

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

- Sonneveldt, E., T. Shaver, and A. Bhuyan. 2008. *Understanding Operational Barriers to Family Planning Services in Conflict-affected Countries: Experiences from Sierra Leone*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

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

- Zosa-Feranil, I., C.P. Green, and L. Cucuzza. 2009. *Engaging the Poor on Family Planning as a Poverty Reduction Strategy*. Washington, DC: Futures Group, Health Policy Initiative, Task Order 1.

APPENDIX B: GUIDING QUESTIONS FOR THE TEXT ANALYSIS—SPECIAL TOPICS

In conducting the text analysis of the policy, the core team should consider essential elements of effective policies, such as clear goals and objectives, implementation and institutional arrangements, funding sources, and indicators of success, as well as any potential conflicts with other existing policies. The guiding questions presented below are designed to help the core team hone in on other key issues—especially poverty and equity, gender, and client perspectives—that likely affect policy implementation. Answers to these questions can help the core teams identify issues for further exploration during the policy implementation assessment.

	Poverty and Equity	Gender	Clients
Priorities	Does the policy consider a high level of poverty and/or low access to healthcare among the poor a priority? If so, what data or information were used or presented to assess the needs of the poor? (e.g., quintile analysis) How does the policy define "the poor"? What groups are included in "the poor"? (e.g., by income/quintile, by assets and amenities, by poverty line, rural/urban, migrant populations, urban slum dwellers, etc.)	Does the policy consider how the issue or problem affects women and men differently? Does the policy consider how social, legal, economic, or cultural taboos or obstacles affect women's and men's access to services? Does the policy consider how social, legal, economic, or cultural taboos or obstacles affect women's and men's access to and control over resources for services? Are sex-disaggregated data used to identify key gender issues or inequities?	Does the policy's description of priority issues consider the impact of health issues and service access on individuals, households, and communities? Or are issues presented in terms of societal needs and national development priorities? How does the policy define clients or intended beneficiaries?
Goals	Does the policy include explicit objective(s) to reduce inequities in service use or in health outcomes for the poor? If yes, how are they expressed? (e.g., increase contraceptive prevalence among the poor, reduce gaps between rural and urban areas, etc.)	Does the policy include explicit objective(s) to reduce gender inequities in service use or in health outcomes? If yes, how are they expressed?	Are client-oriented services or care a goal of the policy?

	Poverty and Equity	Gender	Clients
Involvement in Formulation	Were civil society organizations representing or serving the poor involved in the policy's formulation?	Were civil society organizations representing or serving women involved in the policy's formulation?	Were civil society organizations representing or serving clients or intended beneficiaries involved in the policy's formulation?
	Were the poor involved in the policy's formulation?	Were women's groups involved in the policy's formulation?	Were clients or intended beneficiaries involved in the policy's formulation?
Strategies	Does the policy or implementation guidance call for the involvement of the poor or civil society groups serving the poor in the design, implementation, and/or monitoring of strategies outlined in the policy?	Does the policy or implementation guidance call for the involvement of women's groups in the design, implementation, and/or monitoring of strategies outlined in the policy?	Does the policy or implementation guidance call for the involvement of civil society or intended beneficiaries in the design, implementation, and/or monitoring of strategies outlined in the policy?
	To what extent or in what ways does the policy or implementation guidance promote pro-poor services and strategies?	To what extent or in what ways does the policy promote gender-equitable services?	To what extent or in what ways does the policy promote client-centered services?
	How does the policy address access issues faced by the poor? (e.g., in rural and urban areas)	To what extent or in what ways does the policy promote constructive male involvement?	How does the policy address access issues? Does it lift or add any restrictions to services (e.g., based on age, based on marital status)?
		How does the policy or implementation guidance address different access issues faced by women and men?	Does the policy promote culturally-appropriate services and provision of information? Is information to be designed and made available for low-literacy populations? In local languages?
			Does the policy mention client or patient rights? What are these rights? Are mechanisms mentioned for monitoring and redressing rights violations?
Resources	To what extent does the policy consider level of poverty and inequities in allocating financial resources?	To what extent does the policy consider gender inequities in allocating financial resources? Gender budgeting?	To what extent are additional resources or services available to clients as a result of the policy? (e.g., new insurance schemes, vouchers, etc.)
	To what extent are additional resources or services available to the poor as a result of the policy? (e.g., new insurance schemes, vouchers, etc.)	Are any initiatives included to enhance women's access to or control over resources? (e.g., micro-credit schemes, income generation activities, property and inheritance rights, etc.)	

	Poverty and Equity	Gender	Clients
Institutional Responsibility	Does the policy or implementation guidance give any institution or department authority for ensuring that equity-related goals are achieved?	Does the policy or implementation guidance give any institution or department authority for ensuring that gender-related goals are achieved? Is there a gender focal point?	Does the policy or implementation guidance give any institution or department authority for ensuring that client-centered goals are achieved?
Monitoring and Evaluation	How are the resources and services related to equity goals being monitored? Does the monitoring and evaluation plan include equity-based indicators?	How are the resources and services related to gender-related goals being monitored? Does the monitoring and evaluation plan include gender-related indicators? Are sex-disaggregated data collected and analyzed?	How are the resources and services related to client-centered services being monitored? Do these indicators cover quality of care, culturally-appropriate services, etc.?
Unintended Consequences	Given the policy's priorities, goals, strategies, and resources, to what extent could the policy's implementation have unintended consequences on or create/exacerbate barriers for the poor?	Given the policy's priorities, goals, strategies, and resources, to what extent could the policy's implementation have unintended consequences on gender norms or create/exacerbate gender-related barriers for women and men?	Given the policy's priorities, goals, strategies, and resources, to what extent could the policy's implementation have unintended consequences on or create/exacerbate barriers for clients and beneficiaries?

APPENDIX C: SAMPLE STAKEHOLDER MAPPING FORM

This form provides an example of how to identify and map stakeholders for inclusion in the in-depth interviews and focus group discussions. The core teams can include more or less detail, depending on the specific criteria that are relevant for the assessment.

Name *(or group)*	Organization *(if applicable)*	Level of Authority *(e.g., to make decisions that affect policy imple-mentation)* 1=Low, 5=High	Role in Policy Process *(check √ where appropriate)*					Level *(e.g., national, provincial, district, community)*	Geographic rep.	Gender rep. *(e.g., female or male)*
			Policy Formulation	Policy Implementation	Policy Monitoring	Policy Beneficiary	Other Influential Stakeholder			
Policymakers/Government Officials (health and non-health sectors)										
Donors										
Implementers/Program Managers										
Service Providers (public, private, and NGO)										
NGOs and Civil Society Groups/Leaders										

Name *(or group)*	Organization *(if applicable)*	Level of Authority *(e.g., to make decisions that affect policy imple-mentation)* 1=Low, 5=High	Role in Policy Process *(check √ where appropriate)*					Level *(e.g., national, provincial, district, community)*	Geographic rep.	Gender rep. *(e.g., female or male)*
			Policy Formulation	Policy Implementation	Policy Monitoring	Policy Beneficiary	Other Influential Stakeholder			
Outreach Workers										
Beneficiaries/Clients (including rural/urban, women/men, the poor, and other marginalized groups)										

APPENDIX D: TIPS FOR USING THE EXCEL DATA COLLECTION SHEETS

- Microsoft Excel files, corresponding to the policymaker and implementer/other stakeholder interview guides, are available to aid in data collection and analysis. These files can be accessed through the attached CD-ROM or can be downloaded from the website at www.healthpolicyinitiative.com/policyimplementation. Any adaptations made to the interview guides should also be made to the Excel files.

- Each Excel file is essentially a "workbook" that contains multiple "worksheets," with each worksheet (tab) corresponding to the different sections (dimensions) of the interview guides. The structure of the Excel files reflects that of the interview guides. The same or similar questions are included in the policymaker and implementer/other stakeholder versions, with more detailed implementation questions being asked of the latter group.

- The column headings in the Excel files refer to the questions in the interview guides. The rows are used to enter the perspectives of each respondent. In the "Basic Info" worksheet, each respondent is assigned a specific case number and a row where their pertinent details are entered. In the subsequent worksheets, the answers for each respondent should be entered in the row that matches their designated *case* number. Note, because the top rows contain the question information, the Excel file *row* number will differ from the *case* number. Be sure to enter the responses according to the appropriate case number on each worksheet.

- Responses will be entered as text or numbers. For the open-ended questions, enter as much information as possible based on notes or interview recordings, where available. Having complete information will help the team in identifying key themes, as well as nuances in the perspectives of different respondents.

    - The question-by-question set up of the Excel files will help the core team and data analysts to group the key themes (e.g., facilitators, barriers, resource issues, etc.). Within those broad themes, the team should consider common responses, patterns, trends, relationships, and any findings that are surprising. These themes should emerge from the data and not be imposed by the team.
    - The team should also consider how the perspectives differ or are similar across groups—such as policymakers, implementers/other stakeholders, and clients—or by sector, such as public, private, and NGO/civil society.
    - The team may wish to establish a standardized system to organize the responses as the analysis unfolds, such as highlighting common themes by color or by assigning codes. In the latter case, the team could insert new columns in the Excel files to assign codes to the responses. For example, the team could insert "RES" next to each response that identifies lack of resources as an issue. The responses could then be sorted or counted to determine the frequency of each barrier. Using this type of approach may be more useful when trying to manage larger datasets.
    - Periodically, the team members doing the analysis should meet and discuss their findings and impressions with each other. Doing so may help to identify a fresh perspective on the data or reveal issues that are being overlooked.

- Findings can be presented in narrative form according to relevant topics and categories. Illustrative quotes from the interviews or focus group discussions can help to further illuminate key issues.

For more tips on collecting and analyzing qualitative data, please see *Qualitative Methods in Public Health: A Field Guide for Applied Research* (Ulin et al., 2004) and *Qualitative Research Methods: A Data Collector's Field Guide* (Mack et al., 2005).

- The numeric responses facilitate side-by-side comparisons of the perspectives of policymakers and implementers/other stakeholders. For the questions using Likert-like scales or other numbered responses, enter the appropriate number in the space (e.g., 1–4 for the scales; 1–2 for yes/no questions). Use an "8" to indicate "don't know" and a "9" to indicate missing information or did not answer. In the lower part of each column, the worksheets are already set up to calculate the frequencies of each numerical response, which can be used be used to create graphs to depict the findings. The worksheets currently have space for 50 cases/respondents. If more people are interviewed, insert additional rows above case #50, and then renumber the cases accordingly. If lines are inserted after case #50, the formulas will not factor them in.

- In presenting the findings to stakeholders, the core team may wish to share some of their observations about the data and identify some initial recommendations for discussion. However, the team should also engage in meaningful dialogue and discussions with stakeholders to engender greater support and buy-in for adopted recommendations.

NOTES

[1] Calista, 1994; Love, 2004.
[2] Love, 2003, p. 4.
[3] Alesch and Petak, 2001; Bressers, 2004; Brinkerhoff and Crosby, 2002; Calista, 1994; Matland, 1995; Thomas and Grindle, 1990; and O'toole, 2004.
[4] Pressman and Wildavsky, 1973.
[5] Nakamura and Smallwood, 1980.
[6] Walt and Gilson, 1994.
[7] Calista, 1994; Grindle and Thomas, 1991; and Nakamura and Smallwood, 1980.
[8] Bressers, 2004.
[9] Matland, 1995.
[10] Sabatier, 1986.
[11] Elmore, 1985; Palumbo et al., 1984; and Maynard-Moody et al., 1990.
[12] Calista, 1994.
[13] Ingram and Schneider, 1990.
[14] Alesch and Petak, 2001.
[15] Sharma et al., 2009.
[16] Love, 2003; Love, 2004.
[17] Nakamura and Smallwood, 1980; Walt and Gilson, 1994; Hardee et al., 2004.
[18] Calista,1994.
[19] Klein and Knight, 2005.
[20] Brinkerhoff and Crosby, 2002.
[21] Grindle and Thomas, 1991.
[22] Calista, 1994.
[23] Walt and Gilson, 1994.
[24] Bryson and Crosby, 2005; and Management Sciences for Health, 2004a.
[25] Bhuyan, 2005.
[26] Thomas and Grindle, 1990.
[27] Nakamura and Smallwood, 1980.
[28] Stover and Johnston, 1999.
[29] POLICY, 1999.
[30] Altman and Petkus, 1994; Thomas, 1995; Walt and Gilson, 1994; and Bressers, 2004.
[31] Calista, 1994.
[32] Altman and Petkus, 1994; and Bryson, 1988.
[33] Stover and Johnston, 1999, p. 23.
[34] Nakamura and Smallwood, 1980, p. 31.
[35] Brinkerhoff and Crosby, 2002; Klein and Knight, 2005; and Management Sciences for Health, 2004b.
[36] Humanist Committee on Human Rights, 2006.
[37] Calista, 1994; Klein and Knight, 2005.
[38] Brinkerhoff and Crosby, 2002; and Calista, 1994.
[39] Altman and Petkus, 1994.
[40] W.K. Kellogg Foundation, 2004, p. 24.
[41] Cross et al., 2001.
[42] USAID, 2001; W.K. Kellogg, 2004.
[43] Hardee et al., 2004.
[44] ITAP is the Innovations in Family Planning Services II Technical Assistance Project.

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