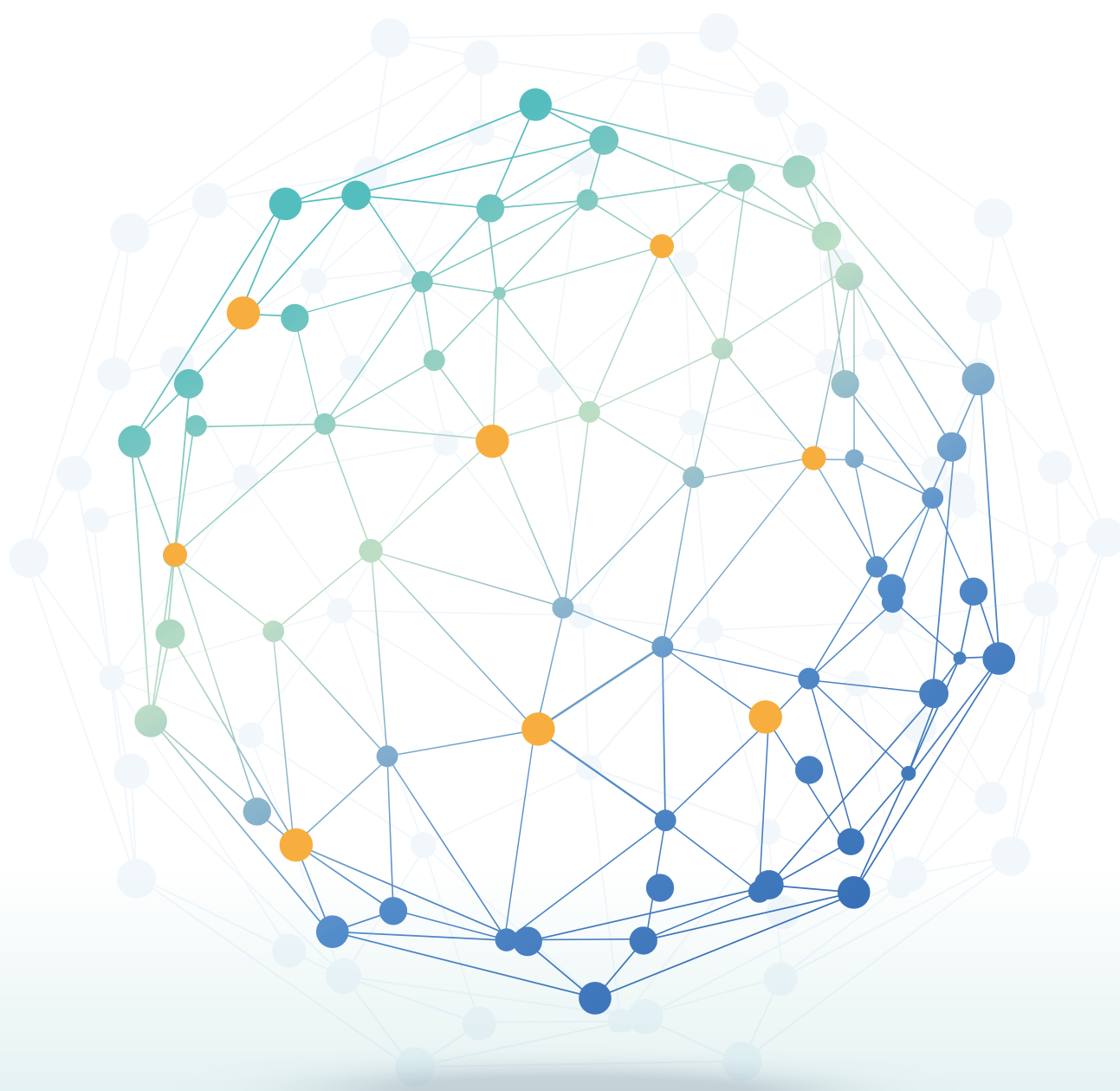


# **A HEALTH POLICY ANALYSIS READER:** THE POLITICS OF POLICY CHANGE IN LOW- AND MIDDLE-INCOME COUNTRIES

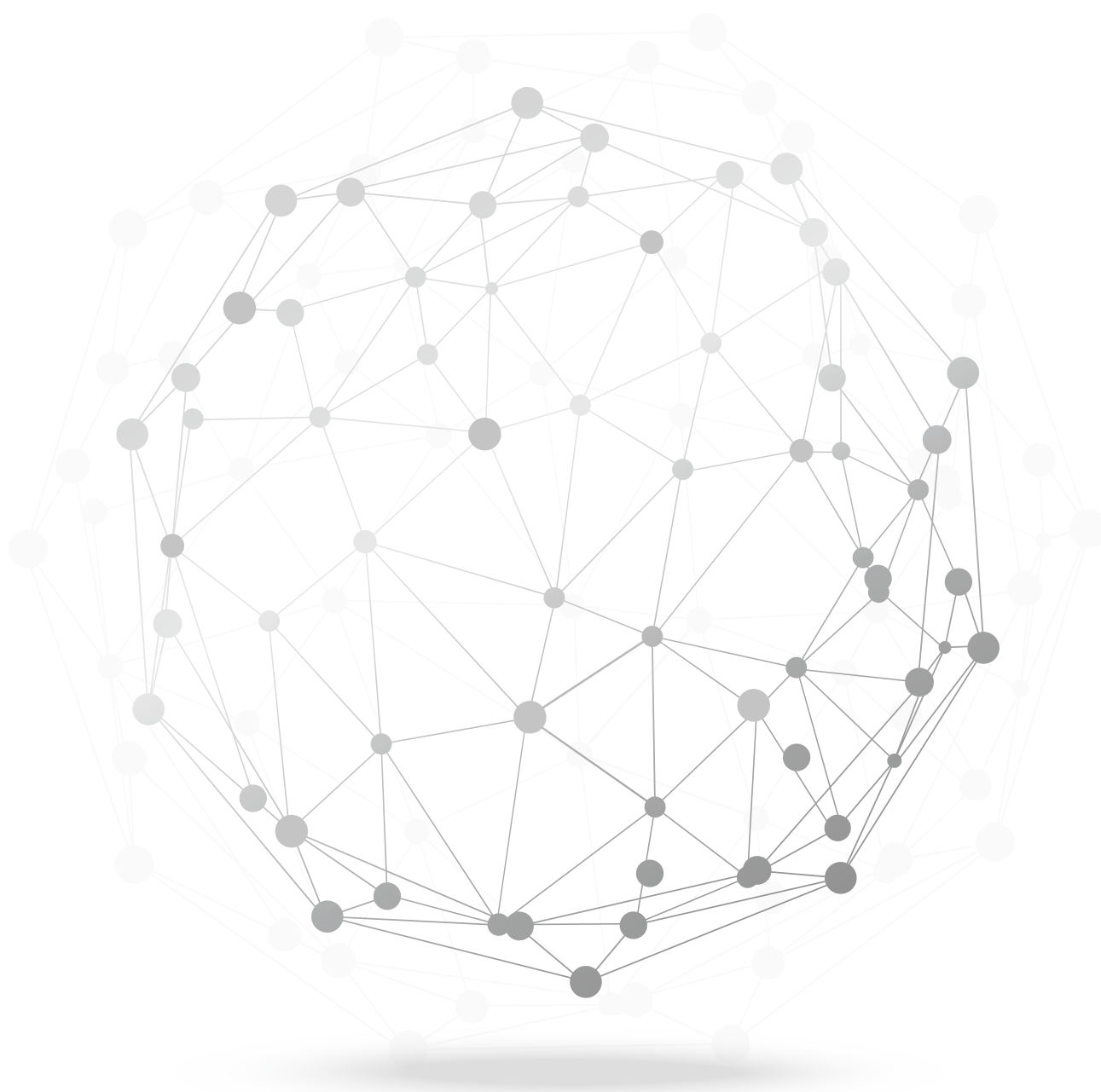
EDITED BY LUCY GILSON, MARSHA ORGILL AND ZUBIN CYRUS SHROFF





# **A HEALTH POLICY ANALYSIS READER:** THE POLITICS OF POLICY CHANGE IN LOW- AND MIDDLE-INCOME COUNTRIES

EDITED BY LUCY GILSON, MARSHA ORGILL AND ZUBIN CYRUS SHROFF



A health policy analysis reader: the politics of policy change in low- and middle-income countries/  
Lucy Gilson, Marsha Orgill, Zubin Cyrus Shroff, editors

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# PREFACE

This Reader is a boon to all those interested in health policy analysis. It offers much: a historical overview of how the field developed; a description of what health policy is and how analysis can be used; and an invaluable set of studies/readings which provide examples of empirical research that has informed policy in many different settings. It invites readers to consider how, and which, theories might be useful, and which methodological approaches might be helpful.

When I first started working in this field, there were very few resources to turn to. The book, *An Introduction to Health Policy: Process and Power*, published in 1994, and the paper describing the policy triangle, written with Lucy Gilson and published in *Health Policy and Planning* the same year, were attempts to redress what we felt was a huge imbalance in the field of health policy. The literature at the time tended to address health policies and policy processes in high-income countries, focus on the content of health policy rather than the politics of policy-making and be largely dominated by writers from high-income countries.

This Reader continues to challenge those limitations by providing a resource which draws on experience from low- and middle-income countries and profiles work by authors from those countries. It gives a special place to the social sciences in health policy work, acknowledging how political science, economics, anthropology and sociology, among others, provide critical insights. The Reader also shows how it is possible to conduct health policy analysis research. It is a tool to develop and guide new researchers, as well as to inspire teachers and their students, thus extending and expanding the field of health policy analysis to include emerging scholars, writers and researchers from low- and middle-income countries in particular. It will also be hugely useful to those in high-income countries who want to work with others from this range of countries.

Those involved in putting the Reader together have brought a breadth and depth of understanding of the field, sharing with readers their own research and teaching experiences. Together, they have brought to this task their abilities to undertake thoughtful, relevant and useful research and to make it accessible to others; to make clear links between theory and practice; and through the exercise of those skills to encourage and develop others to do the same. The perspective the Reader presents is local and grounded, but linked to international and global trajectories. The editorial team has produced a resource which stresses the value of health policy analysis undertaken in low- and middle-income countries. Wherever you are based in the world, this Reader will have interest and resonance for you!

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# FOREWORD

In the real world, multiple social, economic and political factors are instrumental in shaping the design and implementation of health policies. The field of health policy analysis helps to shine a light on these complex realities, and is vital to helping us to understand how we can influence policy processes to achieve health impacts.

Health policy analysis has immense potential in helping to strengthen health systems to achieve health goals. For instance, it is essential for identifying the levers of change that can drive political commitment for universal health coverage. It can also help us to understand and advance intersectoral coordination, essential for the achievement of the United Nations Sustainable Development Goals.

Commencing with an overview of conceptual issues in health policy analysis, followed by a series of empirical papers from low- and-middle income countries (LMICs), this Reader systematically explains how different actors influence policies and, in turn, how contexts influence policy actors in making decisions. In doing so, it draws on diverse traditions of political economy analysis, policy studies and public administration. There is also a helpful section dedicated to using health policy analysis prospectively to support health policy change.

While some countries have taken steps to institutionalize and support health policy analysis, it remains a relatively neglected field, particularly in LMICs, and capacity challenges limit the extent of its generation and use. We hope that this Reader will help to bridge this gap by providing a valuable learning resource for researchers keen to engage in the systematic study of health policy, as well as to health policy-makers and practitioners who are eager to influence policy change.

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# INTRODUCTION

*Lucy Gilson*

## AIMS AND STRUCTURE OF THE READER

The primary objective of the present Reader is to encourage and deepen health policy analysis work in low- and middle-income countries (LMICs).

Health policy analysis is a central element of health policy and systems research (HPSR). It offers insights into “the politics of health policy change, the interests and actors driving the processes through which policies are developed and implemented”, and so “contributes to understanding how to influence policy and take action to strengthen health systems” (Gilson, 2012:22).

The present Reader complements other readers already produced by the Alliance for Health Policy and Systems Research<sup>1</sup> – in particular, the HPSR Reader (Gilson, 2012).

However, whereas the HPSR Reader focuses on the orientation and conduct of HPSR studies, the present Reader focuses primarily on the substantive concerns of health policy analysis. It illuminates the range of health policy analysis studies that have been conducted in LMICs, as well as highlighting relevant theory and pointing to new directions for such work. It also includes some methodological and analytical pointers.

The present Reader’s primary target audiences include emerging researchers, academics and educators interested in a better understanding of health policy processes and health policy change in LMICs. Many people within these groups are likely to come from a broad public health or health systems background, with real-world understanding and experience of health policies but perhaps only limited prior engagement with relevant social science perspectives.

The Reader will, however, also be of interest to those who have specialist policy studies or public administration backgrounds but who wish to understand more clearly the current range of work focused on LMIC health policy processes.

Finally, the Reader will be of interest to those seeking to influence health policy change – advocates, managers, policy-makers or researchers.

### **The Reader is presented in five parts**

In Part A we present key starting points for health policy analysis work in LMICs. We clarify what health policy analysis is and why it is important, and present a brief overview of the current body of health policy analysis work conducted in LMICs. Ten papers providing insights into these starting points are highlighted; their titles appear in bold type.

We also provide a fuller overview of three intellectual traditions that offer valuable insights for those working on health issues. These traditions are: (a) the political economy of development; (b) policy studies and (c) public administration. As this is not a textbook, these overviews are not comprehensive. Instead, they seek to encourage those doing health policy analysis to look beyond the current body of work and realize the breadth of theoretical insight on which they can draw, and which they can adapt, in considering health experiences.

Within Parts B to D of this Reader, each of the nine sections combines a short, focused introduction to the area of work highlighted, with an overview of 10 papers selected as examples of health policy analysis work in that area; here, too, the titles of the selected papers appear in bold type.

In Part B we consider three critical influences over health policy processes in LMICs:

- Section B1: Power in policy change
- Section B2: National contexts
- Section B3: Global health actors and national policy-making.

In Part C we present the current body of empirical work addressing LMIC health policy processes:

- Section C1: National experiences of health policy formulation and policy change
- Section C2: Agenda-setting processes
- Section C3: Research, evidence and policy change

<sup>1</sup> See <http://www.who.int/alliance-hpsr/resources/publications/methodsreaders/en>.

- Section C4: Policy implementation.

In Part D we present two sets of analytical and methodological papers:

- Section D1: Using health policy analysis prospectively to support health policy change
- Section D2: Methodological issues in health policy analysis work.

In Part E we present the set of papers included in the Reader, namely:

- two of the 10 papers from each section (exemplars), deliberately chosen to offer particularly valuable insights for that area of work;
- additional papers from among the 10 highlighted in each section.

### **Note on papers included in Part E**

The papers included in Part E of the Reader comprise empirical papers from LMICs, some conceptual pieces that offer interesting or important insights and, for sections D1 and D2, methodological pieces. The empirical papers focus exclusively on experience in, or of relevance to, LMICs. The selection process also sought to highlight work conducted by LMIC authors, as well as addressing a range of policy areas and country settings.

Although we initially sought suggestions for papers from others working in the field, the final decisions of which papers to include in the Reader were made by the small team involved in its development. These papers are highlighted to stimulate broader engagement with the overall area of work, rather than as a definitive selection of the “best” LMIC health policy analysis papers.

## **HOW TO USE THE READER**

We recommend that those using this Reader dip into it, rather than trying to read it from cover to cover.

Part A gives you a sense of the breadth of the area of work and of relevant scholars and theories about which you might like to read more. The sections of Part B provide an introduction to some critical phenomena and issues. Part C then provides a more focused introduction to some particular areas of work. Finally, Part D presents some analytical and methodological tools for your work.

In addition, the Reader provides an annotated bibliography, as each section includes a set of citations for 10 relevant papers (indicated by titles in bold type), with some commentary on each paper selected.

We encourage budding analysts to go out and read even further!

Read around issues of interest to you, read textbooks that provide overviews of the ways that concepts and theories have developed over time, and use this Reader to identify relevant empirical research from LMIC settings, as well as analytical approaches and methodological tools.

Remember that current ideas always have histories, and in this field they are shaped by multiple disciplinary traditions. Although there is no need to become a disciplinary specialist in multiple disciplines to be a health policy analyst, it is important to have some awareness of the broader array of relevant ideas and concepts.

In research and practice, always be ready to draw on concepts and frameworks already developed – use them to guide your work, and perhaps seek to test and refine them. But also have the confidence to draw in new ideas or different perspectives on similar concepts from other worlds – being thoughtful about how they are similar to, or different from, the existing body of policy analysis work, being reflective about how they inform your insights and why you find them useful (or not).

In addition, there is enormous, practical value in engagement between researchers and practitioners (policy-makers, managers, activists) when conducting health policy analysis and generating theory (Weible and Cairney, 2018). The engagement can be uncomfortable, or even threatening, to long established and unchallenged territories, superiorities and safe zones. However, practitioners do not need to become expert theorists, and expert theorists do not need to become practitioners. It is a matter of the degree of engagement towards theory or towards practice – with recognition of an essential zone of overlap.

As noted in one authoritative textbook, policy analysis is “essentially a bootstrapping activity. No one theory or model is adequate to explain the complexity of the policy activity of the modern state [...] The analysis of public policy therefore involves an appreciation of the network of ideas, concepts and words which form the world of explanation within which policy-making and analysis takes place” (Parsons, 1995:73).

## RESOURCES<sup>2</sup>

### References

- Gilson L, editor (2012). Health policy and systems research: a methodology reader. Geneva: World Health Organization.
- Parsons W (1995). Public policy: an introduction to the theory and practice of policy analysis. Cheltenham: Edward Elgar.
- Weible CM, Cairney P (2018). Practical lessons from policy theories. Policy and Politics. 46(2):183-97.

### Extra resources

#### Journals of relevance to health policy analysis

1. Health journals (\*\* indicates most useful for LMIC health policy analysis work)
  - BMJ Global Health
  - Critical Public Health
  - Global Health Governance
  - Global Public Health\*\*
  - Globalization and Health
  - Health Policy
  - Health Policy and Planning\*\*
  - Health Research Policy and Systems\*\*
  - Health Systems and Reform
  - International Journal of Health Policy and Management
  - Lancet
  - Lancet Global Health
  - Social Science and Medicine\*\*
2. Development journals (selected from a wide range of relevant journals)
  - Institute of Development Studies (IDS) Bulletin
  - Public Administration and Development
  - World Development
3. Public policy, political science and public administration journals (highlighted from among a wide range of relevant journals)
  - Critical Policy Studies
  - Evidence and Policy
  - Governance
  - International Organization and World Politics
  - International Review of Administrative Sciences
  - Journal of Public Administration Research and Theory
  - Policy Sciences
  - Political Science and Politics
  - Public Administration

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<sup>2</sup> All websites accessed 31 July 2018.

## Websites, blogs and Twitter hashtags of relevance

For development policy debates:

- The websites of the United Kingdom Overseas Development Institute (<https://www.odi.org>) and the Developmental Leadership Program (<http://www.dlprog.org>), as well as the blog of Duncan Green, current policy adviser to Oxfam UK (<https://oxfamblogs.org/fp2p/>), offer useful resources.

For policy analysis, two policy blogs are:

- Paul Cairney's blog, which offers many useful resources – including consideration of United Kingdom health policy experiences (<https://paulcairney.wordpress.com/>);
- The blog of the magazine Discover Society, linked to the journal *Policy and Politics* (<https://discoversociety.org/category/policy-briefing/>).

Relevant Twitter hashtags include:

#pdoh (political determinants of health)  
#cdoh (commercial determinants of health)  
#health  
#policy  
#hpsr





PART A.

# HEALTH POLICY ANALYSIS: STARTING POINTS

*Lucy Gilson, Irene Akua Agyepong and Jeremy Shiffman*

This part of the Reader specifically seeks to identify some critical conceptual and theoretical starting points for those new to health policy analysis – and to offer some reminders for those already doing health policy analysis work.

It considers the focus and rationale for such work, and provides a brief overview of the existing body of LMIC health policy analysis research. It also highlights three intellectual traditions that offer key insights for this area of work. These are: (a) the political economy of development; (b) policy studies; (c) public administration.

Ten papers have been selected to offer insights about the health and wider policy analysis work outlined here. They are identified in the text by bold type, and references are provided at the end.

## WHAT IS HEALTH POLICY ANALYSIS?

Policy analysis is commonly understood (Parsons, 1995) to comprise two different approaches:

- analysis OF the policy process: how problems are defined, agendas set, policy formulated, decisions made and policy evaluated and implemented;
- analysis IN and FOR the policy process: this encompasses the use of analytical techniques, research and advocacy in problem definition, decision-making, evaluation and implementation.

The first approach can be seen as retrospective work, undertaken primarily to generate knowledge, and the second as more applied, entailing active engagement with policy processes. Although the majority of papers included in the present Reader can be seen as representing the first approach, these papers also offer important insights relevant to the second approach – and the Reader as a whole is relevant both to those conducting research and to those seeking to act within or influence policy processes.

Indeed, as with the wider fields of HPSR and public health more broadly, health policy analysis is, in many ways, a pragmatic area of work, with many of its proponents bringing an activist perspective and seeking to contribute to societal change. But understanding the world of policy is a vital foundation for action: being pragmatic involves thinking and reflecting, before acting. Policy analysis OF the policy process thus generates insights that can inform and guide policy analysis IN and OF the policy process. It offers entry points for understanding the nature of policy, the forces influencing how it emerges and unfolds, the opportunities to shape and influence it, and even ways of being a policy analyst. At the same time, analysis OF the policy process is also intrinsically valuable, as it enhances and grows our understanding of the world around us.

At national, subnational and local levels, such analysis focuses on the processes of decision-making by political actors and government officials and agents, and how they interact to produce public and health policy and public actions, and with what effects – including at community level (John, 1998). National borders are, however, porous and in LMIC health policy, international actors – multilateral organizations such as the International Monetary Fund, the World Bank, WHO and the United Nations itself, bilateral donors, international nongovernmental organizations and the more recently influential philanthropic organizations and public-private partnerships – are also relevant political and policy actors. Overall, then, health policy analysis is the study of who made what policy decisions, when, why and how, and with what consequences. These chains of decision-making generally unfold over long periods of time, and are influenced by many factors.

Such analysis understands public policy to be both a deliberate and a purposive act, as well as one that is subject to contestation. It recognizes that, in reality, initial policy intentions are likely to change over time, as they are translated and retranslated through continuing processes of decision-making by interacting sets or chains of policy actors.

Although health policy can be understood as “decisions, plans, and actions that are undertaken to achieve specific [health and] health care goals within a society” (WHO, 2018), it is also, in essence, about “process and power [...] it is concerned with who influences whom in the making of policy, and how that happens” (Walt, 1994:1).

From this perspective, “policy reform is inevitably political because it seeks to change who gets valued goods in society” and the inherent choices it reflects are always “value-laden” even when “presented as a technical decision” (**Reich, 1995:49–50**). Policy itself can thus be seen as embracing three strands: a decision-making process; a set of decisions (the policy as represented in specific programmes of action); and the political intentions and impacts of policy in terms of, for example,

government legitimacy, electoral prospects and the broad values and directions of government (McConnell, 2010).

The approach to health policy analysis represented in the present Reader thus focuses on understanding:

- the political conditions that influence the dynamics of policy change, including prevailing values, group competition, regime stability, timing and the distributional consequences of reform (**Reich, 1995**); and
- the role of policy actors in policy change, how they influence and are themselves influenced by contextual factors, why and how they react to policy design details, the processes contingent on developing and implementing policy and – centrally – how power plays out in these processes (**Walt and Gilson, 1994**).

## WHY DOES HEALTH POLICY ANALYSIS MATTER?

For many people working in this area, Gill Walt and Michael Reich are among the founding scholars of LMIC health policy analysis. Walt is a sociologist with global experience and a track record of research on primary health care, community health workers and international health organizations; and Reich is a political scientist with a track record of research on access to medicines, pharmaceutical policy and the political economy of policy-making, and extensive engagement with Japanese health policy issues. In the early 1990s, both called for a stronger focus on understanding the role of politics and power within health policy processes, and their thinking has influenced subsequent work in the area (see below).

In the 1990s, these two scholars reacted to what they saw as the changing ideas and approaches underlying health policy debates at that time, and both identified the World Bank *World Development Report 1993: Investing in Health* as a document that exemplified the new ideas (**Reich, 1995; Walt and Gilson, 1994**). This Report offered global prescriptions for national health policy reform, with the apparent assumption that their implementation would be relatively straightforward. Yet the *World Development Report 1993* was itself political in the particular prescriptions it offered. It reflected a move away from the health policy ideas of the 1978 Declaration of Alma-Ata on primary health care (WHO, 1978), which were underpinned by principles of social justice and equity and saw health as both a social and a political goal. Instead, against a background of global economic crisis and a new macroeconomic orthodoxy, the *World Development Report 1993* presented a health policy programme founded on the promotion of efficiency, by prioritizing health policies and programmes demonstrating cost-effectiveness and encouraging competition and diversity in service provision (Gilson, 1998). Situated within the rise of neoliberal economic ideas worldwide, the *World Development Report 1993* reflected a different understanding of ways to generate health gain (Rifkin and Walt, 1986) and of the role of the State in health and wider development policy (Reich, 2002), compared with the earlier period.

Observing these trends, Walt and Reich, separately, noted the risks of ignoring the role of politics and power in health policy:

There has been little international policy analysis of reform in the health sector. Yet health is central [in understanding public policymaking]: not only because the economic policies of the state will affect health, but because the health sector itself provides the state with one of the most visible outputs of policy, from ambulances, hospitals, health centres and pharmacies, to nurses, doctors and immunization campaigns (Walt, 1994:4).

The tendency in public health is to portray policy reform as a technocratic or economic process. Both economists and health policy analysts tend to provide detailed prescriptions of what should be done, but without clear instructions on how to do it and without good explanations of why things go wrong (**Reich, 1995:48**).

Both also argued that politics is central to policy and that, using the title of Walt's 1994 book, *Power and Process* are the essence of policy and policy change. They called, then, for new analytical approaches that integrated politics, process and power into the study of health policies.

Their arguments have been restated more recently, particularly in the health promotion field, in ways that highlight the enduring importance of recognizing and understanding the politics of health policy. **Bambra et al. (2005)**, included as one of the papers highlighted in this section, provide a clear and succinct summary of these arguments, suggesting that:

health is political because, like any other resource or commodity under a neoliberal economic system, some social groups have more of it than others;

health is political because its social determinants are amenable to political interventions and are thereby dependent on political action (or more usually, inaction);

health is political because the right to “a standard of living adequate for health and wellbeing” is, or should be, an aspect of citizenship and a human right (**Bambra et al., 2005:187**).

In other words, political factors, often in combination with economic factors, act not only as social determinants of health (CSDH, 2008), but also as critical influences, both over the substance of health policy-making – such as noncommunicable diseases (Buse et al., 2017) and universal health coverage (Savedoff et al., 2012) – and over who has a seat at the policy-making table (Dhatt et al., 2017).

Thus, taking action to improve health and, even more so, to tackle health inequity (CSDH, 2008) demands an understanding of how politics and power influence policy and decision-making. As Gill Walt noted over 20 years ago:

If we as health workers, or as teachers, or students, or civil servants, do not feel that we, and the groups or organisations which we belong to, have some power to alter the policy that affects our lives, or the lives of those around us, why get up in the morning? This book offers a framework for thinking about the various influences on health policy, and can be used as a first step in acting to influence change (Walt, 1994:10).

## OVERVIEW: HOW DO HEALTH POLICIES EMERGE AND UNFOLD IN LOW- AND MIDDLE-INCOME COUNTRIES?

Some of the key scholars and areas of work in health policy analysis are highlighted in this section, with more substantial insights provided in the later sections of the Reader.

Gill Walt's original 1994 textbook was substantially revised and updated in 2005 and 2012 (Buse et al., 2012), with all versions being core texts for those working in this field. Since the 1990s, Michael Reich's body of work has fed another important health policy text (Roberts et al., 2008), and he has supported the development of the PolicyMaker software,<sup>3</sup> an open-access resource for analysing and managing the politics of public policy. These scholars' early-1990s foundational papers provide summary accounts of their thinking, as well as presenting frameworks that can be used in analysing and supporting policy change.

The paper by **Walt and Gilson (1994)** sketches out the debates to which they seek to contribute (see above), outlines the disciplinary roots of their thinking and, from a review of relevant literature, identifies core influences over the ways policies emerge and unfold. These issues are summarized in the health policy analysis triangle framework that the paper presents. Founded on ideas drawn from public policy analysis and the political economy of development (see below), it understands policy and policy processes to be contested, involving multiple actors, with different concerns, interests and values, often in competition with each other and influenced by a range of contextual factors and also by, for example, the timing of policy change and the content – the forms and focus – of specific policies. Power dynamics are a central consideration. Against the wider health policy debates of the time (see above), and cross-referencing Reich's PolicyMaker software, the paper argues:

by using a simple analytic model [...] which incorporates the concepts of context, process, and actors as well as content, policy-makers and researchers will be able to understand better the process of health policy reform, and to plan for more effective implementation. The model can thus be used both retrospectively and prospectively (**Walt and Gilson, 1994:354-5**).

The health policy analysis triangle has subsequently been widely used to understand multiple policy experiences in multiple LMIC settings, with applications that encompass both quite simple descriptive narratives and fuller and more explanatory analyses (Gilson and Raphaely, 2008).

**Reich (1995)**, meanwhile, presents arguments for why reform (policy change) is political, examines these political dynamics through a comparative case study of pharmaceutical reform in Bangladesh, the Philippines and Sri Lanka and briefly introduces the method of political mapping. Drawing from political science theory, Reich's work illuminates the values-based contestation that occurs within policy reform processes, discusses the distributional consequences of reform across social groups and the group competition that results, considers how political timing influences the opportunity for reform and outlines the political risks of policy reform. These ideas inform the analysis of pharmaceutical reforms in three countries that is also presented, generating a set of key political variables that are judged to influence the reforms and that inform the political mapping approach

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<sup>3</sup> See <http://www.polimap.com> (accessed 27 April 2018).

that is proposed. Subsequent work (e.g. Bump and Reich, 2012 and Fox and Reich, 2015) has taken forward such analysis.

A systematic review of the literature on health policy analysis in LMICs for the period 1994–2007 provides an overview of the core elements of this body of work (Gilson and Raphaely, 2008). It highlights three groups of empirical studies: those specifically considering which policies are prioritized in policy agendas (agenda-setting) and policy formulation; those considering experiences encompassing broader processes of policy change; and those specifically addressing policy implementation. All are considered further in Part C.

The interplay between ideas, interests and institutions in policy processes is specifically considered within studies of agenda-setting and priority-setting at national and global levels (e.g. Shiffman and Smith, 2007; see also section C2). They also include analysis of the role of policy networks, globally, nationally and across levels and boundaries, in influencing and implementing policy (see e.g. *Health Policy and Planning*, 2016;31(Suppl 1):1-123; see also sections B3, C1, C2). Such studies commonly draw on political science theory about the influence of interests and institutions, understood as rules, norms, routines, over policy actors' behaviour and about the particular importance of ideas in policy and societal change (John, 1998; see below). As **Shiffman (2009:608)** states:

I draw on a paradigm – social constructionism – used by only a handful of scholars concerned with global health to suggest that the rise and fall of a global health issue may have less to do with how “important” it is in any objective sense than with how supporters of the issue come to understand and portray its importance.

This short and clear paper provides a valuable introduction to social constructivism, an influential perspective in wider policy studies research (see later) that also underlies agenda-setting work in health policy analysis. A more recent and growing area of **work addressing ideas, interests and institutions** focuses on the particular role and influence of evidence and research within health policy processes (e.g. Parkhurst, 2017; see also section C3).

Research on health policy implementation, meanwhile, commonly either presents general accounts of implementation experience or considers the views and experiences of implementing actors (Gilson and Raphaely, 2008; see also section C4). One particular contribution of this work to the broader field of HPSR is its recognition that policy implementation is itself a contested process, in which actors often thought to be relatively powerless – front-line providers and managers, patients and citizens – have influence (Sheikh and Porter, 2010). “Their actions and interactions represent the practices that are ultimately experienced not only as health policy but also the health system” (Gilson, 2012:31). These insights create one link between policy analysis work and the wider world of complexity and systems thinking, with analysts arguing that, since health systems run on the daily microdecisions of local actors, it is developing local coping strategies, rather than more oversight, that is essential for improving health and health system outcomes (Chapman, 2004; Geyer and Rihani, 2010).

Although this Reader places a particular focus on understanding health policy processes within LMICs, it is important to acknowledge the influence of global actors over national and local policy processes (see section B3). Some early work specifically considered, for example, the influence of donors and processes of aid coordination in national settings (see e.g. *Health Policy and Planning*, 1999;14(3)). A wider body of work, not presented here, has considered policy dynamics at the international or global level. This includes the changing ideas and actors involved in international and global health policy (Birn, 2009; Brown et al., 2006), the changing array of, and power balances among, global health policy actors (e.g. Buse and Walt, 2000; Lee et al., 1996), and the development of both global health policy frameworks (e.g. Collin et al., 2002; Lencucha et al., 2011) and wider frameworks with health consequences (Friel et al., 2013). Globalization and health (e.g. Hanefeld, 2015) and the governance space for global health (e.g. Kickbusch and Szabo, 2014) are related areas of work.

## THE POLITICAL ECONOMY OF DEVELOPMENT: EXPLAINING POLICY CHANGE

Both Reich and Walt were influenced by broader work on the political economy of development. Political economy analysis considers the interaction between economic and political factors in explaining policy change.

In the 1980s and 1990s, a range of scholars (e.g. Meier, 1991; Nelson, 1989) sought to understand how these interactions, at both global and national levels, explained LMIC policy responses to the economic crisis of the time. Where earlier economic models of policy reform had assumed the “best” policies would be implemented, the new generation of analyses paid more attention to the

political and institutional factors (e.g. rules, norms, routines) influencing whether and how policy was implemented (Hudson and Leftwich, 2014).

**Grindle and Thomas (1989)**, for example, present an analytical framework that illuminates these factors and their influence over policy decision-making (see also Crichton, 2008; section C2). Their work was specifically acknowledged by Reich and Walt, and their framework is very closely aligned with both the Walt and Gilson health policy analysis triangle and Reich's PolicyMaker analytical approach. This paper, and the associated book (Grindle and Thomas, 1991), present an analysis of 12 LMIC social policy case experiences from the 1980s. These experiences demonstrate that "policy elites" (those with positions in government who make or implement authoritative decisions for society) critically influenced the timing, content and political feasibility of policy change – and were able to bring about significant economic and policy reform. This analysis challenged then-dominant views in two ways – first, by showing that broader economic structures did not determine how policy reform played out, although contextual factors did influence elites' decision-making (see also section C2) and, second, by showing that self-interest or "rent-seeking" was not the primary driver of this decision-making.

Other work at around the same time offers further insights into the importance of understanding policy actors and of seeing policy as a process. The 1989 book by Dreze and Sen, *Hunger and Public Action*, considered what forms of State or government action to address hunger and deprivation are feasible, given the balance of power among interest groups and in society more widely. Ultimately, they argue that public action is needed, i.e. purposive collective action towards shared goals. Such action is enabled in plural political systems where the distribution of power among societal groups supports and allows for public influence on governments. Indeed, it is "essential to see the public not merely as 'the patient' whose well-being commands attention, but also as 'the agent' whose actions can transform society" (Dreze and Sen, 1989:279). The notion of public action is, then, also linked to understanding policy as itself a dynamic social process, rather than a prescription – recognizing that both the situations giving rise to problems and the pressures for policy change are themselves always changing (Thomas, 1998). Policy analysis should "help us to understand the role and influence of different policy 'actors' within specific historical and institutional contexts" (Wuyts et al., 1992:285).

Robert Chambers and Norman Long paid close attention to front-line actors' roles in policy change, and the everyday realities of rural development and societal change (see also section C4). Long's "actor-oriented perspective" focuses on understanding how policies are transformed in implementation and socially constructed through the language and meaning-making practices of political, bureaucratic and social actors (Long, 1992; 2001). In his books, *Rural Development: Putting the Last First* (1983) and *Challenging the Professions* (1993), Chambers called for reversals in development and bureaucratic practice. These included new approaches to management procedures and new forms of evaluation that recognize community and front-line knowledge and allow processes of learning to support social and economic change in the interests of the poor.

Subsequent, related work has provided insights that illuminate the "political conditions" (**Reich, 1995**) and institutional factors that sustain policy implementation for social benefit (see also section C4). Such analysis was, in turn, linked to wider discussion of what entailed "good governance" and how to strengthen it in LMICs (Grindle, 2007).

Judith Tendler's 1997 book *Good Government in the Tropics*, for example, includes a case study about the early development, in one state, of what has subsequently become the widely praised and nationally implemented Brazilian family health welfare programme (see also Tendler and Freedheim, 1994). More recently, Booth and Cammack (2013) examine the factors influencing maternal health care provision in four African countries. Tendler specifically highlights the dedication and motivation of public-sector workers as a factor supporting policy change. She also pays attention to how they were supported, deliberately and accidentally, through a three-way dynamic among local government, civil society and an active central government. Booth and Cammack, similarly, highlight the influence of discipline and motivation among public-sector workers, as well as a context of policy coherence over time, which creates a stable policy environment for sustained change and allows local-level problem-solving to support service delivery. These scholars also argue that new political visions and agreements led by political elites, such as power-sharing arrangements or ring-fenced investment areas, as well as a supportive aid agenda, are important influences.

Another strand of political economy analysis has applied economic theory to politics. It is perhaps best exemplified by Elinor Ostrom's institutional analysis and development framework. Based on a rich programme of work in the United States of America and across a range of LMIC settings, this framework



essentially considers how collective action is enabled through chains of decision-making by multiple actors across multiple levels. It considers how rules, physical and material conditions, attributes of the community and the incentives individuals face influence and affect decision-making (Ostrom, 2007). Batley and McLoughlin (2015) also use economic theory in their framework for analysing how the characteristics of different public services affect the politics of service provision. They suggest that this framework can be used to inform policy responses and organizational reforms.

Overall, however, the political economy work of the last 15–20 years has generally recognized that politics shapes development processes and its outcomes. Although this work has tended to focus on the institutional forces and power balances shaping these processes, the role of leaders and political leadership has also been acknowledged (Lyne de Ver, 2008). Recognizing that political actors have agency within structural and institutional contexts, Hudson and Leftwich (2014) have also more recently called for a deepening of political analysis within studies of development change. They argue that the value of such analysis is that it “focuses on how the structures and institutions of power shape how agents behave, and how they do or can strategize, frame, generate, use, mobilize and organize power and institutions to bring about domestically owned deliberation and appropriate change in the politics of development” (Hudson and Leftwich, 2014:7). Recent work examining the dynamics of African bureaucracies offers important insights in this regard (Bierschenk and Olivier de Sardan, 2014), with particular relevance to policy implementation (see also section C4).

The overall body of development thinking has generated tools for development practitioners that also have value for health policy analysts (see also section D1). The ideas of Grindle and Thomas (1991) fed, for example, into Brinkerhoff and Crosby’s 2002 book, *Managing Policy Reform*, which presents a range of approaches and tools to assess and manage policy reforms that can be used by country-level policy-makers. In the early 2000s, the “drivers of change” and “power analysis” approaches were developed to support donors and inform their programming by assessing the political context (Hyden, 2006; see section B1). More recently, Hudson and Leftwich (2014) provide practical ideas about how to carry out the sort of political analysis that identifies whether there is room for manoeuvre within political realities. Meanwhile, as part of the wider “doing development differently” agenda,<sup>4</sup> there have been calls for “politically informed development programming” (Dasandi et al., 2016) and new forms of analysis and practice for development assistance have developed, such as problem-driven iterative adaptation (Andrews et al., 2017).

Development thinking and practice is, of course, subject to critique. Largely developed by scholars and analysts based in the global north, it stands within the broader development traditions of paternalism, neocolonialism and a liberal modernizing agenda. Yet it does offer insights about the challenges of policy implementation, as well as ideas for how to improve it, that reflect wider policy studies and public administration thinking (see below). Muyumbu (2018) argues that the sorts of methodologies, tools and approaches currently being promoted can “help local actors reconstruct power relations”, “design more sustainable ways for states and communities to overcome obstacles that perpetuate poverty” and “bring together actors and systems to overcome low accountability traps and to bridge the divide between the capability of the state and its legitimation by civil society”.

## POLICY STUDIES AND PUBLIC ADMINISTRATION

Policy studies and public administration are different and yet clearly overlapping fields of work, and both have direct relevance to understanding health policy change (see for example, Balla et al., 2015). Policy studies focuses broadly on the process of policy-making and, from the 1950s and 1960s, is sometimes seen as a subdiscipline of political science. Public administration can trace its roots back into the 19<sup>th</sup> century; however, it has a specific focus on the implementation of government or public policy and is sometimes seen as a subdiscipline of both political and administrative sciences. Although both embrace a concern for the design or content of policies, here we consider in more detail some of their insights for understanding the process of policy change.

As it has emerged, and compared with other social science disciplines, the three key distinguishing features of policy studies are that it is: problem-oriented, deliberately addressing public policy problems to generate ideas about how to address them; multidisciplinary; and value-oriented, recognizing that neither social problems nor analysts are value-free and that policy analysis seeks to promote human dignity and the realization of human capabilities (DeLeon, 2006). As Walt (1994) also notes about health policy analysis, policy studies can be seen as a “‘persuasion’ that aspires

<sup>4</sup> See [www.doingdevelopmentdifferently.com](http://www.doingdevelopmentdifferently.com), accessed 31 July 2018.

to normatively committed intervention in the world of action” (Goodin et al., 2006:6) – it is about values-based action; or, more bluntly, *Speaking Truth to Power* (Wildavsky, 1979).

Policy studies together with public administration research have, moreover, informed the thinking and practice of public management, leadership and strategy. Indeed, this rich line of related work is reflected in the range of related textbooks and guides that have been published over the years (from Hogwood and Gunn, 1984 and Wildavsky, 1979, to Bochel and Duncan, 2007; McConnell, 2010; Moore, 1995; Mulgan, 2009; T’Hart, 2014). Dror (2006) and Cairney (2015) meanwhile consider how to train policy-makers.

## **Origins of policy studies**

Policy studies texts generally trace the roots of their field to the United States in the 1950s, and the move to develop a “policy sciences” field through which a cadre of policy experts would be trained to provide relevant policy advice for Government decision-making (Lerner and Lasswell, 1951). Emerging against the backdrop of rising poverty rates in the post-Second-World-War environment of the United States, policy studies was initially linked to the 1964 “war on poverty”. This committed the federal Government to implementing an array of social programmes, including health-care programmes, to address poverty, and led on to a federal requirement for evaluation and reporting – stimulating both policy design and policy evaluation work (Fischer, 2003). Interestingly, Goodin et al. (2006) comment that this modernist ambition of early policy analysis work could also be seen in the work of the International Monetary Fund and management consultancy groups in the 2000s – in which policies were seen as instruments to exercise control and shape the world.

Early policy analysis was associated with the understanding that policy-making is a rational and linear process, in which problems can be clearly identified, policy goals established and alternative policy options considered and compared in terms of costs and consequences, with policy-makers then choosing the alternative that maximizes the achievement of their goals (Hogwood and Gunn, 1984; Lasswell, 1956). The underlying understanding of the policy process has come to be known as the “policy stages” model or “the stages heuristic” (Walt, 1994).

However, in the United States, even by the late 1960s, the limits of this rationalist understanding of policy change were clear. The social programmes developed were not as successful in alleviating poverty as had been intended. Further inquiry pointed to the political challenges of implementation and the ways in which policy goals get translated in implementation through conflicts, negotiation and interpretation (Pressman and Wildavsky, 1973). Over time, there was growing recognition that complex and sociopolitical problems are not easily addressed by technical interventions; and, in fact, that little of the policy evaluation research undertaken was actually used in policy-making (Fischer, 2003).

This realization led to the emergence of new bodies of policy theory and work that recognized policy-making as a complex social process.

## **Decision-making and power**

(See sections B1 and B2.)

The first, classic age of policy analysis work placed a key focus on the question: why do policies emerge and how do political actors seek to influence them? (John, 2018:3).

Central to every part of the policy cycle, decision-making forms a core area of policy studies theory (Parsons, 1995). Classical theorists include Herbert Simon and Geoffrey Vickers, while Kuruvilla and Dorstewitz (2010) offer a contemporary take on the topic, rooted in pragmatism. They argue that “people across society would prefer that public policy-making is ‘rational’. Sound reasoning should make for well-informed decisions and successful strategies. However, different perspectives proffer conflicting opinions on what constitutes rationality” (Kuruvilla and Dorstewitz, 2010:2).

The positivist model of rationality embedded in the policy stages model had been subject to critique from the late 1950s. Lindblom (1959) argued that the policy process is, instead, one of negotiation, bargaining and adjustment between different interest groups in pursuit of their own concerns (a process he termed “partisan mutual adjustment” or “muddling through”). In later work, he also took account of his critics (Parsons, 1995) in accepting that some interest groups have more power than others because of the range of their resources (e.g. financial, informational, networks), and that many issues are simply excluded from decision-making altogether (Lindblom, 1979). Alford (1975) presented an example of interest group decision-making, considering three sets of interest groups



shaping hospital reform in New York: medical and other health professionals, rational planning groups in government or insurance companies and community health advocates.

While socioeconomic models suggest that the structure of economic and social power determines policy decision-making (John, 1998), other scholars pay more attention to political factors. Dahl (1961) suggested that, in a plural system, even relatively weak groups could exercise power over decision-makers, at least by voting. Bachrach and Baratz (1962) highlighted the possibility of non-decision-making, in which powerful groups keep issues off the policy agenda. Then Lukes (1974) introduced the notion of the third face of power, power as thought control; the ability to shape the meanings and perceptions of others. These ideas were, in turn, underpinned by changing understandings of how power is distributed in society and how that influences the political system (Walt, 1994).

### **Ideas and networks: agenda-setting and policy transfer**

(See sections B3, C1, C2 and C3.)

In the 1980s, a range of United States analyses began to explore how policy change results from the interaction of multiple factors. The role of ideas and argumentation was particularly emphasized (Majone, 1989; Stone, 1989). Indeed, John (2018) observes that three now-classic frameworks developed in this era and all paid particular attention to the role of ideas, alongside interests and institutions, in explaining policy change. These were the frameworks of Kingdon (1984: agenda-setting, multiple streams), Sabatier (1988; Sabatier and Jenkins-Smith, 1993: advocacy coalitions, policy change) and Baumgartner and Jones (1993: punctuated equilibrium, policy change). All offer ways for understanding both policy stability and policy change, and have been applied across multiple policies and in multiple settings (Sabatier, 2007).

By seeing coalitions of interests as central to the shaping of public policies, the advocacy coalition framework drew on the thinking around policy networks first brought into policy studies by Hecl (1978). Policy network theory was then taken forward in the United Kingdom (e.g. Marsh, 1998; Marsh and Rhodes, 1992; Rhodes, 1997). This body of work has identified, for example, different types of networks (highly integrated and closed policy communities versus more open and less stable issue networks), highlighted their role as a source of policy inertia favouring the existing balance of interests (Hudson and Lowe, 2004) and considered the network features and wider factors that shape their ability to influence policy change (Adam and Kriesi, 2007).

The importance of ideas was, in addition, central in the United Kingdom literature on lesson-drawing (Rose, 1991) and policy transfer (Dolowitz and Marsh, 1996), which considers how policy-relevant knowledge is transferred from one time and place to another time and place. There can be transfer of ideologies, ideas and policy goals or more specific policy content, programmes or instruments, but transfer may not always be complete or appropriate. Such transfer generally involves insiders, such as politicians, civil servants and party officials; outsiders, such as think tanks and pressure groups; and global players, such as policy experts, international nongovernmental organizations and supranational governmental organizations (e.g. WHO).

International relations theory has also influenced discussion about policy transfer (John, 1998); for example, through the notion of the epistemic community – a community of experts who transmit and maintain beliefs about the truth and usefulness of particular forms of knowledge (Haas, 1992). Wider international relations theory, meanwhile, supports understanding of global influences over national health policy (see section B3). For example, it considers how international norms influence states, the role of international organizations in disseminating new international norms and models and the efforts of activists to change social understandings and social movements (Finnemore and Sikkink, 2001).

### **New institutionalism**

As noted above, concern for interests and institutions accompanied the focus on ideas and networks. Indeed from the 1980s, and in line with social science developments more broadly, renewed attention was given to understanding how institutions influence the interactions between political actors. This focus on institutions, rather than actors or groups, was seen as providing better understanding of policy processes as they “are the arena within which policy-making takes place” (John, 1998). However, there are various strands of institutional analysis each offering different understandings of what institutions are and how they influence policy-making (John, 1998; Parsons, 1995).

Older studies of political institutions tended to focus on describing formal procedures and administrative processes. In the “newer” work there was greater focus on the way political institutions

influence the distribution of power, constitute rules of behaviour and express the dominant values in a political system. Scholars thus conducted cross-national analyses to consider how differences in parliamentary or presidential systems influence political behaviour (Weaver and Rockman, 1993). They also considered the politics of the bureaucracy, examined central government policy-making, considered central-local systems and examined the influence of institutions on policy change over time (John, 1998).

Immergut (1990; 1992), for example, specifically examined the historical development of the Swedish, Swiss and French health-care systems, and suggested that differences in their political systems explain the different ways their health-care systems developed. She specifically points to the way in which Swiss medical professionals used the veto points available to them to resist proposals for the socialization of medicine. Wider institutional analysis also points to the ways in which policy choices made in the past constrain choices in the future – this path dependency means policy change evolves in a slow, incremental manner. It also shows how the creation of new interests through policy has unintended consequences (Hudson and Lowe, 2004).

To some extent, then, the “new” focus on institutions challenged the rational choice or economics perspective, that self-interest drives political actors and processes (e.g. political parties and elections: Downs, 1957; bureaucracies: Niskanen, 1971). However, new institutional economics, associated with transaction cost economics and agency theory, has maintained the place of an economics perspective in policy studies (Parsons, 1995). Ostrom’s institutional analysis and development framework, developed over the 1980s and 1990s (see above), is situated in this field, and draws on political economy perspectives in seeking to explain collective action.

## **Implementation theory**

(See also section C4.)

Implementation is both a separate focus of policy analysis work in itself, and one that has been informed by broader political analysis. Although sometimes seen as developing only after Pressman and Wildavsky’s widely cited 1973 book, Hill and Hupe (2009) note that implementation research in the United Kingdom (drawing on public administration, sociology and organizational studies, for example) predated this book. They acknowledge, however, that until the end of the 1960s there had been a tendency to assume that administrators broadly did what their political principals expected of them, whereas Pressman and Wildavsky clearly showed the more political nature of implementation.

Hill and Hupe (2009) comprehensively outline the work of the classical top-down and bottom-up scholars that emerged from the 1970s onwards in the United States and Europe. The top-down approach (e.g. Hogwood and Gunn, 1984; Pressman and Wildavsky, 1973) is largely based on the rational model of decision-making. In this tradition, implementation research is broadly concerned with what makes it difficult to achieve the goals set in policy; its recommendations focus on the conditions necessary for successful implementation. In contrast, bottom-up theorists like Lipsky (1980, 2010; street-level bureaucracy), Hjern and Porter (1981; focusing on implementation structures formed across organizations) and Barrett and Fudge (1981; focusing on policy-action interactions) highlighted the forces shaping decision-making at the front line of service delivery. They argued that policy was the outcome of front-line decision-making by, for example, street-level bureaucrats, rather than being the product of central/national-level policy-makers. “In reality, policymaking is still in progress at the moment of delivery. Indeed, it can be plausibly argued that there is no real distinction between policy and implementation” (Hudson and Lowe, 2004:209). Bottom-uppers also pay particular attention to the institutional and organizational influences over front-line decision-making. The key difference is, then, that top-downers essentially focus on hierarchy, discipline and compliance with the demands of policy elites, whereas bottom-uppers are concerned with empowerment and the relationship between service users and professionals at the point of delivery (Hudson and Lowe, 2004). Theorists have also made efforts to bridge the gap between top-down and bottom-up theory, considering, for example, features of policy design (see also political economy work) and the role of networks. Sabatier’s advocacy coalition theory (1988) is commonly seen as a synthesis of top-down and bottom-up insights.

**Barrett (2004)**, one of the leading bottom-up implementation theorists in the United Kingdom, presents a personal reflection on implementation research over three decades (1970s–1990s). The three key issues she considers are: (1) the analytical difficulties of understanding the role of bureaucratic discretion and motivation; (2) the problem of evaluating policy outcomes; and (3) the need to focus on the micropolitical processes that occur in public service organizations. Noting the rise of change management and performance targets in the 1990s, linked to the “new public

management”, she reasserts the continued importance of implementation studies. She identifies three key priorities for future research – recognition of the need to balance control and autonomy in achieving desired performance outcomes, multidisciplinary working and increased attention to ethics and social responsibility in research and practice.

Writing a little after Barrett’s paper, Hill and Hupe (2009) argue that the growing focus on networks in implementation research reflects broader debates about the role of government in society, and the change towards a focus on governance rather than government. They present their own framework, the multiple governance framework, as an approach both for looking at implementation through a governance lens and, more broadly, for understanding the overarching policy process. Inspired partly by Ostrom’s thinking (see above), the framework recognizes that decision-making entails different forms (“action levels”: constitutive, directional and operational governance) and occurs at different levels (“action scales”: individual, organization, system).

## **Evaluation, and the use of research and evidence in policy change**

(See also section C3.)

Evaluation work forms one element of policy analysis IN and FOR the policy process and was initially stimulated by the United States “war on poverty” in the 1960s. Within the ambitious and modernist post-Second-World-War United States policy agenda, this form of analysis strove “to translate political and social issues into technically defined ends to be pursued through administrative means” (Fischer, 2003:4). Particular attention was then placed on rigorous quantitative analysis and the search for generalizable policy prescriptions to address social problems across contexts (Hogwood and Gunn, 1984). The rise in the 1990s of what has been called in the United Kingdom the “evaluative state” further fuelled demands for such evaluation. Indeed, as part of the scrutiny of public services linked to changing ideas about the role of the State in societal development, there has been a global focus on evaluating “value for money”. Such evaluation reflects the idea of a rational policy process, and is founded on the positivist understandings that facts and values are distinct and that facts can be observed and measured (Gilson, 2012). Recent evaluation work has, then, embraced the use of experimental methods, such as randomized controlled trials, to measure the impact of policy interventions and recommend to policy-makers “what works” (Fischer, 2003).

However, over time, critique of the positivist basis of much evaluation work (e.g Weiss, 1991) has led to the use of a wider range of evaluative approaches and methods. These include formative evaluation based on a social constructivist position (Hudson and Lowe, 2004) and evaluation addressing the question “what works for whom in what circumstances?” based on a realist world view (Pawson, 2013). There has also been a growth in research on whether, and how, evidence influences policy-making that recognizes political and institutional forces (e.g. Nutley et al., 2000), drawing on earlier work on lesson-drawing and policy transfer (see above). Policy analysts in the post-empiricist tradition also propose very different roles in policy change for researchers (see below).

## **The argumentative turn and deliberative policy analysis**

Since the late 1970s, policy analysis thinking has been influenced by the broader social constructivist/relativist perspective. In contrast to the positivist position, this understands that social phenomena, such as policies, are produced through interaction among social actors. They do not, then exist independently of actors but are, essentially, constructed through the way actors interpret and make meaning of their experience. Social constructivists focus on understanding people’s intentions, beliefs, values, reasons and the way they make meaning; recognizing also the researcher’s role in constructing knowledge through their own interpretation (Gilson, 2012).

The influence of this perspective can be seen in the recognition that ideas are important in policy change (see above), in changing understandings of power and in the acknowledgement of knowledge as power, for example. Deborah Stone’s (1989) work on causal stories and the formation of agendas is an important exemplar of this line of thinking, and the perspective has also strongly influenced international relations theory (Finnemore and Sikkink, 2001).

One area of work in this tradition relevant to LMIC health policy analysis considers the social construction of target populations within policy design. This theory suggests that public policy-makers develop ideas of target populations “in negative and positive terms and distribute benefits and burdens so as to reflect and perpetuate these constructions” (Ingram et al., 2007:93). Their thinking and ideas are shaped by the need to secure public approval or offset public concern. Policy designs are thus informed by previous experiences and the existing distribution of power, and influence both the subsequent opportunities for participation in policy-making and the allocation of material resources.

Possibilities for changing the underlying social constructions of target groups lie in the unanticipated consequences of previous policy designs.

Fischer (2003) also argues that the distinction between understanding of the world and how to “know” about it, underlies the divergence in policy analysis between those who seek to understand the causal pathway of policy change and those who have focused more on argumentation and discourse.

Some social constructionists question the positivist belief that the world exists entirely independently of human observation, but accept that truth claims about the world can be examined empirically (**Shiffman, 2009**). Paul Sabatier, for example, has developed the advocacy coalition framework theory as a causal account of policy change that is specified in ways that allow its testing and further development. The first edition of his 2007 book *Theories of the Policy Process* (see also subsequent editions) also presents a wider selection of causal theory – and identifies from each theory a set of propositions about critical relationships among the multiple factors explaining policy change – that can be empirically tested and so further developed.

In contrast, Fischer and Forester (1993), Fischer (2003), and Hajer and Wagenaar (2003) represent a post-empiricist or post-positivist tradition of work that rejects the very idea of being able to test and prove or verify explanatory propositions, which, they judge, serves to support the dominant political elites. Instead, they understand public policy to “take shape through socially interpreted understandings” and the politics of policy-making to be, then, “the discursive struggle to create and control systems of shared social meanings” (Fischer, 2003:13). Building on the early work of Rein (1976), who called for more focus on the role of social values, and Majone (1989), who wrote about *Evidence, Argument and Persuasion in the Policy Process*, post-empiricists seek to understand the competing meanings and values that drive policy actors and how they interpret policy (Fischer, 2003). They pay particular attention to language, discourse and communicative power in the policy process. They have considered, for example, the meanings that policy has for different social actors, how policy meanings are transmitted and the “frames” used in meaning-making – seeing policy-making as storytelling and thick description as essential to the analysis (Fischer, 2003). They have also developed particular analytical approaches for interpretative (Schwartz-Shea and Yanow, 2012; Yanow, 2007) and discursive (e.g. Bacchi, 2016) analysis of language, documents, objects, acts that carry meaning for policy issues.

Finally, post-empiricist policy analysts argue that the policy analyst should act as a facilitator of dialogue and deliberation in the policy process (Fischer, 2003). This form of participatory or deliberative policy analysis seeks to provide access to, and explanations of, data for policy actors, empower the public to understand analyses and promote serious public discussion among decision-makers, citizens and analysts (Hajer and Wagenaar, 2003). In some ways reflecting the concerns of bottom-up theorists (see above), such approaches are also reflected in the wider political theory debates about deliberative democracy (Dryzek, 2000) and concern for a social science that matters (Flyvbjerg, 2001).

**Fischer and Gottweis (2013)** provide a useful overview of the thinking and practice of the argumentative turn for health policy analysts. In this reflective essay, these two leading scholars take stock of 20 years of thinking, noting that they did not develop a systematic theory of argumentation and discourse in the policy process. They present their critique of positivist policy analysis as well as deductive explanation (theory testing), outline the core elements of their thinking and consider its implications for governance. They argue that the role of the public servant should be “a facilitator of public engagement” and the public administrator, “the creator of communities of participation” (**Fischer and Gottweis, 2013:430**).

### **What are the main lines of policy analysis thought?**

Goodin et al. (2006) provide a useful summary of critical, sometimes interlinked and sometimes competing, strands of policy analysis thinking as it has developed over the years.

- Politics and policy-making are largely a matter of persuasion – policy-makers must carry people with them, to have legitimacy and for their decisions to be accepted.
- Policy is about arguing and bargaining.
- Governing is less a matter of command and control through hierarchical authority and more a matter of negotiating sets of decentralized alliances or networks.
- As networked governance becomes dominant, policy-making is about steering not rowing – top-down, command-and-control practices are limited.

- Path dependency limits the conditions for new policy development.
- Policy-making is always a matter of choice under constraint.
- Policies change for many reasons, and sometimes because the people subject to policies want them to change.
- Policy gets made in response to problems, but what is perceived as problematic is itself not fixed, and changes over time.

## THREE CONCLUDING THOUGHTS

Reflection on the intellectual traditions outlined above offers three key takeaway points for the budding health policy analyst.

First, the argumentative turn of Fischer (2003) and others, as well as the earlier work of Chambers (1983; 1993), asks questions about how you understand the world – and thus, also, how you understand policy change.

Those who think the policy process is rational and that better evidence can by itself improve health policy might find the field uncomfortable. As the theory outlined here makes clear, there are multiple and complex influences over policy processes, including ourselves as researchers and managers. Those who recognize these multiple factors then need to decide whether they are more comfortable researching it, or whether they would prefer to become public managers and leaders, or even facilitators of deliberative processes; or perhaps, more realistically, what combination of roles makes sense for where and who you are.

Whatever position you adopt, it is worth remembering that policy analysis is an art and a craft, not a science (Wildavsky, 1979).

Second, there is much to learn from those who have already sought to understand and engage with policy processes. The overviews of theory provided here represent a starter pack for the budding health policy analyst, rather than a comprehensive or exhaustive outline of any intellectual tradition. They are presented to encourage analysts to get to know their field, read up on its origins and learn from experience outside the health sector. Working with theoretical lenses is simply part of being a health policy analyst.

It is also important to note critical issues across intellectual traditions. These include the focus on understanding what power is and how it plays out in policy change; understanding institutions, the form they take and the way the influence actors' behaviour; or on thinking about how policy design itself shapes the wider policy process and its political consequences. A central point of connection is in the interaction between structure and agency.

Comparison of these issues against the current body of health policy analysis work in LMICs points to research gaps. One such gap is the limited consideration so far given to the place of ideas in health policy and policy change.

**Koon et al. (2016)** argue that little work has so far been conducted to consider frames and framing in health policy processes, basing their argument on a scoping review of relevant literature. Frames are the ways actors make sense of the world, and framing is argued to offer insights into the nature of political debate by providing an explanation of both structure and agency in the policy process. Indeed, these authors conclude that framing can help researchers and policy-makers to understand opaque and highly charged policy issues, and that this may facilitate the resolution of protracted policy controversies (see the discussion of the “argumentative turn” above). The paper outlines the underlying theory, considers the relevant health research and presents a set of 11 questions to consider when conducting future research on frames and framing.

**Béland and Ridde (2016)** then consider the role of ideas within policy implementation processes, noting that little of the relevant theory addresses implementation specifically. Using the example of user fees in Africa, they discuss the possible role of ideas in policy implementers' resistance to this policy change. Finally, they identify three propositions that could direct future, related research: “1. The ideas actors involved in the implementation process have about specific policy problems and solutions can help account for the success or the failure of this process; 2. The more these actors witness implementation problems, the more they are likely to oppose the policies being implemented; and 3. The greater the gap between the policy solution at hand and the assumptions

of these front-line workers, the more likely implementation will face opposition on their part” (**Béland and Ridde, 2016:19**).

Third, in the further development of LMIC health policy analysis work we must engage more closely with the political theory and analysis of our own countries and regions, as well as considering the particular actors, interests, ideas and institutions shaping health as a particular terrain of policy and action. **Olivier de Sardan and Ridde (2015)** provide useful reflection on key lines of policy analysis thinking and their links to the broader field of HPSR, as well as discussing particular contextual features of Sahelian Africa (Burkina Faso, Mali and Niger) relevant to consider in analysis.

Policy analysts must also, and finally, keep our eyes on the wider, ever-changing context – as it brings new opportunities and challenges for health policy change. The global digital revolution, linked to the rise of social media and current debates about “fake news”, is only one relevant example, that may support action to tackle inequality, or deepen it.

## RESOURCES

### List of selected papers<sup>5</sup>

Ten papers were selected to illuminate this section, and are presented above.

The two exemplar papers included in the Reader for this section are **Reich (1995)** and **Walt and Gilson (1994)**.

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Béland D, Ridde V (2016). Ideas and policy implementation: understanding the resistance against free health care in Africa. *Glob Health Gov.* 10(3)  
(<http://blogs.shu.edu/ghg/files/2016/12/2016-Winter-Special-Issue.pdf#page=9>).

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<sup>5</sup> All websites accessed 31 July 2018.



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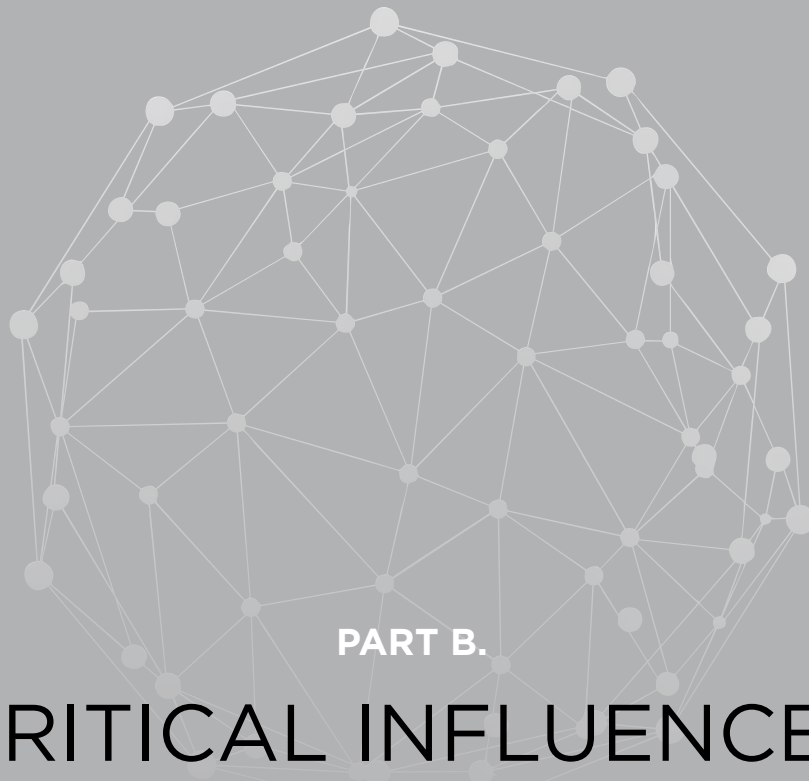


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## PART B.

# CRITICAL INFLUENCES OVER HEALTH POLICY PROCESSES IN LOW- AND MIDDLE-INCOME COUNTRIES

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# B1.

## POWER IN POLICY CHANGE

*Lucy Gilson and Jeremy Shiffman*

### INTRODUCTION

The exercise of power is the central phenomenon within every policy process. Indeed, understanding power is essential in sustaining the policy change needed to tackle existing health inequalities and transform health systems (Sriram et al., 2018). However, LMIC empirical research on health policy processes often fails to consider power adequately (Gilson and Raphaely, 2008). It is imperative to address this weakness in future analysis and research – and this section of the Reader presents a set of empirical and conceptual papers that explicitly address power and policy change, to support deeper and more critical inquiry.

Power is, of course, the core focus of a huge body of social and political theory. In analysing health policy processes, our central focus is on understanding the nature and forms of power, and how the exercise of power supports and enables policy change, as well as how it underpins resistance to such change. It is also important to recognize that power is as central to policy implementation as it is to, say, agenda-setting.

One relevant definition of power is that it is “the ability to influence people, and in particular to control resources” (Buse et al., 2012:21). Such power is relational, exercised in relation to people and resources and to policy change itself. The discretionary power exercised by front-line officials in implementation, more specifically, entails choices “among possible courses of action and inaction” (Davis, 1969:4), and can be seen in, for example, the way implementors adapt or subvert policy rules, or how they engage with their clients. It occurs because there are limits on the power that can be exercised over them by higher-level authorities. Power always has multiple dimensions, however, and is generated from, or constrained by, the broader societal, political and organizational context of policy decision-making.

Sriram et al. (2018) usefully highlight the fact that the wider body of power theory offers insights on power sources (how power emerges), dimensions (how power is channelled) and expressions (the ways in which power is overtly or covertly expressed). They also note that this theory emphasizes that power is exercised both formally and informally: for example, not only by those whose obvious and legitimate political or bureaucratic positional power allows them to instruct others, or demand compliance from them, but also by those whose personalities and ways of behaving, or technical expertise, allow them, in particular contexts, to influence others.

Power sources, then, include technical expertise, political and bureaucratic power, financial power, networks (based in turn on, for example, collective knowledge and action), and personal attributes. Bourdieu’s forms of capital (1986/2008), meanwhile, go beyond positional and economic power, to acknowledge the importance of cultural capital, that is, power gained from education, academic titles and knowledge (which has particular resonance in the field of global health), as well as social capital (the power of networks and connections) and symbolic capital (power emanating from ceremonial office, for example).

In addition, theory illustrates that power is exercised both in ways that can be seen, and in ways that are hard to observe. Stephen Lukes, a prominent policy theorist (1974; 2005), argues, for example, that there are three faces of power in policy change. First, holding a particular position in the political or organizational hierarchy gives that person the power to take certain decisions. Second, however, power can be exercised by policy actors “behind the scenes” to keep issues off the decision-making agenda (non-decision-making). Third, which is even harder to see, power can be exercised by influencing the preferences of others to accept or comply without much thought with existing conditions or policies, and so prevent the possibility of policy change, or of adopting new behaviours.

This “thought control” form of power can be seen, for example, in how commercial forces (in the tobacco, food, beverage and alcohol industries) have insidiously encouraged lifestyle and eating choices that underpin the global chronic disease epidemic (Kickbusch et al., 2016), as well as in the ways in which the dominant forces of gender, race and sexuality, among others, have prevented policy

action to address abuse and discrimination. **Burgess and Campbell (2016)** address the influence of gender power relations and patriarchy over social policy change in Uganda, for example (see below). As Sriram et al. (2018) note, additional insights about this “thought control” form of power are offered by Foucault (1994) and Gramsci (1999), who point out that “the socially accepted truths”, which shape and limit discourse, are the core dimension of power. Bourdieu (2008) and Giddens (1984) suggest, moreover, that while power can be exercised proactively by actors (demonstrating agency), actors are at the same time constrained and influenced by the social structures in which they exist. Although not a focus within this Reader, the ways in which such forces directly impact on people’s health is, of course, always important to recognize in public health work (Farmer, 2004).

## SELECTED PAPERS

The 10 papers selected for this section purposely combine papers reporting empirically based health policy analyses in which power has been explicitly examined, and papers providing conceptual insights about power. The two exemplar papers included in the Reader for this section present an empirical analysis of policy change in Niger (**Dalglisch et al., 2015**) and a conceptual (descriptive) framework focused on the practice of discretionary power in implementation (**Gilson et al., 2014**) that was derived through a review and synthesis of existing empirical work.

We briefly describe each of the 10 papers below, as well as our rationale for selecting them as illustrative examples of ways to examine power in policy change.

Among the six empirical papers, two illuminate the exercise of power in national experiences of health policy change.

First, **Dalglisch et al. (2015)** consider how three forms of power, political authority, financial resources and technical expertise, interacted in the *successful development and implementation of integrated community case management in Niger in late 1997–2011*. The authors also explain how the neopatrimonial State context underlay the power dynamics observed and, in this instance, supported successful policy implementation, emphasizing the importance of contextual understanding for policy analysis (see also section B2), and provide insights on how external actors (donors) can work within such a context to promote “pro-poor” policies. The paper’s rich discussion is complemented by a useful methods section, including a set of guiding questions for this form of power analysis (see also section D2).

Second, **Koduah et al. (2016)** examine how power dynamics influenced *Ghanaian maternal health policy agenda-setting and formulation over a 10 year period (2002–2012)*. More specifically, the paper presents a very detailed analysis of the institutionalized health policy dialogue processes, involving national-level Government actors and donors, through which five-year programmes of work (strategic plans) are developed. The analysis was based on participant observation as well as interviews and document review. The paper explains how policy actors drew on different sources of power to define maternal health problems and frame their policy narratives as they negotiated policy change through these processes over the period of focus. It illustrates how specific maternal health policy issues were either reinterpreted over time (obstetric care), or disappeared, to reappear unchanged (family planning) or were expanded over time (user fees for maternal care). The specific power sources identified included legal and structural authority; access to authority by way of political influence; control over and access to resources (mainly financial); access to evidence in the form of health sector performance reviews and demographic health surveys; and knowledge of broader national plans.

**Mwisongo et al. (2016)**, meanwhile, specifically examine how power played out in a coordinated programme of policy dialogues convened to support *the development of national health policies, strategies and plans to support progress towards universal health coverage in five African countries (Cabo Verde, Chad, Guinea, Liberia and Togo)*. Policy dialogues are increasingly being promoted to support the use of evidence in policy-making and to achieve interactive and inclusive policy-making. Across the five countries, the dialogues included some held at community and facility level, as well as at district and national levels, and were supported by the European Union, WHO and the Government of Luxembourg. In an unusual analysis, drawing on the power framework of **Arts and Van Tatenhove (2004)** (see below), the paper presents a detailed analysis of the exercise of actor power within these dialogues, considering both how power enabled and constrained engagement among the actors involved and how decision-making unfolded.

The analysis also illustrates the ways in which the broader context, and changes within it, influence power dynamics among actors (see also section B2).



**Abihiro and McIntyre (2013)** then present a stakeholder analysis, undertaken in 2010/11, around a *proposed financing policy change in Ghana (premium payments under mandatory National Health Insurance)*. This quite widely used form of analysis within health policy analysis work focuses on explicitly understanding actors' power and positioning around a specific policy, and so allows consideration of the political feasibility of a new policy. The paper thus includes specific assessment of the sources and levels of power of key policy actors, and offers useful ideas for ways of representing and presenting the findings of such an assessment. It also well illustrates the fact that the devil is often in the detail in relation to policy change – in the sense that actors' reactions to very specific, and perhaps poorly thought-through, aspects of policy design may themselves undermine the feasibility of the reform.

The ways in which wider social forces can act to block social and health policy change is demonstrated, unusually, in the paper by **Burgess and Campbell (2016)**. In this case, the authors show how gender power relations and patriarchy in Uganda threw up obstacles to the *development of the Ugandan Marriage and Divorce Bill*, which was intended to strengthen women's agency in marriage. Initially tabled in parliament in 2009, the bill was eventually shelved when it was debated in 2013. Founded in a social constructivist perspective, the authors' analysis suggests that the obstacles the bill faced included the understanding and manipulation of concepts such as "culture" and "custom" in public discourse, the impact of economic inequalities on women's understanding of their gendered interests and women's low degree of trust in the law and the political process. The paper well illuminates the influence of Lukes' third "face of power" over policy change in shaping the way many women understood their interests, and considers the implications for conceptualizing agency, gender and social change as tools for gender policy.

Finally, **Lehmann and Gilson (2013)** present an explicit analysis of the exercise of power in policy implementation, considering *experience in one South African province in the early 2000s, with respect to two competing community health worker policies*. Drawing on VeneKlasen and Miller's (2002) categorization of multiple dimensions of power (power over, power with, power to and power within), the paper illuminates how almost all the policy actors considered therein exercised some form of power – from authoritative power, derived from hierarchy and budget control, to the discretionary power of those working at lower levels to withhold labour or organize in-service training. Each of these exercises of power had their rationale in different actors' efforts to make the intervention "fit" their understandings of local reality. While each had a limited impact on policy outcomes, their cumulative effect produced a significant "thinning-down" of the policy's intent. However, and importantly, one manager's use of discretionary power led to a partial reconstruction of the original policy intent. The authors argue that the exercise of discretionary power does not, therefore, always undermine policy implementation, and so can be an important resource for implementation towards policy goals.

These empirical pieces are complemented in this section by four papers providing conceptual insights about the nature and practice of power in policy change. Drawn from different policy analysis traditions, the papers offer insights about the nature of power as it influences all stages of policy change. They are presented to encourage LMIC health policy analysts to understand broader thinking about policy and power.

Two papers are drawn from the development studies literature, and reflect the move towards recognizing the importance of "good governance" and citizen engagement for development in LMICs. **Gaventa's (2006) power cube framework** (see also [www.powercube.net](http://www.powercube.net)) has been promoted as particularly useful for civil society organizations and activists seeking to understand power dynamics, in order to influence policy change. The paper outlines both related power concepts and the framework itself – which combines Lukes' three faces of power with the recognition that power can be exercised at or across multiple levels (local, national and global) and within different spaces (closed, invited, claimed/created). The value of this framework lies in its recognition of the multidimensional and dynamic nature of power, and in its potential use in both understanding power dynamics and supporting strategy development (see also section D1).

Rooted in a summary of 40 years of wider development debates and policies, **Hyden (2006)** argues that the move towards a focus on "good governance" from the 1990s required that donors take power seriously in understanding the political and social realities of African countries. It is these realities, he argues, that determine the effectiveness of reforms, policy interventions and donor programmes. He presents a *framework for conducting "a power analysis"* that entails consideration of the constitution and distribution of power (considering socioeconomic structures and informal institutions, i.e. informal relations, incentives and rules) and its exercise and control (human agency) across the various stages of the policy process (agenda-setting, formulation, implementation and the effects achieved). The paper's reflection on development policy debates offers value for health

policy analysts (see section A), as does its focus on the range of social and political factors that will influence power in the health sector.

**Arts and Van Tatenhove (2004)**, meanwhile, are European policy analysts, whose *power framework*, as noted, is used by Mwisongo et al. (2016). Again reflecting the focus on “governance” in public policy analysis from the 1990s, these authors seek to reaffirm the importance of power in understanding and explaining policy practices. The paper briefly describes the policy arrangements approach that they had previously developed to understand how policy domains (such as health policy) are shaped in particular settings at particular times. It recognizes, like the powercube framework, the multilevel nature of governance (see also section C2). The paper then highlights and discusses three layers of power: relational power linked to agents and policy innovation; dispositional power, rooted in policy arrangements, rules and resources, which shapes actors’ capacity to act; and structural power, the macrosocietal forces that both shape the conduct and nature of individuals and organizations and are, ultimately, changed through human conduct.

Finally, **Gilson et al. (2014)** specifically highlight the *exercise of power in policy implementation*. These authors present a qualitative synthesis of empirical papers reporting experience with implementing decentralization policies and a range of reproductive health policies. They identify the multiple practices of discretionary power (expressed in action and the failure to act) exercised by front-line health workers and managers or street-level bureaucrats (Lipsky, 1980; 2010). In addition, they generate a conceptual framework highlighting the forces shaping the practice of this “discretionary power”. This framework emphasizes the ways in which a new policy interacts with the context in which it is implemented (see also section B2), as well as the actors responsible for its implementation; and points to the potential for the exercise of discretionary power either to promote or to undermine the achievement of policy goals and, wider public value. The authors also discuss the implications of this framework for thinking about how to manage the exercise of power in policy implementation (see also section D1).

The 2018 *Health Policy and Planning* paper, “10 best resources on health policy and systems in low- and middle-income countries” (Sriram et al., 2018) provides an additional and excellent companion piece to this set of papers.

## FUTURE RESEARCH

These 10 papers offer a range of conceptual starting points about how to think about, and so research, power in policy change. Other relevant theory so far barely used in LMIC health policy analysis work includes that of Bourdieu (see above). (See also section B3.)

All papers point to the importance of understanding the context of policy change, in order to understand the power dynamics playing out in experience. National and local context factors are considered further in section B2, and international power dynamics as an influence over national policy-making experiences are considered in section B3.

Finally, the papers also provide practical ideas about how to investigate power dynamics (e.g. **Abihiro and McIntyre, 2013**; **DalGLISH et al., 2015**; see also section D2) and how to present analyses that foreground power dynamics. The paper by **Burgess and Campbell (2016)** is noteworthy because it illuminates the power of thought control, a hard-to-see face of power.

## RESOURCES

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## B2.

# NATIONAL CONTEXTS

*Lucy Gilson and Irene Akua Agyepong*

## INTRODUCTION

Analysing context or, more specifically, the political economy context, is critical in understanding any policy process (**Walt and Gilson, 1994**).

However, empirical research in public health is commonly criticized by social scientists for ignoring the ways in which sociopolitical contexts influence policy-making, focusing instead on epidemiological and demographic factors (Navarro, 2008; Russell et al., 2008). Ostebo et al. (2017) consider this criticism in relation to the Ethiopian Health Extension Program. From a review of relevant public health literature, the authors found that the vast majority of publications ignore the larger political context, with nearly 80% containing no mention of the term “political”. They argue that this silence leads to a focus on political will and strong political leadership, and on particular individuals, as core factors explaining success, ignoring how the broader political context might influence popular participation or State legitimacy, with consequences for health system development. Yet, as recognized in the wider terrain of policy and development studies theory, politics matters to policy (see Part A above).

Those conducting health policy analysis must, then, proactively engage with the policy context. It is not simply the background against which policy processes unfold, or a factor shaping the scale and scope of the problems that policies seek to address. Rather, it is always a source of critical influences over policy decision-making. The national sociopolitical context has a particularly important influence over actors’ values and interests, and thus their reactions to policies, as well as their opportunities to participate in decision-making. As the papers in section B1 illustrate, such factors also influence the sources, forms and levels of power that policy actors draw on within policy processes. Other contextual factors influence the availability of financial, managerial or technical resources (Grindle and Thomas, 1991). All must be considered as part of the policy process, in order to understand how decision-making unfolds.

So, which features of context must be considered in health policy analysis work?

Three context categorizations that offer useful pointers and are currently quite widely used within LMIC health policy analysis are those of: Collins et al. (1999), with an LMIC health policy focus; Grindle and Thomas (1991), addressing development policy experiences in LMICs; and Leichter (1979), drawn from comparisons of British, German, Japanese and Russian experience. The table below presents a synthesis of key contextual factors across these frameworks, and provides examples of the influences of these factors over health policy change.

Overall, the table illustrates that these influences encompass:

- both national/local factors and global/international factors – global actors and influences are considered further in section B3;
- more permanent, structural factors (economic and political systems) and more transient, timebound, situational influences (epidemics, natural disasters);
- factors widely acknowledged in public health and health systems work (demographics, epidemiological profiles, macroeconomic factors) and those social factors less often examined in these traditions (political systems, ideology, culture, history, other policies).

**Table 1. Contextual influences over policy change**

Contextual features	Influences – for example
Sociopolitical pressures and interests e.g. electoral cycles, socioeconomic structures, gender relations, dominant or contesting ideologies	<ul style="list-style-type: none"> <li>• Which interest groups have what level of power</li> <li>• Policy elite perceptions of what is feasible</li> <li>• Other actors' perceptions of their interests and concerns</li> <li>• Use of State resources for patronage</li> <li>• Timing of policy</li> <li>• Implementation feasibility</li> </ul>
Historical context e.g. legacy of colonialism	<ul style="list-style-type: none"> <li>• Forms of governance</li> <li>• Nature and functioning of civil service</li> <li>• International alliances</li> <li>• Collective memories – what public policy action is deemed appropriate</li> <li>• Legitimizing values</li> </ul>
The national political and legal system e.g. State governance structures, systems of accountability	<ul style="list-style-type: none"> <li>• Policy elite perceptions of what is feasible</li> <li>• Who participates in formal decision-making processes</li> <li>• Which actors have which levels and forms of power</li> <li>• Levels and forms of accountability</li> <li>• Legitimacy of State action</li> </ul>
National economic conditions and policy e.g. macroeconomic situation and policy, state role in national economy	<ul style="list-style-type: none"> <li>• Timing of policy change</li> <li>• Resource support for policies</li> <li>• Social policy options</li> </ul>
Administrative capacity (skills, structures)	<ul style="list-style-type: none"> <li>• Capacity to marshal the range of necessary resources to support implementation</li> </ul>
International context e.g. international events, agreements, resources	<ul style="list-style-type: none"> <li>• Economic conditions (and policy)</li> <li>• Dependency relationships with external actors</li> <li>• Norms driving policy change</li> </ul>

Many factors highlighted in the table are relevant across contexts; some are clearly most relevant in LMIC settings. These include the legacy of colonialism, which has also shaped the forms of national and local governance within countries, the place of the civil service within government, and current-day international economic relationships. It is always important, then, to consider the specific features of each policy context and to recognize the layers of influence within it. Grindle and Thomas (1991:39) argue that historical factors influencing decision-making include the “collective historical memories of national experiences such as wars, revolutions, invasions, coups, depressions, and the triumphs and myths surrounding great national leaders and periods of nationalist assertion and expansion”, all of which “help establish what is considered to be appropriate policy, what is an appropriate role for the state, and what values are appropriate for legitimizing policy choices”. They also note that a key characteristic of policy-making in many LMICs is uncertainty – given limited data, rapid demographic and epidemiological change, vulnerability to natural disasters and fragile economies strongly influenced by global forces.

Although the factors highlighted in the table above have a bearing on every stage of decision-making, additional organizational and local-level contextual factors are also relevant to policy implementation (see also section C4). These include organizational capacity and culture, linking also to the pattern of centralization/decentralization in the health system and the nature of local-level relationships, local histories and cultures and the multiple other policies already being implemented and that may conflict with, or enable, a new policy.

Finally, it is always important to remember that contextual factors interact with other factors in influencing policy decision-making. On the one hand, while contextual factors influence interest groups or policy actors' positions and power, policy actors also have some “room to manoeuvre”. As Grindle and Thomas (1991) argue, the “policy space” for change is dependent on the ability of what they call policy elites (those with positions in government who make or implement authoritative decisions for society) to use the technical, economic, political and bureaucratic resources available to them.



On the other hand, the personal context of these elites and their values, ideologies, professional expertise, past experiences, position, commitment and loyalties in turn influence this ability.

## SELECTED PAPERS

The 10 papers included in this section have been chosen as they provide varied and rich insights into the national and local contextual influences over health policy change in LMICs. The two exemplar papers included in the Reader highlight the particular influence of sociopolitical factors over national-level policy-making (**Carbone, 2011**) and over policy implementation (**Olivier de Sardan et al., 2011**). We briefly describe each of the papers and our rationale for selecting them as illustrative examples of the national contextual factors relevant in examining LMIC health policy change.

Four of the 10 papers focus primarily on context rather than a health policy experience, illuminating the macropolitical, societal and health system factors, that influence policy decision-making. These papers offer ideas about contextual factors to examine as part of understanding policy change.

**Flores et al. (2009)** consider the nature of power relations within society and its implications for social participation as a means to demand and realize human rights. More specifically, they discuss the *contextual forces influencing public participation and societal power relations within Guatemala*, and strategies for enhancing that power. They explore how decades of repression, conflict and violence disempowered citizens and undermined trust in the State. They also identify the new spaces for participation emerging in the mid-2000s, and suggest that civil society organizations could work through these spaces to help rebuild trust between the State and citizenry – including by addressing demands for health service improvements. Drawing on the language of the powercube (section B1), they suggest that these organizations could garner power to hold the State accountable by expanding spaces of citizen participation, using health system issues as an entry point.

In their historical, cross-country analysis of *experience in five Asian countries (Cambodia, Myanmar, Mongolia, People's Democratic Republic of Korea and Timor-Leste)*, **Grundy et al. (2014)** consider, first, how health systems are shaped by, and infused with, historical and political forces, and, second, *how health system development is influenced by the combination of technical policy directives and sociopolitical forces*. This paper shows how political and health system reform interact and together act as context for future policy development. For each country, they track political economy, health system and health policy timelines over 30-50-year periods. They argue that the cross-country analysis shows that technical, health policy directions exert pressures towards specific health goals, whereas broader sociopolitical factors exert pressures for macro-level economic, administrative and political reform. During times of political and social transition, caused by conflict, liberal economic reforms and political transformation, sociopolitical pressures may themselves lead to radical redirection of health policy. Rather than directing the change, health policy-makers must then navigate in a transformed sociopolitical terrain. The authors assert that “[by] recognizing the historical and political foundations of policy and systems change, policy-makers and development specialists will be better informed of the feasibility, challenges and boundaries for realistic health policy reform in such settings” (**Grundy et al., 2014:158**).

An in-depth, historical analysis of *health system decentralization in Ghana* (**Kwamie et al., 2016**) then illuminates how district-level managerial decision-making space has expanded and contracted over 30 years, given the multiple and parallel processes of administrative, financing and political decentralization. Despite earlier efforts to strengthen the district level, at the end of the period examined the balance of power continued to favour national policy actors. The development of the Ghana Health Service, including the formalization of district health management structures and appointments, counterintuitively led to a centralization of power, given, for example, pre-existing administrative centralizing tendencies and the upwards accountability associated with the nature of the new district financing mechanism. Overall, the paper illuminates the multilevel nature of bureaucracies and the changing balance of power between national and lower levels that is a common influence over health policy implementation. Although implementation is often seen primarily as a process of the local level, the multilevel nature of bureaucratic structures means that it is always influenced by higher levels and the enduring contestation between levels represents an important part of implementation complexity.

Finally, for this group of papers, **Olivier de Sardan (2011)** offers important insights into *local contextual features that influence policy implementation*. Based on wider and long-term anthropological research in Niger, the paper outlines eight coexisting and overlapping archetypes of “local governance” through which goods and services, including health care, are delivered. These eight archetypes are:

the chiefly mode of local governance; the associational mode; the municipal mode; the project-based mode; the bureaucratic mode; the sponsorship-based mode; the religious mode; and the merchant mode. Some of them are legacies of the colonial period, while some arise out of post-independence political transitions and some from northern-driven development policies. Each comprises both a set of official norms and procedures and an, often different, set of “practical norms (patterns of informal shared practices which move around, or outside of, official norms)” (**Olivier de Sardan, 2011:29**) which concern “collective action, power and the delivery of goods and services” (**Olivier de Sardan, 2011:29**). Each has adapted and changed over time, and while they coexist, their particular influence varies across levels and geographical areas. The author argues that it is the particular mix of modes of governance, and balance of official and practical norms, that represents local political culture and that shapes political behaviour – influencing health service delivery and policy implementation. A wider body of work provides further evidence of the influence of these local governance contexts and practical norms over policy implementation (see section D4; Bierschenk and Olivier de Sardan, 2014).

The remaining six papers show how clearly identified contextual factors influenced specific experiences of health policy change.

**Smith (2014)** presents a comprehensive analysis of *maternal health policy development and implementation in India through a comparison of experience over time across two states with varying maternal health outcomes (Tamil Nadu relatively better and Karnataka relatively worse)*. Drawing on the process-tracing methodology (George and Bennett, 2005), the analysis specifically considers the constitutional, governing and social structures and political contexts in each state, as well as the actors and ideas (and other forms of power) influencing policy change. It illuminates, then, the historical, bureaucratic and political contextual dynamics that explain these states’ differing policy experiences. The author argues that the Tamil Nadu experience particularly highlights the influence of historical factors, and social movements specifically, on its stronger maternal health performance. In contrast, in Karnataka weak public health management and variable district governance were explanations of its relatively poor performance. Across states, stable values and priorities around maternal health offset the possible influence of changes in political regimes on policy.

Writing from a political science perspective, and presenting an historical argument based on review of relevant literature and documentation, **Carbone (2011)** specifically considers *how the move from authoritarian rule to democracy in the early 1990s influenced health financing reform in Ghana*. By comparing experiences between two time periods around a particular political change (the new Government of 2000), he analyses how the political dynamics unleashed by democracy led to the speedy introduction of the National Health Insurance Scheme by a new Government whose ideological principles might have been expected to run counter to this type of policy. The analysis thus pays attention to electoral competition as a trigger for health policy change, while also recognizing the influence of past experience (unpopular user fees alongside community-based and Government insurance scheme pilots) and international ideas (the promotion of universal health coverage). This paper provides important background for other available reports of this Ghanaian experience, including **Agyepong and Adjei (2008)**, in section C2.

The other four papers in this set have a particular focus on policy responses to HIV/AIDS. Two of them report cross-national analyses.

First, **Gómez and Harris (2015)** examine these *HIV/AIDS policy responses in the five BRICS countries (Brazil, Russian Federation, India, China and South Africa)*, considering the ways in which national political environments have shaped State-civil society relations and the nature of the responses. Presenting both an historical and a cross-country analysis, the paper illuminates the very different national contexts and experiences of these countries, and argues that the nature of State-civil society relations influenced the responses in each setting. The authors argue that, although collaborative State-civil society relations produced an aggressive response and successful outcomes in Brazil, democratic openness and State-civil society engagement did not necessarily achieve the same results in other countries. In South Africa, AIDS denialism and antagonistic State-civil society relations catastrophically delayed the Government response. In the Russian Federation, the lack of opportunities for civil society mobilization and growth combined with political centralization and State unwillingness to work with nongovernmental organizations led to an ineffective response. Top-down bureaucratic rule and reluctance to work with civil society delayed India’s response; but China has responded well, despite a regime type that allows only limited engagement with civil society. The authors conclude that more research is needed on the links between democratic openness, political repression and policy responses to epidemics. Second, in an unusual analysis using quantitative data, **Strand (2012)** explores *the influence of public opinion over political leadership, in relation to HIV/AIDS policy response*



in Africa. The paper draws on polling data for 20 sub-Saharan African countries across the period 1999–2008, as well as relevant epidemiological and socioeconomic data. It argues that, against the dominant context of patron-client relations, the political constituency demanding an effective policy response in any country was, at that time, small and weak. It could not, therefore, change the tide of public opinion to demand such a response.

Considering, specifically, the experience of *HIV/AIDS policy development in the late 1990s–early 2000s within the quasi-federal State system of post-apartheid South Africa*, **Steytler (2003)** examines how subnational units (provinces), “operating within a constitutionally mandated system of cooperative government, can influence national policy, and, in the process, limit the ‘monopolistic impulses’ of the national government” (**Steytler, 2003:61**). Analysing the period of AIDS denialism in South Africa, the author explores critical features of the national political and governance system and their influence over health policy in this period. This analysis illuminates the political dynamics of national-provincial relationships in the country, which interconnect with governing/opposition party dynamics, as well as the roles of the Constitutional Court, the established guardian of the newly established Bill of Rights, and of civil society in bringing about policy change. It thus throws further light on civil society roles in policy change (see also **Gómez and Harris, 2015**), while illustrating the potential for bottom-up exercises of power in the South African political system, in contrast to the top-down dynamics in Ghana revealed by **Kwamie et al. (2016)**. This paper provides important background to other available reports of South African HIV/AIDS policy experience, including **Schneider et al., 2010**, in section C4.

Finally, **Parkhurst et al. (2015)** present detailed insights into policy resistance to the implementation of a global policy prescription, *male circumcision for HIV prevention, in Malawi in the 2000s*. Through rigorous qualitative analysis of media and document reviews, as well as interviews, these authors illustrate the political narratives and social meanings that fuelled this resistance and consider the historical and political context in which they were embedded. Two key narratives were identified: a “narrative of defiance” around the need to resist donor manipulation, and a “narrative of doubt” which seized on a piece of epidemiological evidence to refute global claims of efficacy. As the ethnic and religious divisions that dominated broader political movements aligned with different circumcision practices, discussion about circumcision through these narratives provided opportunities for ethnic identities and claims to power to be negotiated and used to support wider claims of political legitimacy. Noting the broader critique that public health research ignores political influences over decision-making, the authors argue that the analysis shows how “the global transfer of policy will be shaped by how the policy, and the specific artefacts that constitute the policy, intersect with local cultural, political and economic contexts” (**Parkhurst et al., 2015:20**) (see also section B3).

## FUTURE RESEARCH

Alongside the theoretical categories and ideas presented earlier in the introduction to the section, these papers offer additional insights about the types, nature and influence of contextual factors over policy change. They provide pointers both about what to consider when analysing policy change experiences, and about ways of deepening consideration of the contextual influences that shape and interact with other factors.

All 10 papers illuminate and offer further insights: first, into the ways sociopolitical contextual factors influence power dynamics among policy actors and in relation to policy change (see also section B1). Second, all 10 reveal the strong influence of history over present-day policy processes, and some specifically consider the path dependency of policy change (**Grundy et al., 2014; Kwamie et al., 2016**).

Specific papers then provide further insights into:

- the role and power of the public and civil society in policy change and how contextual factors specifically influence them (**Flores et al., 2009; Gómez and Harris, 2015; Smith, 2014; Steytler, 2003; Strand, 2012**);
- the way the multilevel nature of governance and bureaucratic structures can open-up or close down opportunities for change (**Kwamie et al., 2016; Smith, 2014; Steytler, 2003**);
- the role of local norms and meanings in resisting policy change, including resistance to globally generated policies (**Olivier de Sardan, 2011; Parkhurst et al., 2015**, see also sections B3 and C4);
- the influence of timing over the possibility of policy change (**Carbone, 2011; Steytler, 2003**).

The papers also offer some methodological strategies for considering the complex pathways of influence of contextual factors. These include:

- comparing one policy experience across time periods, bounded by a significant political event (**Carbone, 2011**);
- comparing policy experiences across subnational governance units within one country, perhaps selected for their different policy outcomes (**Smith, 2014; Steytler, 2003**);
- comparing similar policy experiences across countries (**Gómez and Harris, 2015**);
- tracking change across governance levels (**Kwamie et al., 2016; Steytler, 2003**);
- using polling data to understand trajectories in public opinion within and across settings (**Strand, 2012**);
- the value of historical, anthropological and discourse analysis in this work (**Flores et al., 2009; Grundy et al., 2014; Olivier de Sardan, 2011; Parkhurst et al., 2015**).

Finally, as Ostebo et al. (2017) note, health policy analysts must recognize that investigating political context is not always comfortable or straightforward. They suggest that the silencing of political factors may be a result of being too close to government positions, or reflect concern for research access or the safety of informants; and it may generate social desirability bias in interview responses. Researchers must, then, always be self-aware, recognizing their positionality in relation to their work, and sensitive to how context may influence respondents (see also **Walt et al., 2008**, section D2).

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## B3.

# GLOBAL HEALTH ACTORS AND NATIONAL POLICY-MAKING

*Jeremy Shiffman and Johanna Hanefeld*

## INTRODUCTION

Many forces that shape national health policy processes and outcomes in LMICs have global rather than domestic origins. Since the Second World War, globalization has proceeded at a rapid pace as trade, population mobility and communications infrastructures have expanded, bringing people and governments closer together (Hanefeld, 2015; Keohane and Nye, 2000; Rosenau, 2003). Simultaneously, global health governance has become more complex (Walt, 2001: chapter 13), evolving from a system involving primarily national governments and WHO to one that also includes multiple international organizations beyond WHO, bilateral donors, public-private partnerships, international nongovernmental organizations and philanthropic organizations.

A large literature has emerged on the global health governance system (see, for instance, Elbe, 2010; Frenk and Moon, 2013; Harman, 2012; McInnes and Lee, 2012; Ottersen, 2014; Rushton and Williams, 2011). Many of these works draw on international relations and global governance theory, engaging issues such as the relative power of interests versus ideas and global versus local forces in shaping global governance outcomes.

Overlapping this global health governance literature is work that draws on theory from political science, anthropology and sociology to consider the influence of global health actors on national health policy processes. Understanding national health policy-making requires consideration both of the influence of globalization and of the new global health governance actors. That is the focus of this section.

To consider the forms of power exercised in global-national relationships, we draw on a taxonomy developed by Michael Barnett and Raymond Duvall (2005). This is not the only relevant framework for analysing power in health policy processes (see section B1), but it is particularly germane for this section, since it has an explicit focus on international politics.

The taxonomy has two dimensions. The first dimension concerns the nature of relations between actors – interactive or constitutive. Interactive relations pertain to those between existent actors – some of which possess power and use it knowingly to shape the behaviour of others. Constitutive relations pertain to how actors are created – the social processes that define who these actors are, with consequent effects on what they are able to do. The second dimension involves the specificity of these relations – direct or diffuse. Direct relations pertain to those between actors in close proximity; diffuse relations to actors operating at a distance from one another. These two dimensions lead to the identification of four forms of power: compulsory, institutional, structural and productive.

We traditionally understand power in compulsory terms (in the taxonomy: interactive and direct) – the immediate control of one actor over another. The classic definition is by Robert Dahl (1961): “A has power over B to the extent that he can get B to do something that B would not otherwise do”. For instance, when a national leader resigns under threat of invasion by another country, the latter country’s government is using compulsory power to secure its preferences. Compulsory power can be used for principled ends as well. For instance, international nongovernmental organizations use shaming tactics to pressure governments to follow human rights norms.

Institutional power is also interactive, but diffuse in form. An example are rules secured by the World Trade Organization (WTO). Without exerting direct control over other countries, by establishing the WTO and other institutions certain powerful countries have constructed a global trade system that works to their benefit. That system also compels weaker countries to conform to trade and investment practices that may be contrary to their interests.

Structural power is direct and constitutive. It pertains to the social structures that shape the way we define ourselves in immediate relationship to one another, in ways that enhance the capacities

of some and limit those of others. A stark historical example is the institution of slavery and the construction of the categories of master and slave.

Productive power is constitutive but diffuse. It pertains to the way we create meaning, particularly through the use of categories that lead us to think about the world in some ways but not others. For instance, in the international system, States become identified by various labels: “developed”, “underdeveloped”, “hegemonic”, “rogue”, “democratic”, “repressive”, and so forth. We often take these categories as given and precise, overlooking their historically contingent and ambiguous nature.

## SELECTED PAPERS

These 10 papers illustrate the diversity of global actors and the effects they have on national health policy processes. We briefly describe each of the papers selected as well as our rationale for selecting them as illustrative examples of this underreported area of LMIC health policy analysis work. We also consider here the forms of power the actors exert, using the Barnett and Duvall taxonomy outlined above. The papers included employ several methodological approaches, including ethnography, discourse analysis and historical and comparative case analysis (none use large-scale quantitative methodologies; the employment of such approaches might enhance the field).

We include two exemplar papers for this section. The first, by **Ogden, Walt and Lush (2003)**, was one of the first in the health policy analysis literature to explore the relationship between international organization activity and national health policy-making, and presents a particularly rich analysis of these interactions. The second, by **Hawkins and Holden (2016)**, is a strong and detailed example of the analysis of the influence of multinational corporations – entities not traditionally thought of as “health policy actors” – on national health policy-making.

### Actors and their effects

The actors identified in these papers include ones from global civil society (epistemic communities, international nongovernmental organizations, private philanthropic foundations), the for-profit private sector (multinational corporations), the public sector (international organizations, States), as well as entities that link sectors (global health initiatives).

Global civil society: three articles focus on the role of epistemic communities – networks of knowledge-based experts. Peter Haas (1992) introduced this concept to the global governance field, prompting extensive research on expertise as a form of power. **Dalglisch, George, Shearer and Bennett (2015)** examine an epistemic community on integrated community case management of childhood illness (iCCM). They consider how this community overcame internal conflicts and positioned iCCM as the preferred solution to address child mortality in low-income settings. However, in doing so, the authors suggest, the iCCM community overlooked relevant local expertise that might have contributed to developing solutions more appropriate for local contexts. **Storeng and Béhague (2017)** provide a critical perspective on *the proliferation of measurement initiatives in global health*, raising questions about the type of knowledge this produces and whose interests are served. They examine the global maternal health community – consisting largely of demographers, epidemiologists and statisticians – and their success in making maternal mortality ratio a major global health indicator. They delineate several imperatives beyond a desire for better metrics that motivated the work of the maternal health community, including the need to secure political priority for the issue and to satisfy donor demands for evidence of return on their investments. They also claim that the emphasis on building better global measures of maternal mortality may have hampered the development of national health information systems needed to monitor progress and shape strategy at national and local levels. Networked policy initiatives have emerged as a key feature of the global health architecture. **Shiffman et al. (2016)** investigate *global health networks* – webs of individuals and organizations linked by a shared concern for a particular global health problem – many of which are constituted by knowledge-based experts. They consider six such networks, *addressing maternal survival, newborn survival, tuberculosis, pneumonia, tobacco control and alcohol harm*. They find that network effectiveness has been a function of capacity to identify issue framings that resonate with national political elites and to build political coalitions that extend beyond the health sector. They also raise questions about the legitimacy of these networks, including their potential distortion of national health priorities.

If knowledge is the primary form of power for epistemic communities, principled ideas play the same role for international nongovernmental organizations. **Kaufman (2012)** shows how international nongovernmental organizations, including the South-Africa-based Treatment Action Campaign, linked up with domestic *nongovernmental organizations to encourage the Chinese Government to*

adopt global norms pertaining to HIV policy on such matters as HIV prevention among sex workers, protection from discrimination and access to essential medicines. This paper provides evidence of the influence of global norms, as promoted by the global health actors considered in this chapter, on national health policy processes. **Robert and Ridde (2013)**, conducting a discourse analysis through analysis of documentation, find that *international nongovernmental organizations* have been particularly forceful in delegitimizing a mechanism of health-care financing initially proposed in the 1980s, *user fees*, as an unfair burden on the most impoverished members of society.

The articles also find extensive influence of private philanthropic foundations. For instance, **Storeng and Béhague (2017)** note that the Bill and Melinda Gates Foundation has been a major funder of efforts to address maternal mortality, and the maternal health measurement community's focus on mortality measurement is a direct response to the Foundation's interests in accountability. Also, these entities, especially the Gates Foundation, have been central to the establishment of *global health initiatives*, which now exist for many high-burden conditions that LMICs face (see discussion below and papers by **Kapilashrami and McPake, 2013** and by **Hanefeld, 2010**).

For-profit private sector entities, particularly multinational corporations, have also influenced national health policy processes. **Hawkins and Holden (2016)** argue that a proliferation of international investment agreements between states have provided a mechanism for *multinational corporations to block national legislation beneficial to health*, such as restrictions on tobacco marketing. Corporate threats to sue for breach of treaty agreements has had a chilling effect, especially on the governments of low-income countries, which fear the economic consequences of enacting pro-health, anti-corporate legislation.

**Rushton and Williams (2012)** point to a deeper phenomenon at work pertaining to private sector interests. They observe *the influence of neoliberal ideas in global health policy-making*, which they describe as the “privileging of market-based policy responses, [the] commodification of [...] healthcare, [and] the individualization of risk and responsibility for health”. These ideas have favoured the pursuit of profit over social equity aims, and, the authors argue, have crowded out alternative ways of thinking about global health policy-making.

Public-sector actors – including international organizations and powerful nation-States – have also been central to global health governance, with notable effects on national policy processes. **Rushton and Williams (2012)** identify the influence not just of private sector actors, but also of international organizations, including the World Bank, International Monetary Fund and WTO, in establishing rules and practices that advance a neoliberal agenda in global health. **Ogden, Walt and Lush (2003)** examine *the role of international organizations* – especially the World Bank and WHO – in *the cross-national spread of a strategy for tuberculosis control: directly-observed treatment short-course (DOTS)*. They show that this was not a simple case of the deployment of technical expertise, but rather a contested process. With agenda-setting intent, these organizations branded DOTS as the solution to the problem, drawing criticism that the solution was simplistic, and resulting in uneven national ownership and implementation.

Most global governance scholars recognize that States remain the primary actors in the global governance system, despite the emergence of numerous non-State actors in the post-Second-World-War era. The papers provide evidence of their power. For instance, as **Hawkins and Holden** point out, States negotiate the international investment agreements that benefit multinational corporations. These agreements benefit certain powerful States and corporations at the expense of weaker States and their citizens. Also, as **Kaufman (2012)** demonstrates, the normative influence that international and national nongovernmental organizations wield in China is possible only because the Chinese State permits their activities.

Global health initiatives (GHIs) – many linking public, private and civil society entities – have proliferated over the past three decades and are another set of global actors that have become increasingly influential in national health policy-making, often in ways that diverge from their expressed aims. An analysis by **Kapilashrami and McPake (2013)**, selected for inclusion because of its rich account of the experience, show that despite a stated intent to involve national civil society institutions in addressing high-burden diseases, *one GHI operating in India – the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund)* – actually helped to sustain the power of global actors. Moreover, its efforts to address HIV/AIDS in the country contributed to health system fragmentation and conflict among national actors. Offering insights into GHI implementation processes, an article by **Hanefeld (2010)** found similar effects of *the Global Fund and another GHI – the United States President's Emergency Plan for AIDS Relief (PEPFAR) – in Zambia and South Africa*. While contributing to the scale-up of



antiretroviral treatment for HIV/AIDS, their activities exacerbated problems of national programme cohesion, sustainability and equity.

The discussion above illustrates the variety of effects these global actors have on national health policy-making. Several might be assessed as positive:

- offering new strategies to address long-standing problems (e.g. epistemic community and international organization involvement in developing iCCM for child mortality and DOTS for tuberculosis);
- pushing States to guarantee rights and address stigmatization of marginalized populations (e.g. engagement of international nongovernmental organizations with HIV policy in China);
- challenging policies that place an undue burden on the poor (e.g. international nongovernmental organization critiques of user fees for health facilities).

Other effects are problematic, including:

- fragmenting health systems and complicating national health policy processes (e.g. global HIV/AIDS initiatives in India, South Africa and Zambia);
- distorting national health priorities (e.g. global maternal health measurement initiatives crowding out efforts to develop national health information systems; global health network initiatives distorting national health priority-setting);
- provoking conflict among national actors over resources and policy priorities (e.g. global HIV/AIDS initiatives in India);
- weakening national capacity to regulate addictive substances (e.g. trade agreements that cause States to fear corporate litigation);
- spreading over-simplified solutions insufficiently tailored to the national context (e.g. iCCM for child mortality and DOTS for tuberculosis);
- limiting the scope of policy debate (e.g. global neoliberal discourse that favours private interests over social equity concerns).

### **Forms of power: compulsory, institutional, structural and productive**

The articles offer several examples of attempts to exercise *compulsory power*. Philip Morris has brought court cases against the Government of Uruguay – a leader in enacting anti-tobacco legislation – as a means not only of seeking to repeal these laws, but also to warn other countries not to follow suit (**Hawkins and Holden, 2016**). The Gates Foundation has steered money towards a global maternal health measurement community as a means of ensuring that its members work on developing maternal mortality indicators. One reason has been to find ways to evaluate whether Foundation funds have been put to good use (**Storeng and Béhague, 2017**). Global health initiatives, including the Global Fund and PEPFAR, have provided resources to low-income countries to ensure scale-up of ARVs (**Hanefeld, 2010; Kapilashrami and McPake, 2013**). Even without global funding, maternal health experts may have developed indicators and national governments delivered ARVs; however, the funding likely augmented their level of effort at the expense of other priorities.

The articles also show *institutional power* at work. A global system of international investment agreements between countries has established rules that have enabled corporations to sue national governments over health legislation that threatens corporate interests. The existence of these rules makes small countries reluctant to pursue such legislation, fearful that they will have to expend considerable resources to fight lawsuits if they do (**Hawkins and Holden, 2016**). States delegate authority to international organizations such as WHO to propose health regulations and policies. Such delegation empowers the officials who staff these organizations to press governments to adopt particular policies (**Ogden, Walt and Lush, 2003**), and in some cases to use legal authority (such as the International Health Regulations (2005)) to order these governments to do so.

With respect to *structural power*, epistemic communities construct themselves as creators and arbiters of biomedical and health policy knowledge – experts who should be listened to – and assume the governments of low-income countries are information-deprived and in need of their input (**DalGLISH et al., 2015; Shiffman et al., 2016; Storeng and Béhague, 2017**). Officials in international organizations do the same (**Ogden, Walt and Lush, 2003**). Many national government officials resist, but, as evidenced by their frequent acceptance of this input, others accept these expert-beneficiary designations.



The articles also provide examples of *productive power* at work. The analysis by **Rushton and Williams (2012)** suggests that the neoliberal paradigm shapes and constrains global health policy-making options, pushing actors towards market-based ideas and solutions. **Storeng and Béhague** provide evidence for this point, noting that donors emphasize a neoliberal concept – value for money – in justifying and assessing their maternal health investments. **Kaufman (2012)** identifies the power of principled ideas in the form of international norms, such as prohibition of discrimination against those living with HIV, in shaping national government responses to pandemics. **Robert and Ridde (2013)** illustrate the various discourses – moral, economic and pragmatic – that global actors invoke to make the case against user fees.

## FUTURE RESEARCH

The Barnett-Duvall taxonomy and the 10 papers suggest a number of areas for future research on the influence of global forces on national health policy processes. We discuss four areas here.

One issue pertains to **Rushton's and Williams'** thought-provoking argument that global health is shaped by a neoliberal world view – what they term a “deep core” of beliefs – that constrains policy-making. In the terminology of the taxonomy, the constrictive effects of this world view are an example of the exercise of productive power. Researchers would do well to take up Rushton's and Williams' challenge to investigate the content of the deep core and its effects. In doing so, they might draw on moral foundations research from social psychology, whose subject is precisely these kinds of foundational beliefs (see for instance Haidt, 2012). Among the questions that researchers might ask: Are Rushton and Williams accurate in claiming that neoliberal ideas constitute the deep core? Alternatively, are the set of ideas more varied and contested – for instance also including norms pertaining to social justice and fairness? And how powerful is the deep core vis-à-vis other influences in structuring global health policy-making? What methodologies are needed to answer these questions?

A second area, related to the first, pertains to a large issue debated in the field of global governance (Finnemore and Sikkink, 1998; Mearsheimer, 1994; Sil and Katzenstein, 2010): the role of interests and material forces, on the one hand, and norms and ideational forces on the other, in shaping policy-making. To what extent do the material interests of corporations and dominant nation-States overwhelm health policy-making in smaller and politically weaker countries (**Hawkins and Holden, 2016**), coopting national actors and restricting the capacity of proponents to advance health policies that benefit citizenries? What power do proponents advancing principled ideas have to challenge these interests (**Kaufman, 2012**)? What role does expertise – another form of ideational power – play in shaping health policy-making and challenging these interests (**Dalglisch et al., 2015; Ogden, Walt and Lush, 2003**)?

A third set of questions, also a concern in the global governance field, pertains to the way in which national and local actors resist global influence, and themselves shape global health policy. Researchers have critiqued global governance scholarship for presenting governments as “norm-takers”, for presuming that the flow of norms is largely from global to local, for downplaying the considerable local resistance to international norms, for overlooking the local origins of many international norms and for missing the considerable heterogeneity of norms that exist at local levels (Acharya, 2004; Elgström, 2000; Zwingel, 2012). **Ogden, Walt and Lush** consider global to national and national to global flows, and both national influence and resistance. More such studies that are bidirectional rather than unidirectional in orientation, and that explore the nuances of national and local influence on and resistance to global power, would enhance the field (see for example, **Parkhurst et al., 2015**, section B2; **Shiffman et al., 2004**, section C2; **Olivier de Sardan et al., 2017**, section C4 for valuable examples).

Finally, the papers raise questions surrounding the legitimacy of global actors: by what authority do they exert power? All 10 papers touch on this issue, either explicitly or implicitly. **Rushton and Williams** question the justness of the neoliberal world view that underpins global health policy-making. **Hawkins and Holden** are concerned about the capacity of multinational corporations to block health policy legislation in small countries. **Storeng and Béhague** query donor goals in supporting a global maternal health measurement community, as well as the motivations of community members themselves. **Kapilashrami and McPake** and **Hanefeld** are concerned that leaders of GHIs retain power even as they claim to be supporting national civil society engagement. **Ogden, Walt and Lush**, and **Dalglisch and colleagues** note that international organizations and epistemic communities advance technical solutions that are inattentive to local expertise and conditions. **Shiffman and colleagues** find reasons not just to affirm the legitimacy of global health networks (providing technical input; raising attention

to neglected issues) but also to question their right to exert power (fragmenting health systems; insufficient representation by actors from low-income settings). **Kaufman** and **Robert and Ridde** note some positive effects, including involvement of international nongovernmental organizations in challenging unjust national health policies. Collectively, the papers raise questions pertaining to the criteria and the ethical frameworks we should be using to assess the legitimacy of global actors' involvement in national health policy-making. The authors also remind us that the exercise of global health power is not just an empirical, but also a normative issue, and researchers must be attentive to both of these aspects.

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**PART C.**

# **HEALTH POLICY PROCESSES IN LOW- AND MIDDLE-INCOME COUNTRIES**

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# C1.

# NATIONAL EXPERIENCES OF HEALTH POLICY FORMULATION AND POLICY CHANGE

*Lucy Gilson and Irene Akua Agyepong*

## INTRODUCTION

Some policy analysis papers can be clearly categorized/identified by their particular theoretical framing or policy stage – such as Kingdon’s theory of agenda-setting (1995; see section C2) or Lipsky’s theory of street-level bureaucracy (1980, 2010; see section C4). However, many of the available empirical analyses of LMIC health policy change cannot be identified in this way.

Perhaps this is not surprising, given the dynamic nature of policy processes, comprising multiple different forms of interaction among policy actors, in various policy settings and unfolding unpredictably over time. Some papers seek to represent and understand these long trajectories of change, not limited to a particular “policy stage”. Others seek to examine in detail a particular facet of experience within such trajectories, perhaps drawing on theoretical framings that fall outside the classical body of policy analysis theory.

This section presents an array of such papers, with the aim of demonstrating the diversity of current analyses that consider national experiences of health policy change. It is shaped, then, by the papers currently available, rather than by a distinct body of theory. The papers included here were also selected because they report rich analyses of experience around different areas of health policy (financing, pharmaceutical dispensing and prescribing, nutrition and a range of infectious diseases), are drawn from a variety of geographical settings and themselves draw on a range of conceptual frameworks and theoretical lenses.

## SELECTED PAPERS

The focus of many of the papers included in this section lies, broadly, around policy formulation and adoption, although they do not identify themselves as specifically addressing this “policy stage”. Several address a much wider scope of policy experience and decision-making, and many show how the particular experience unfolded over long periods of time. All papers identify the importance of policy actors and policy networks in policy change, and commonly seek to explain their behaviours and actions, and the consequences for the policy process, by using analytical concepts and conceptual frameworks. Some also illuminate contextual influences, as highlighted in sections B2 and B3; others provide insights on agenda-setting (section C2), while yet others offer insights for the strategic management of actors in policy change (section D1).

The two exemplar papers included in the Reader for this section present, first, a useful categorization for understanding the steps and dynamics between agenda-setting and implementation, drawn from a systematic narrative analysis of empirical research (**Berlan et al., 2014**); and second, a framework and theory-driven empirical analysis explaining policy change by reference to networks, institutions, interests and ideas (**Shearer et al., 2016**).

We briefly describe each of the papers selected as well as our rationale for selecting them as illustrative examples of the scope of this area of LMIC health policy analysis work.

The wide-ranging analysis of **Pelletier et al. (2012)** focuses on the challenges experienced in the unfolding process of *agenda-setting, policy formulation and implementation around undernutrition in five countries in Asia and Latin America*, and ways to overcome them. The findings offer insights on agenda-setting that add to the studies presented in section C2 – such as the range of strategies that can be used in getting nutrition on to the policy agenda and that a clear evidence-based solution is not always needed. They show that policy formulation processes were difficult – being

constrained, despite windows of political opportunity, by capacity constraints, differing professional views of undernutrition and disagreements over interventions, ownership, roles and responsibilities. In terms of implementation, the analysis uses the Potter and Brough (2004) framework to consider capacity further. As weaknesses in human and organizational capacities from national to front-line levels were identified, the paper concludes that a systemic and comprehensive approach to capacity strengthening is needed. The paper also considers the commitment needed to bring about policy change, using an adapted conceptual framework (Heaver, 2005). Again complementing the agenda-setting work (section C2), the analysis suggests that political attention is not sufficient to bring about nutrition policy change, and that instead both political commitment (including allocation of authority, accountability and resources to relevant ministries) and system-wide commitment on the part of mid-level managers is needed, which only high-level political champions may be able to generate. Ultimately, therefore, the paper concludes that the large investment needed to identify efficacious nutrition interventions is unlikely to reduce the burden of undernutrition unless or until systemic (strategic and management) capacity constraints are addressed.

Focusing on only one country, but still addressing a wide sweep of policy-making experience, **El-Jardali et al. (2014)** trace the *policy-making process for voluntary health insurance over a period of 12 years in the Lebanon*. Using the **Walt and Gilson (1994)** heuristic as well as Kingdon's (1995) multiple streams theory, the paper draws on a chronological media review, in-depth interviews and document reviews. Presenting a detailed timeline of policy change, the analysis shows that this policy process was stimulated by a governmental decision to tackle an urgent political problem, and that the resulting policy-making process neither involved a wider range of actors nor drew on relevant evidence. Barriers to evidence use included the lack of relevant evidence, the political context, personal interests and resource constraints. The paper complements other work considering the factors influencing evidence and research use in policy, as presented in section C3.

**Berlan et al. (2014)** stand back from the details of any particular policy experience. Through a narrative synthesis of available empirical work, they seek to tease out *the contours and dimensions of the processes lying "between" agenda-setting and implementation*. This is the terrain of what is generally called policy formulation and adoption; processes often understood in the public health field to entail technical analysis and straightforward evidence use. However, the paper identifies seven distinct activities in this broad terrain that entail political as well as more technical processes. These activities comprise: deliberation, consultation, advocacy, lobbying and negotiation, as well as the generation of policy alternatives and drafting policy and implementation guidance. The actors exercising decision-making power in these processes include not only various governmental entities, but also civil society, commissioners, nongovernmental organizations and other social actors. Although not a theory-building paper, this synthesis does offer researchers ideas that they could draw on to deepen their understanding of how policy formulation and adoption unfolds. Bertscher et al. (2018) present the first empirical application of this approach to understanding "the bit in the middle".

**Thomas and Gilson (2004)** unpack in more detail the sort of dynamics that can occur among actors during policy formulation, considering four ad hoc policy committees established to generate policy proposals on *health insurance development in South Africa during 1994-99*. The paper describes the processes by which actors were drawn into health insurance policy development and the details of their engagement with each other, and identifies where deliberate strategies of actor management were attempted, as well as the results of these strategies for proposal development. The analysis of actor management strategies draws on Eden's (1996) framework. It shows that differences among those actors primarily responsible for driving these processes, as well as opposition from other actors, ultimately derailed efforts to establish adequate support for any form of social health insurance, even as private insurance regulatory proposals received sufficient support to be enacted in legislation. Five potential strategies by which the drivers of any policy process might create alliances of support sufficient to overcome potential opposition to proposed policy changes, are discussed. These findings provide a foundation for further analysis of such issues, and complement papers presented in section D1.

Two other papers use stakeholder analysis, both drawing on **Varvasovszky and Brugha (2000)**, to understand key policy actors' interests, positioning around and influences over policy change. **Onoka et al. (2014)** examine *the Nigerian experience of national health insurance policy proposal development over more than 20 years (1984-2007)*. They present detailed stakeholder analyses for four different time periods, showing how actors' positioning around the proposals, and relative power, changed over time. The most successful period of the policy process occurred when a new Minister of Health (strongly supported by the President, who had displayed interest in universal health coverage) provided leadership through the Federal Ministry of Health, and effectively managed stakeholders'



interests and galvanized their support to advance the policy. This experience suggests that strong political leadership can enhance the pace of the policy process. However, acknowledging the influence of context over policy change (section B2), the analysis also shows that the shared authority between federal and state governments in the democratic era allowed for more contestation around the policy than under military rule. In such a setting, attention has to be paid to securing commitment from both federal and state level to advance policy change. **Lim et al. (2012)**, meanwhile, analyse the *experience of the Republic of Korea in developing and implementing a law that separates the dispensing and prescribing of drugs, over the period 1993–2001*. Paying careful attention to different periods and experiences of conflict, they describe critical events over time, the role of different policy committees, contextual influencing factors and the details of actors' interests, values, positioning and engagement. They highlight the failure of bureaucrats in the Ministry of Health and Welfare to manage the policy process in the public interest, leading to their capture by strong interest groups and, in turn, unintended, negative consequences for policy outcomes. The authors argue that bureaucrats should be responsible to the public rather than interest groups, and that civic groups, which engaged in, but had limited influence over, this process, should be strengthened and more systematically involved in future health policy development.

The remaining four papers in this section, then, consider the particular role of policy networks in policy change. Two present rich narratives of experience and two draw on social network analysis.

**Tantivess and Walt (2008)** present a careful and rich analysis of *the scale-up of antiretroviral therapy in Thailand 2001–2007*, illustrating the crucial contributions of non-state networks across policy stages and system levels. The paper is situated against a range of relevant network theory (such as Marsh and Rhodes, 1992), and presents a rich narrative of experience. It outlines the role of national networks comprising non-State and government actors in policy formulation as well as the role of local networks in implementation; and the role of global networks in supporting the compulsory licensing of some HIV drugs. Drawing also on Marsh (1998) and Rhodes (1997), **Cliff et al. (2004)** examine the role of policy networks or communities in *over 20 years of policy change around clinical care for tuberculosis and sexually transmitted infections in Mozambique*. They describe the ways in which such communities – within the country, within the region and connecting actors at national and global levels – influenced the processes linked to these policies. More specifically, in the 1980s, new clinical practice approaches were developed for both conditions, through initial experimentation within tight-knit Mozambican policy communities in engagement with regional and international policy networks. These practices fed “bottom-up” through these communities into global policy development by international organizations, generating policy guidelines which then descended back to the country in a top-down manner, now formulated as TB DOTS and STI syndromic management. Acceptance of these global policy guidelines in Mozambique brought access to new resources, but wider organizational and contextual factors presented problems for larger-scale implementation of these guidelines in the 1990s.

**Wonodi et al. (2012)** apply social network analysis, based on in-depth interviews and a short quantitative social network survey administered to individuals, with respondents identified by snowball sampling, in *understanding vaccine decision-making in Nigeria* in relation both to vaccine introduction and vaccine programme implementation. These processes involve many stakeholders who provide technical information, mobilize finance, implement programmes and garner political support and who are likely to have different levels of interest, knowledge and motivations to introduce new vaccines. The analysis considers the roles, relationships and perceived influence among the two actor networks considered. It indicates relatively robust engagement among the key national-level Nigerian stakeholders centred around the federal Minister of Health and other Ministry actors, but also that some economic and implementation stakeholders did not appear to play as central a role as had been expected. International donors appear to have limited influence. These findings may suggest a need to strengthen decision-making processes by integrating actors responsible for financial decisions and programme implementation more closely into policy decision-making processes.

Finally, **Shearer et al. (2016)** deepen network analysis by proposing a conceptual framework integrating consideration of networks with concern for institutions, interests and ideas, and testing it on three cases of policy change. Drawing on, among others, Marsh and Smith (2000) and Lavis et al. (2004), this comprehensive and rich *analysis of child health, HIV and malaria policies in Burkina Faso over a 25-year period* demonstrates the approach of theory-driven policy analysis. The study found that, while network changes were associated with policy reform, this relationship was mediated by one or more of institutions, interests and ideas. In a context of high donor dependency, new donor rules affected the composition and structure of actors in the networks, which enabled the entry and dissemination of new ideas and shifts in the overall balance of interest power ultimately leading to

policy change. Strategic networking, by civil society actors, occurred in only one case, suggesting that network change is rarely the spark that initiates the process towards policy change. Overall, the analysis highlights the important role of changes in institutions, interests and ideas in driving policy-making, but hints that network change is a necessary intermediate step in these processes. The paper provides an important foundation for further health policy analysis research that actively engages with these phenomena.

## FUTURE RESEARCH

These papers illuminate the range of research questions that could be addressed in considering national policy change experiences, but do not offer clear guidance on specific research questions that could direct future research.

They do, however, show the value both of zooming in to consider particular facets of policy experience (**Thomas and Gilson, 2004**: the role of policy committees) and zooming out to consider the breadth of policy change (**Pelletier et al., 2012**). They show the value of a well told narrative (e.g. **Tantivess and Walt, 2008**) as well as a theoretically-driven analysis (**Shearer et al., 2016**). They also illuminate the application of two analytical techniques – stakeholder analysis (**Onoka et al., 2014**; see also section D1), and social network analysis (**Wonodi et al., 2012**).

Finally, the papers offer two broader insights for analysis. They highlight a range of relevant theory that could be used more widely – and specifically, the “bit in the middle” framework (**Berlan et al., 2014**), and they demonstrate the different ways in which theory can be used in analysis. In some papers, theory or concepts are essentially discussed quite loosely, almost as the background against which the analysis is situated; in others particular concepts or frameworks provide support for elements of the analysis; and in yet others more substantial theory-driven analysis. The more active use of theory and concepts supports a more analytical orientation within the paper, and might be argued to allow deeper understanding of the experience (see also section D2).

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## C2.

# AGENDA-SETTING PROCESSES

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## INTRODUCTION

Agenda-setting – or how issues appear on governmental agendas for action – addresses a question fundamental to public policy – namely why do policy-makers pay attention to particular issues, out of all the range of issues that confront them? (Howlett and Ramesh, 1995; Kingdon, 1995).

As the first of the policy process stages, some argue that agenda-setting is also the most critical. Through its role in determining the issues and alternatives that the government will consider, as well as the probable choice of solutions (Cobb and Elder, 1972), the agenda-setting process is said to profoundly influence subsequent policy stages as well as policy outcomes (Howlett and Ramesh, 1995). As noted in Schattschneider's memorable phrase, "the definition of the alternatives (is) the supreme instrument of power" (Schattschneider, 1960).

Definitions of agenda-setting differ with respect to the source of that power. Thus Cobb, Ross and Ross (1976) define agenda-setting as "the process by which demands of various groups in the population are translated into items vying for serious attention of public officials". In line with an underlying pluralist view of public policy then dominant in American political science, in this understanding of agenda-setting social groups are key in defining alternatives and driving public policy more generally. On the other hand, Kingdon defines the agenda as "the list of subjects or problems to which government officials, and people outside of government closely associated with those officials, are paying some serious attention to at any given time"; agenda-setting, according to this understanding "is the process (which) narrows the set of conceivable subjects (that governments could be paying attention to) to the set that actually becomes the focus of attention" (Kingdon, 1995). This latter understanding thus gives a far greater importance to government officials and those close to them as the sources of policy alternatives and drivers of policy change. In spite of these differences, both definitions are in agreement that the agenda-setting process is fundamentally a priority-setting process, helping identify issues for what both definitions term the "serious attention" of policy-makers.

So, how do problems come to be recognized as needing government attention?

Rational models emphasize a process in which policy-makers survey the field and identify problems to solve based on their importance (in terms of some objective measure such as highest number of deaths caused or greatest burden of disease), develop and choose from possible solutions based on objective criteria, and implement these solutions (Buse et al., 2012; **Shiffman et al., 2002**). This idealized view was contested, notably by Braybrooke and Lindblom, who claimed that the rational approach failed to represent real-world policy-making, in which policy-makers often made decisions in the face of inadequate information about problems and solutions. Policy-making, they argued, took place through "successive limited comparisons" among a limited number of alternatives that were only incrementally different from the status quo. Not only did this greatly simplify decision-making, but the incremental nature of policy change also minimized the potential to do serious damage (Braybrooke and Lindblom, 1963; Lindblom, 1959).

The notion of problems having a purely objective existence (central to the rational approach and implicit in incremental models) was challenged by a growing understanding of the role of ideas in defining norms and problems (in terms of deviations from those norms). Problems were thus increasingly seen as socially constructed, with problem conceptualization or framing recognized as having major implications for how they were in turn addressed by decision-makers (Berger and Luckmann, 1966; Buse et al., 2012; Cobb and Elder, 1972; Edelman, 1988).

The importance of the construction of problems in the agenda-setting process is demonstrated in Baumgartner and Jones' (1993) work in this area. Examining a range of issues, including nuclear energy policy, in the United States, they make the case for what they term a "punctuated equilibrium" model of the policy process, characterized by long periods of stasis punctuated by short bursts of abrupt change. The long periods of stasis are characterized by a widespread acceptance of a particular conceptualization and framing of an issue (policy image) that is maintained and perpetuated by

groups, actors and institutions responsible for a given issue, often holding monopoly power (policy venue). The bursts of policy change result from the successful portrayal of a new policy image (which can result, for example, from a new understanding of an issue) by new actors, which in turn results in a new policy image and venue (Baumgartner and Jones, 1993; Parsons, 1995; **Shiffman et al., 2002**).

**Grindle and Thomas (1989)** examine the role of policy elites (defined as “political and bureaucratic officials who have decision-making responsibilities in government and whose decisions become authoritative for society”) in the agenda-setting process in LMICs, which they argue is central but constrained by political, historical and economic contexts. They assert that the circumstance under which a reform emerges is a key variable in explaining agenda-setting. Thus reforms carried out in response to situations perceived as a crisis by policy elites typically involve a small number of high-powered decision-makers, are characterized by high economic and political stakes, may be forced upon governments by circumstances beyond their control and often result in major departures from existing policies. On the other hand, “politics-as-usual reforms”, that are largely the norm in non-crisis situations, often respond to issues that decision-makers choose for action, are characterized by lower stakes, typically involve mid-level officials and result in incremental changes to policies already in place. Further, while decision-making in crisis situations is primarily driven by concern for regime stability and legitimacy, individual careers and interagency competition for power and budgets typically influence decision-making related to “politics-as-usual” reforms.

In contrast, for Hall (1975), drawing on United Kingdom experience, whether or not an issue gets on to the government agenda is largely a function of where it falls along three distinct dimensions, namely: legitimacy (an issue which a government feels it should or is obliged to intervene in), feasibility (where action can realistically help address the issue) as well as a degree of support (at least from key interest groups). An issue that is high along all three dimensions (public action is seen as legitimate, with a feasible solution in place and one that commands widespread support) is far more likely to emerge on the policy agenda and be addressed than one that does not share these characteristics (Buse et al., 2012; Hall, 1975).

Kingdon's framework (1995), based on his book comprising case studies of agenda-setting in the United States, is one of the most widely used approaches to study agenda-setting. Building on the Cohen-March-Olsen garbage can model of organizational choice, the framework recognizes the chaotic and somewhat unpredictable nature of decision-making. It posits that the coming together of favourable conditions in three independently flowing streams of problems, policies and politics can help bring issues on policy agendas. Numerical indicators showing a worsening situation, formal and informal feedback to government officials and focusing events (which can vary from international conferences to plane crashes) can all serve to bring problems to notice. Issue emergence is also facilitated by the presence of feasible and politically acceptable policy solutions to the problem at hand. Typically, favourable events in the politics stream include elections as well as less tangible phenomena, such as a favourable national mood. However, issue emergence is a far from automatic process. The coming together of the three streams in turn creates an open policy window, described by Kingdon as “opportunity for pushing pet proposals”. These open policy windows are taken advantage of by policy entrepreneurs to bring attention to issues and solutions in which they are interested (Kingdon, 1995).

A more recent health-specific framework is that of Shiffman and Smith (2007) who have sought to understand factors influencing political priority for GHIs. Drawing on Shiffman's earlier work on national priority-setting for maternal health (Shiffman, 2007), this later framework comprises four elements: (1) actor power (or the strength of interested individuals and organizations); (2) ideas (or the portrayal of the issue by actors); (3) political contexts; and (4) issue characteristics (problem attributes). It identifies 11 factors across these elements that are argued to explain political priority for GHIs. Policy community cohesion, strong leadership, the presence of effective organizations and institutions (guiding institutions) as well as mobilization by civil society are all crucial factors in increasing the power of interested actors. Similarly, a common internal frame (the extent of policy community coherence about problem definition and solutions) and a framing to the outside world that resonates with wider society, particularly with the political leadership, can greatly influence political support. Among political contextual factors, political support can be increased through effectively using policy windows and having in place global governance mechanisms, including frameworks and treaties, favourable to collective action. Finally, the presence of clear indicators, particularly numerical indicators and disease burden, as well as the presence of effective, easy-to-implement and cost-effective interventions, are all features of the problem that facilitate the generation of political priority (Shiffman and Smith, 2007).



As a particularly well-developed area of policy theory there are an array of conceptual frameworks relevant to agenda-setting. Those discussed in detail above are highlighted because they are explicitly applied within LMIC health policy analysis papers. Other frameworks include those by Schattschneider (1960), Bachrach and Baratz (1970), Cobb, Ross and Ross (1976) and Heclo (1978), as well as Birkland (1997), who builds on Kingdon's work, emphasizing the role of "focusing events".

## SELECTED PAPERS

The 10 papers included in this section well reflect the conceptual terrain discussed in detail above. While the Kingdon framework is the most frequently used in LMIC health policy analysis work, several papers selected here demonstrate the use of other theories and approaches discussed above.

The first six papers presented are national-level case studies (drawn from Africa, Asia and Latin America) that examine policy processes around issues as diverse as maternal and child health, health insurance programmes and gender-based violence. These are followed by two papers on global agenda-setting processes (for disease control priorities and cervical cancer, respectively). By using multiple agenda-setting frameworks to analyse the issue at hand, as well as systematically considering non-decision-making within the ambit of agenda-setting, these two papers deepen our understanding. A paper that tests the Shiffman and Smith framework against the LMIC empirical literature on agenda-setting, which has the primary objective of theory-building, is presented next. The final paper uses Sabatier's advocacy coalition framework, a policy framework not typically associated with agenda-setting exclusively, to explain non-adoption of a policy in the Islamic Republic of Iran.

Of the 10 papers, the Reader includes two exemplar papers. The first of these, the paper by **Shiffman et al. (2004)** on agenda-setting for maternal mortality reduction in Honduras, illustrates the role of the interaction of national and global factors and actors in influencing the process. In addition, this paper makes a significant theoretical contribution to the literature by using constructivist and policy transfer theories to complement traditional agenda-setting theory in explaining political priority for the issue. The second paper, by **Walt and Gilson (2014)** is chosen as a quite unusual example of a theory-building paper that seeks to improve a pre-existing framework by testing it against relevant empirical literature and suggesting specific modifications to enhance its explanatory power.

We briefly describe each of the papers, as well as our rationale for selecting them as illustrative examples of the scope of LMIC work on agenda-setting for health.

Three papers are selected to illustrate the use of Kingdon's framework in LMIC health policy analysis work, and all generate ideas for ways of developing this framework in future applications. **Shroff et al. (2015)**, first, explain how *India's national health insurance scheme (Rashtriya Swasthya Bima Yojana – RSBY)* came on to the national policy agenda and was adopted. The paper describes how the 2004 national election offered a window of opportunity for agenda-setting, enabling a series of policy entrepreneurs – both politicians and bureaucrats – to bring together the three streams of problem, policy solution and politics and support the design and adoption of a new health insurance programme. In addition to providing in-depth insights into the emergence of what is potentially one of the largest health insurance programmes globally, the paper provides larger lessons about taking health reform processes forward. Reflecting **Agyepong and Adjei (2008)**, these include how the involvement of particular bureaucratic actors and ministries influences policy design and implementation choices. In the RSBY case, the involvement of the Ministry of Labour was critical to the choice of an insurance based programme, and the World Bank encouraged the use of new technological innovations in the scheme design. Also important was the "framing" of events and issues (the particular view of social reality presented), as it influenced both the policy responses and the interest groups mobilized. For example, the framing of the national election as a defeat of the "India Shining" agenda led to the creation of the National Advisory Council, which gave a group of activists an official seat at the policy-making table. Finally, the paper draws lessons for the wider use of the Kingdon model, suggesting that what constitutes being "on the agenda" is contingent on the political system and balance of legislative and executive authority. It also points to the need to look at interactions among the three streams and the way they influence and shape each other, independent of their coupling.

The issue of framing is also central to the second paper in this group, by **Colombini et al. (2015)**, which examines the policy processes that led to *the emergence of gender-based violence as a health policy issue in Nepal*, exemplified by the passage of a legal and policy framework to address gender-based violence. The authors argue that the interaction of contextual factors, actors and multiple

frames characterized the slow and somewhat tortuous evolution of policies to address gender-based violence in the country. In addition to contributing to the relatively sparse literature on agenda-setting for gender-based violence, the paper explicitly incorporates a discussion on framing into Kingdon's framework, illustrating how this influences the construction of problems, solutions (policies) and the opening or closing of policy windows. Initial framings of gender-based violence in terms of gender equity and development failed to result in legislation. However, the promotion of a human rights frame, enabled by a new Constitution and with political support from the highest level, led to the development and implementation of a legal and policy response, opening a window of opportunity to link gender-based violence with health. The paper also highlights the added value of a more nuanced understanding of the politics stream in agenda-setting – examining national and global level factors and their interactions and the way these influence the various framings of the issue.

The third paper applying Kingdon's ideas, by **Llamas and Mayhew (2016)**, illustrates factors influencing *the emergence of the traditional vertical birth (VB) practice within the public health system at the local level in Otavalo, Ecuador*. The paper uniquely examines the emergence of a practice (or policy with a small p) to illustrate the implementation of a larger policy of intercultural health (a combination of practices from both western and traditional medicine). The paper demonstrates how increased access to education among indigenous people over previous decades was critical to their being able to frame, at national level, the problem of maternal mortality as one of ethnic inequity, highlighting the long-drawn nature and deep roots of policy change. The focus on the micro level then demonstrates the role of a different set of policy actors (hospital managers and directors) in policy change to those traditionally envisioned as “policy elites”. Finally, the paper illuminates the interactions between practice and formal policy. While the increased space for intercultural health at the national level enabled the emergence of the VB practice, the implementation of the practice at the local level, in turn, played a significant role in the development of an intercultural policy on maternal health at the national level.

The next two papers pay special attention to the role of national policy elites in agenda-setting. **Agyepong and Adjei (2008)**, first, examine the political challenges associated with the *development of Ghana's National Health Insurance Scheme (NHIS)*, using Grindle and Thomas's framework. The authors assert that Ghana's NHIS came on to the policy agenda in 2001, in response to a strong sense of crisis. As it was a major electoral promise of the newly elected Government, the stakes were high, and there was high-level political support to act quickly to develop a programme. Political loyalists, who were seen to understand better the political compulsions underlying an urgent need for reform than technical specialists, thus dominated the policy process. This often resulted in decisions (such as those about benefit package design and contributions) that responded almost purely to political considerations and were not grounded in much evidence, with negative implications for the scheme's long-term sustainability and viability. The paper is unique in its use of participant observation based on the personal reflections of the authors, who were deeply involved in the policy process. It makes the case for technical and political actors to better understand each other in the interest of optimal policy design. While the former need to better appreciate the political nature of policy change, political actors would do well to show greater sensitivity for the need for technical analysis to inform their decisions in the interest of long-term sustainability. The interactions between researchers and policy-makers are considered further in section C3.

In contrast to the previous paper's focus on agenda-setting in a perceived crisis, **Crichton (2008)** analyses the difficulties in maintaining policy commitment in “politics-as-usual” circumstances, drawing on the **Grindle and Thomas (1989)** framework. This paper also, uniquely among the papers selected, considers the challenge of maintaining attention on an issue over time, as opposed to bringing it on to the policy agenda for the first time. The paper specifically analyses *the fluctuating commitment to family planning policies in Kenya in the 1990s and early 2000s*. Explaining variations over time in “policy space” (or “room for manoeuvre” influencing individual policy-maker agency for reform), it shows how changing contextual factors eventually enabled policy actors within the Kenyan Government to influence parliamentarians and wider public opinion to secure Government budgetary commitment for family planning – over a decade after an initial contraction in policy space, due to falling donor commitments not being replaced by national funding. In addition to serving as an excellent example of the empirical application of the policy space framework, the paper highlights the potential use of the framework as a tool for policy advocates to map policy space boundaries and develop particular strategies to increase policy space. Advocacy experiences and prospective policy analysis are considered further in section D1.

The paper by **Shiffman et al. (2004)** reports one of five studies on national priority-setting for maternal health (Shiffman, 2007). It examines factors underlying *the emergence of political priority*



for maternal mortality reduction in Honduras between 1990 and 1997, during which time there was a 40% decline in the national maternal mortality ratio. The paper argues that this decline was enabled by a high degree of cooperation between actors in global networks and national ministry officials, which allowed for the successful transfer of policies to address the maternal mortality ratio at the national level, as well as their implementation. National political stability, genuine partnership between national and international officials and global norms enabled policy transfer, while national and global focusing events enabled the institutionalization of political priority within the country. At an empirical level, the paper is unique to this selection in describing and analysing interactions between global networks and ministries of health, and the way this influenced domestic priority-setting and policy implementation. Picking up on issues raised in section C3, it challenges traditional conceptualizations of the largely unidirectional flow of policy influence from global to national actors, as well as questioning the neat demarcation of stakeholders as global or national-level actors, raising several important questions for future research. Finally, the paper makes an important theoretical contribution by incorporating an examination of the origins of policy preferences of States (constructivist theory) and the movement of policy across national boundaries (policy transfer theory) as part of an explanation of political prioritization for a policy issue, greatly enhancing the paper's explanatory power.

The next two papers examine global-level agenda-setting. **Shiffman et al. (2002)** seek to understand the policy processes underlying *the emergence of global disease control priorities* in terms of three distinct models of policy change – the rational model, the incremental model and the punctuated equilibrium model. Examining the post-Second-World-War histories of efforts to control poliomyelitis, malaria and tuberculosis, the authors argue that the punctuated equilibrium model best explains the way that disease control priorities emerged. Short bursts of attention are explained on the basis of the convergence of three factors – a general acceptance of a specific disease condition as a threat, the disease being seen as amenable to intervention, and the coming together of actors across national boundaries. Long stable periods are explained by the groundwork that must underlie the creation of each of these factors. There are several reasons for this paper's inclusion. First, it serves as an excellent empirical application of the punctuated equilibrium model. Going beyond this, however, by systematically testing the empirical evidence for three disease conditions against three different models of the policy change process, it has significant explanatory power. It also makes an important theoretical contribution by demonstrating the limitations of rational and incremental approaches to understand how policy change happens. The paper thus also serves to locate the agenda-setting stage of the policy process within broader, more all-encompassing models of policy change.

**Parkhurst and Vulimiri (2013)** seek, unusually, to explain *the relative non-attention given to cervical cancer on the global health agenda*; this is a condition that, in spite of being preventable and amenable to treatment, remains the second most common cause of cancer death in women globally. Based on insights into this issue generated through the application of four agenda-setting frameworks in their analysis (Geneau et al. ,2010; Hall, 1975; Kingdon, 1995; Shiffman and Smith, 2007) they identify four potential strategies to increase global attention for the issue. These are: increased availability of local-level data; a greater mobilization of those affected by the condition; framing cervical cancer to link it to the larger agendas of noncommunicable diseases and women's rights; and taking advantage of global-level policy windows related to noncommunicable diseases and the post-2015 agenda. The paper's application of four complementary frameworks to address a single case provides a range of perspectives and insights and enhances confidence in its findings. It also makes a methodological contribution to the literature through a reflection on the strengths and weaknesses of the different frameworks when applied at the global level; bringing to the fore differences in factors influencing national and global-level agenda-setting as well as the need for more research on global-level agenda-setting processes to better understand these differences. Section D1 discusses advocacy strategies in greater detail.

**Walt and Gilson (2014)** test *Shiffman and Smith's framework* against a set of 22 LMIC empirical papers on *agenda-setting* to (a) understand how the different parts of the framework facilitate the identification of factors influencing national and global-level agenda-setting; and (b) suggest modifications that might strengthen its future use. Each of the four elements – actor power, ideas, political context and issue characteristics – were found to be relevant. Notable adjustments suggested include an emphasis on the role of the media in framing issues (under the ideas element), an explicit examination of national and global governance, as well as the role of formal and informal institutions under political context, and a consideration of contestability or conflict as a potentially important issue characteristic. The paper also adds a new element, termed “outcome”, to judge how seriously the issue is being considered, defined in terms of an authoritative decision being made or resources being allocated. The paper concludes with thoughts for a future research agenda, emphasizing

the prospective application of frameworks, increased definitional clarity around concepts such as governance and institutions and comparative studies examining similar issues or topics in order to generate hypotheses around causal links and mechanisms.

Although Sabatier's advocacy coalition framework is commonly seen as a framework spanning policy stages, **Khayatzaadeh-Mahani et al. (2016)** use it to examine *an Iranian policy experience*. They seek to explain why advocates in Kerman province, Islamic Republic of Iran, failed in ensuring that a 2013 national-level law banning shisha (water pipe) smoking in public places was effectively enforced. Using a variety of framings to characterize shisha smoking (a threat to public health, a gateway to criminality, harmful effects on the environment), advocates succeeded in getting the provincial governor to pass an order enforcing the ban, only to see its implementation overturned the very next day. The authors explain this provincial policy stasis as a result both of fundamental disagreements among stakeholders with respect to their core and policy beliefs, leading them to disagree over what was acceptable evidence, and of the inadequate attention given by advocates to generating broad public support for the ban's enforcement. The paper serves as an interesting example both of a study of a failed advocacy effort and of the use of the advocacy coalition framework to examine an issue of increasing importance in most LMICs, given the rapid increase in the burden of noncommunicable diseases.

## FUTURE RESEARCH

Taken together, these papers raise several issues that have implications for future agenda-setting research. The first lesson is that, while agenda-setting can be examined exclusively at national and global levels, in many instances the process runs across these levels, something that is well illustrated by the **Shiffman (2004)** paper on Honduras and the **Colimbini et al. (2015)** paper on Nepal. It is thus important to examine explicitly how global-national-level interactions influence agenda-setting processes (see also section C3).

Second, even within national boundaries, it is important to recognize the role of different levels of government in agenda-setting processes, depending on the political system (see section B2) as well as the issue under consideration. For example, while national ministries were the central actors in setting the agenda with respect to issues involving national policy design and budgetary allocations (big P policies), in agenda-setting processes that were closer to issues of practice and policy implementation (little p policies), as in the Ecuadorian and Iranian cases, local and provincial actors were the major drivers.

The third lesson regards the range of actors involved in agenda-setting processes; in almost all the papers above, these go well beyond those who would be traditionally considered as policy-makers – including those working on the ground as implementers, academics, officials in international agencies and in advocacy groups, both issue-based and those representing particular population groups.

Another lesson is around framing. As seen in both **Shroff et al. (2015)** and **Colombini et al. (2015)**, the way the issue was constructed was critical in influencing which actors got engaged in each process, the policy solutions proposed and the potential windows of opportunity that they were able to open.

A fifth lesson concerns the role of technical and political actors in policy design and implementation processes. While technical analysis is a sine qua non of policy design, inadequately engaging with political actors to understand their interests and demands may lead to the process being completely taken over by them, resulting in policy design uninformed by evidence. The experience of the NHIS in Ghana, which has faced serious sustainability challenges, reflects this. There is thus a need for both groups to engage closely throughout the policy process towards a policy design that is as technically sound as possible while remaining politically feasible (**Aggepong and Adjei, 2008**). The centrality of interactions between researchers and policy-makers for policy processes more broadly is discussed in greater detail in section C3.

Finally, the papers demonstrate how agenda-setting, whether at the global or national level, is often a long and tortuous process, characterized by an unpredictable mix of rapid change, stasis and even setbacks (as the papers from Kenya and the Islamic Republic of Iran clearly show). The papers also raise the challenges of defining when an issue is actually on the agenda, as well as separating agenda-setting from policy adoption and implementation. Walt and Gilson's proposition to modify Shiffman and Smith's framework by explicitly including one or more outcome indicators to identify

where an issue is placed in the policy process is thus a fruitful area for further research (**Walt and Gilson, 2014**).

Taken together, the papers also highlight several gaps in the literature that need to be addressed. The first four would enhance the rigour of the analyses presented, enable theory building and so deepen understanding.

First, the lack of multicountry empirical research on agenda-setting is clear, as existing research typically focuses on either single country cases or on global-level agenda-setting. Cross-country analyses, comparing agenda-setting for a single issue using a single framework across multiple settings, would both increase confidence in the explanation of what happened and contribute to theory-building. Such research could, for example, potentially help to explain the relative contribution of each of Kingdon's three streams or better illustrate conditions associated with periods of stability and indicate when one can expect rapid change when applying the punctuated equilibrium model.

Second, single country case studies would be much strengthened by the use of multiple theoretical frameworks, as exemplified by **Shiffman et al. (2002; 2004)** and **Parkhurst and Vulimiri (2013)**. This analytical approach could help to shed light on agenda-setting frameworks and theories best suited to address particular issues and most applicable to particular circumstances.

Third, it may also be useful to use a single framework, such as Walt and Gilson's adaptation of Shiffman's framework, to examine agenda-setting for multiple policy issues in a single country, which could help to refine our understanding of particular mechanisms underlying the policy process within that one setting. Also, while the Kingdon model has much applicability, which accounts for its widespread use, there is a need to use other frameworks, either on their own or complementing Kingdon's framework, to enhance and deepen our understanding of agenda-setting processes.

Fourth, while theories and frameworks for agenda-setting do not typically lend themselves to quantification, this might be an interesting area for future research, including the further development of appropriate definitions, measures and metrics.

Finally, there is a paucity of literature on agenda-setting that is prospective or which explicitly combines learning from the past to inform how to move forward, in other words there is little published material on ways of systematically bringing things on to (or keeping them off) policy agendas, something that is of immense practical importance to policy and decision-makers (see also section D1).

## RESOURCES

### List of selected papers<sup>15</sup>

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# C3.

## RESEARCH, EVIDENCE AND POLICY CHANGE

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### INTRODUCTION

The role and power of ideas and knowledge in policy-making is central to policy analysis work. As noted in Part A, theory and practice has grappled with what knowledge is and how it feeds into policy and policy processes, as well as the role of the analyst within these. Since its early years, some policy analysis work has taken a positivist orientation and, reflected in the evaluation step within the policy stages cycle, has seen evidence primarily as an input into policy decision-making. However, based on a social constructivist perspective, discussion of agenda-setting specifically considers the role both of “credible data” and “ideas” (the portrayal of the issue by actors) in explaining why some issues receive policy attention and others do not (see section C2). The “argumentative turn”, meanwhile, sees policy analysts as facilitators of dialogue and deliberation in the policy process, rather than producers of evidence (Fischer, 2003; Part A).

Against this broader background, we first briefly outline the key lines of theory addressing how research influences policy and then, second, provide an overview of related issues within health debates and research.

Theoretical insights offer three different “models” of how research influences policy (Buse et al., 2012; Walt, 1994). First, and associated with the rational (and top-down) model of policy change, the engineering model assumes that research evidence is directly used in decision-making, as it solves a problem identified by policy-makers. Second, the interactive research utilization model posits that research and researchers are only one part of a process that also includes a range of other participants, who pool their knowledge and expertise to make sense of a problem. The process of decision-making is influenced as much by factors such as political insight, pressure and judgement as it is by evidence. Third, as the renowned evaluation theorist, Carol Weiss, specifically argues (1979), social science research most often influences decision-making through an “enlightenment” process, in which concepts and theoretical perspectives influence decision-making, rather than specific research findings. Weiss also suggests that research utilization can be a political or tactical process, where research is used as an element of argument for a particular decision and against others, or as a way of deflecting criticism of decisions made. In the useful Lavis et al. (2002) summary, health research may, then, have any or all of instrumental, conceptual and symbolic impacts.

The different models of research utilization also present different ways of understanding the researcher’s role – from neutral scientist (in the engineering model) to lucky bystander or active advocate (in the interactive and enlightenment models). They also see research itself as objective, scientific and neutral (a positivist lens) or as a contested form of knowledge (a social constructivist, interpretivist or post-positivist lens). In another seminal paper, meanwhile, Weiss (1991) argues that policy research findings can be seen as data (findings, research conclusions), ideas (in which findings are absorbed into a story) or argument (in which advocacy is added to research). She goes on to explore the conditions in which each research form is likely to be most influential, considering the level of contestation over values and goals among policy actors, the level of certainty or risk in the wider situation, the stage of decision-making and the arenas where decisions are made (e.g. decentralized units or the national legislature). Finally, addressing the issue of whether researchers should take on an advocacy role, Weiss (1991:50) notes that “at a minimum there are two obligations: to see that data are not distorted and to make the full body of evidence available to all sides in the debate”. Researchers must also make their values clear, so readers and decision-makers know their starting points.

The interface between health research and health policy has become an important focus of attention worldwide. Global health actors have been concerned about “getting research into policy and practice” (Whitty and Kinn, 2011) and have translated this concern into a focus on communications, research uptake and research impact within globally funded health research projects. The term “evidence-



informed policy” is also now widely used in the health arena, referring to “an approach to policy decisions that is intended to ensure that decision-making is well-informed by the best available research evidence” (Oxman et al., 2009:4). This concern has, in turn, supported the development of systematic review and evidence synthesis methodologies (e.g. Lavis, 2009), including for qualitative research (Tong et al., 2012) and advanced the strategies and tools of knowledge translation and exchange (Siron et al., 2015).

However, a recent systematic review of relevant research argues that the public health community has depoliticized the process of evidence use because it is primarily interested in if, by how much or how quickly pieces of evidence are taken up by policy-makers (Liverani et al., 2013). These authors note that, despite relevant theoretical insights, very little past health policy analysis research has explicitly examined the broader political and institutional influences over the use of evidence in public health policy. Such factors include the level of State centralization and democratization, the influence of external donors and organizations, the organization and function of bureaucracies and the framing of evidence in relation to social norms and values.

A related area of global debate within the health, as well as social and development, policy arenas, is determining what sorts of research questions and what sorts of research evidence are most useful for policy decision-making. In the recent past, a heavy emphasis has been placed on the questions “what works?” and “what does not work?” and, drawing from the evidence-based medicine movement, the randomized controlled trial (RCT) has been seen as the methodological gold standard for this work (Bédécarrats et al., 2017; Nutley et al., 2003). However, RCTs are increasingly recognized to have technical limits when used to assess public health and health system interventions (e.g. Victora et al., 2004), and have been criticized as being driven by particular actors and interests (e.g. Bédécarrats et al., 2017). Discussion about other research questions and forms of evidence has, then, become more common in social policy (e.g. Nutley et al., 2003), and HPSR certainly embraces a wide array of research questions and a non-hierarchical approach to research design (Gilson, 2012; Sheikh et al., 2011).

Empirically, particular attention has been paid to understanding the institutional barriers to research uptake and use in LMIC health policy-making. For example, El-Jardali et al. (2012) present the views of Lebanese researchers and Uneke et al. (2017) the views of Nigerian health policy-makers, while Uzochukwu et al. (2016) present experiences of seeking to bridge the gap between health researchers and policy-makers in Nigeria. These types of studies are founded on a wider understanding of the research and policy worlds as two separate communities, each shaped by different cultures, imperatives and incentives (Buse et al., 2012; Green and Bennett, 2007). Such studies commonly identify factors facilitating research use such as personal contact, timely relevance and the use of summaries with policy recommendations; whilst commonly identified barriers to research use include absence of personal contact, lack of timeliness or research relevance, mutual mistrust and power and budget struggles (Innvaer et al., 2002).

These types of studies have also fed into capacity development initiatives that seek to enhance the supply of and demand for health research evidence (e.g. Hawkes et al., 2015; Shroff et al., 2015). However, the idea of embedded research (Koon et al., 2013; WHO, 2012) moves HPSR beyond a “two worlds” understanding of the research-policy interface, towards new research approaches that entail collaboration between researchers and decision-makers and learning over time (see, for example, the Alliance for Health Policy and Systems Research programme of decision-maker led implementation research<sup>17</sup> or the RESYST-supported “learning site” approach<sup>18</sup>).

## SELECTED PAPERS

The papers selected for this section have been chosen to throw light on the interacting institutional and political factors that influence the use of research and evidence in policy decision-making, since this is a key gap in the current empirical literature (Liverani et al., 2013). The papers address the range of policy stages and so complement other sections in Part C.

Some papers also consider the forms of “evidence use” or “policy impact” achieved. Many offer ideas about strategies and approaches that might strengthen the interface between research/evidence and policy-making (see also section D1). The two exemplar papers that are included for this section of the Reader were chosen because they offer conceptual, practical and empirical insights into the

<sup>17</sup> See <http://www.who.int/alliance-hpsr/projects/dmir/en/>, accessed 31 July 2018.

<sup>18</sup> See <http://resyst.lshtm.ac.uk/sites/resyst.lshtm.ac.uk/files/Learning%20site%20brief.pdf>, accessed 31 July 2018.



institutional strategies and principles that can be applied in supporting evidence-informed health policy-making (**Hawkins and Parkhurst, 2016; Ongolo-Zogo et al., 2018**).

Together the 10 papers illustrate:

- the multiple forms of evidence/research use and impacts, which are difficult to tease apart in practice, and the fact that the array of actors who use evidence in decision-making extends beyond high-level and formal policy-makers (**d'Ostie-Racine et al., 2016; Gilson and McIntyre, 2008; Tulloch et al., 2011**);
- differences in the forms of evidence used at different stages of the policy cycle and by different types of policy actors indicating the importance of addressing a range of questions in research to support decision-making across the policy process (**Burchett et al., 2015; d'Ostie-Racine et al., 2016; Mirzoev et al., 2013**);
- differences in experience between policy issues, given greater contestation around more systemic and redistributive policies compared with distributive policies (**Gilson and McIntyre, 2008; Ongolo-Zogo et al., 2018**);
- the role of ideas and argument in research use and policy-making, and the role of policy networks in spreading them and bringing them to bear on decision-making (**Gilson and McIntyre, 2008; Ongolo-Zogo et al., 2018; Parkhurst, 2012; Woelk et al., 2009**);
- the fact that the institutional and political influences over research and evidence use differ between countries and policies, although the culture of evidence use has relevance across settings (**Gilson and McIntyre, 2008; Mirzoev et al., 2013; Parkhurst, 2012; Sumner and Harpham, 2008; Tulloch et al., 2011; Woelk et al., 2009**);
- a range of strategies and principles to strengthen institutional partnerships that support evidence-informed policy (**Gilson and McIntyre, 2008; Hawkins and Parkhurst, 2016; Ongolo-Zogo et al., 2018**; see also section D1).

We briefly describe below each of the papers selected, as well as our rationale for selecting them as illustrative examples of this area of LMIC health policy analysis work.

Considering, first, *maternal health decision-making in Ghana*, the paper by **Burchett et al. (2015)** was selected to offer insight about the different types of research identified as valuable in this setting. Both policy-makers and researchers were interviewed, the majority of whom were Ghanaian. Most respondents understood the concept of research quite broadly, encompassing not only formal studies, but also routine data, reports and informal insights. Reflecting the wider body of relevant research (see above), the two key factors commonly identified as enhancing the use of research were the relevance of the topic and the speed with which findings were generated. Interestingly, however, respondents distinguished between “large R” and “small r” research. The former entails large-scale projects, most of which assessed the effectiveness of interventions, involved non-Ghanaian collaborators and were funded externally; these were regarded as most relevant to global policy actors. The latter, sometimes regarded in the public health community generally as less rigorous work, focused on identifying routine problems and considering how to address them. “Small r” research was often undertaken by managers in the system who were in a position to act directly on the findings. The authors conclude that country-level health policy and systems decision-makers need research that addresses more than the “what works” question.

Two papers then examine directly how evidence feeds into decision-making, including discussion of different types of impact. The papers consider, first, the experience of those commissioning evaluations and second, of those conducting research.

**D'Ostie et al. (2016)** report, unusually, on experience with the *use of evaluation evidence by a humanitarian nongovernmental organization based in Burkina Faso*. The organization's staff supported the trial of a user fee exemption programme – that led on to national implementation by the Government, and that was accompanied by evaluation studies considering the effects, processes and relevance of the programme. The paper considers how the evaluation findings were used by the evaluation partners (managers of nongovernmental organizations, local managers and advocacy groups), and also offers reflections on the evaluation process itself. It concludes that evaluation partners began to understand and value the utility of the evaluation once they were exposed to its findings, which were then increasingly used in their decision-making. It was not easy, however, to tease apart instrumental, conceptual and symbolic (or persuasive) use (Alkin and Taut, 2003), while using the evidence to persuade political decision-makers proved challenging. The evaluation

processes, meanwhile, provided opportunities for the partners to reflect together and strengthen partnerships, even as they expressed some concerns about each other.

Presenting an insider account of experience generated through systematic reflection, **Gilson and McIntyre (2008)** consider both *the impact of a single HPSR project* that investigated South African health financing policy change in the 1990s and the range of wider *strategies implemented to engage with the policy world by two university-based and grant-funded research groups*. The project considered was unusual in its focus on the politics of policy change, rather than policy design, and, unlike the work examined in **D'Ostie et al. (2016)**, it was not commissioned by research users. The authors argue that this type of research is more likely to have conceptual than instrumental use (Lavis et al., 2002), and that in encouraging policy debate such use may itself stimulate longer-term policy change. At the same time, researchers may themselves bring about the instrumental use of findings through their wider engagement in policy processes. However, tracing these pathways of influence for one specific project proved difficult – in part because the research units routinely engaged with the national policy world in multiple ways (e.g. through different forms of research, as well as responding to requests for advice and teaching). These experiences themselves illustrate the opportunities for institutional engagement that come both from researchers being embedded in a particular policy setting and from researchers being entrepreneurial in policy engagement.

The next five papers report analyses of the political and institutional factors influencing the use of research and evidence in specific policy change processes in specific settings.

**Woelk et al. (2009)** present a rich, inductive analysis of the factors influencing *the use of research in policy-making for eclampsia treatment and malaria control, across three southern African countries (Mozambique, South Africa and Zimbabwe)*. Reflecting the broader literature (see above), the common influences identified by policy-makers and researchers included the perceived relevance of the research evidence, the backgrounds and experience of policy-makers and researchers, cultures of evidence use and broader national political (e.g. elections, policy windows) and bureaucratic (e.g. drug procurement and distribution) processes. Another important factor was the role of policy networks beyond the national setting as a conduit for transferring research findings into policy. However, comparison across policies showed that developing a common understanding of evidence was more difficult within the looser, regional issue network for malaria (with a “broader footprint”), compared to the narrow national and international policy community of eclampsia (with a “narrower” footprint). In addition, local champions were also important in translating research into policy-making, as national contexts filter the translation process through policy networks.

Again considering multiple policies in multiple national settings, **Mirzoev et al. (2013)** report *Asian experience about the role of evidence (from China, Guangxi Zhuang Autonomous Region; India, Gujarat State; and Viet Nam), around three maternal health policies*. The strong analytical approach involved the purposive selection of policies to support comparison between cross-sectoral and one-sector issues, between socially accepted and socially sensitive issues, and between internationally accepted technical interventions with interventions where there was less clear consensus. Drawing on the health policy framework presented in Green and Bennett (2007), the paper considers the role of evidence across policy stages, including implementation. This comprehensive study drawing on the views and experience of multiple actors, illustrates that across settings and policies the range of evidence used in decision-making progressively narrowed as agenda-setting, policy development and implementation were considered. As a result, the authors recommend that multiple (rather than single) policy options should be considered in policy development, and that sustainable means of generating evidence relevant to implementation are required. However, evidence use across the policy cycle is also influenced by policy actor perceptions of the robustness of evidence, power balances among these actors and their own agendas, as well as by the broader culture around evidence use and other political and contextual factors. The authors ultimately draw out five lessons for enhancing the use of evidence in maternal health policy processes.

**Sumner and Harpham (2008)** also report *Vietnamese and Indian (Andhra Pradesh State) experience, but consider child health policy*. The two settings allow comparison between a society with, historically, more limited political freedom but with some recently introduced participatory processes and a fledgling civil society (Viet Nam), and a free participatory democracy with vibrant civil society (India). Drawing on wider development policy theory and experience, as well as public policy theory, the authors identify three interlocking domains as commonly present in policy processes: policy narratives and discourses; policy actors and networks; policy-making context and institutions. The paper then presents and tests a series of hypotheses, grouped by these domains, about how specific factors are likely to impact on the supply of and demand for evidence. Summarizing data

collected through semi-structured phone and face to face interviews in a variety of ways, the authors conclude that the findings show that the extent of political freedom in a country is not necessarily a determining factor of research use and that in the countries of focus there remain “two worlds” of policy and research – while donor influence is strong, the demand for evidence is influenced by its supply. Finally, methodological rigour was found to be less important to research use than where researchers publish, their institutional base and how they package evidence.

Considering both the influencing factors proposed by Sumner and Harpham (see also Sumner et al. 2011), as well as the continuum of research use proposed by Nutley et al. (2007), **Tulloch et al. (2011)** present *four case studies of seeking policy impact through sexual and reproductive health research*, to consider both policy barriers to research use and the role of policy-researcher networks in enhancing its use. The case studies were developed by different researchers and presented and discussed at a meeting of researchers, communications specialists and donors with the aim of identifying strategies to influence research uptake. Their analysis highlights the importance of relationships and communications, but recognizes that, even when policies change, front-line practices may not. The authors conclude that long-term and continuous engagement between policy-makers and researchers is important in supporting evidence use, that such networks must engage policy-makers and practitioners, and that communication strategies must be sensitive to the specificities of technical, political and cultural contexts.

The last paper in this group (**Parkhurst, 2012**) focuses on one influencing factor – policy actors’ belief systems. Founded on a Foucauldian perspective and taking an interpretivist policy analysis approach (Fischer and Forester, 1993), the paper presents a critical discourse analysis of interviews and texts addressing experience around *implementing PEPFAR’s ABC<sup>19</sup> policy for HIV prevention in Uganda*. It explains the differences between the United States supporters and critics of PEPFAR in their understanding of the ABC policy, and in particular, abstinence promotion for HIV prevention. The analysis highlights the key concepts used by actors to support their differing claims, linking pieces of evidence to policy arguments or recommendations, and using additional texts to link the ideological concepts to their core beliefs on sexuality and sexual behaviour. Overall, the study helps to illustrate how cognitive processes affect how evidence is itself understood, with consequences for its use in policy development.

The two final papers, then, offer practical and conceptual ideas about how to develop institutional platforms and institutionalised processes that support evidence use in policy decision-making.

Presenting comprehensive analyses of experience around two policy processes in each country, **Ongolo-Zogo et al. (2018)** assess, unusually, *the long-term impact on policy processes of knowledge translation platforms established in Cameroon and Uganda*. Enabling partnerships among policy-makers, researchers, civil society organizations, the media and others, the platforms draw on a range of knowledge translation tools and strategies, such as stakeholder analysis, evidence briefs, policy dialogues, rapid response units, evidence clearinghouses and capacity development to demand, produce and use evidence. The analysis highlights the range of political and technical factors influencing decision-making, and suggests that the knowledge translation platforms had both direct and indirect (conceptual) impact derived from the combination of their activities. At one level, they were assessed to help actors make sense of key issues by presenting evidence-based frames of health problems and feasible policy options; at another level, the platforms were judged to alter the balance of power between actors, encouraging the development of policy issue networks and enhancing the democratic culture of policy-making. However, in both countries, impacts varied between policy issues, with less impact on more complex and contested systems-level policies (health district governance in Cameroon and task shifting among health workers in Uganda) compared with service specific policies (malaria control interventions in Cameroon and skilled birth attendance in Uganda).

Finally, **Hawkins and Parkhurst (2016)** present *a conceptual framework for guiding and evaluating evidence use by policy-makers* that reflects some of Weiss’ thinking (1979; 1991). Recognizing the political nature of policy decision-making, the authors start from the position that empirical evidence can inform policy-making but cannot settle the conflicts over values, interest and ideas that are central to these processes. Rather than offering ideas about how to improve the quality or timeliness of evidence or how to assess the impact of evidence in terms of the policy decisions taken, they develop a set of criteria by which to assess “good governance” in evidence use. They propose that these criteria should be applied to the processes by which evidence is identified, interpreted and used within decision-making, and should be institutionalized within the structures and bureaucratic links

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<sup>19</sup> ABC: Abstinence, Being faithful, and Condom use.

established to engage policy-makers and maintain accountability to local populations. The criteria embrace concern both for democratic principles of process and good evidentiary practice (see also Parkhurst, 2017).

## FUTURE RESEARCH

These papers all show the multiple influencing factors at play in policy decision-making, and suggest that future research should move beyond descriptive explorations of particular policy actors' views and experiences of the use of research and evidence.

Further work must, in particular, continue to develop and assess the experience of institutional partnerships, as **Ongolo-Zogo et al. (2018)** have done. Particular attention could be paid to whether, and how, new research and synthesis approaches are found to be valuable within these partnerships. Understanding and assessing partnerships that engage front-line managers and implementors, including the new forms of embedded research currently being promoted within HPSR, are also likely to be important. The "good governance of evidence" principles (**Hawkins and Parkhurst, 2016**) could be purposively applied, tested and reviewed within such work, considering power dynamics among actors, the power of ideas and discourses and the influence of broader political contexts. Attention could also be given to the long-term consequences of such partnerships, for researchers' development and career trajectories as well as policy change (**Ongolo-Zogo et al., 2018**).

Methodologically, several papers show how comparisons across policies and/or geographical areas enable deeper inquiry into policy decision-making and influences over it. Future studies might purposively select countries to be compared, based on characteristics of their political or administrative systems that are recognized to be important influencing factors. While rich case studies are likely to remain central to this area of work, data can be summarized and synthesized in various ways to aid analysis, and larger-scale hypothesis testing might draw on more structured interview and analysis approaches (see **Sumner and Harpham, 2008**). **Parkhurst (2012)** demonstrates the particular value and place of discourse analysis in this type of study. Future research could also more deliberately apply relevant theory and conceptual frameworks in comparative work across policy issues and settings, to test and develop theory. There would be value both in going back to older theory, such as that of Weiss, and in using the frameworks considered in some of these papers (**Mirzoev et al., 2013; Sumner and Harpham, 2008; Tulloch et al., 2011**) to deepen and develop the insights derived from related research. Tracking processes and influences over the long term will also be important, given the long trajectory of policy change. This would allow, for example, further consideration of the evidence needs of different policy actors, their changing perceptions of what research is and how different types of impact interact and change, across different stages of the policy cycle. Finally, systematic reflection by participants involved in research/policy partnerships, as presented by **Gilson and McIntyre (2008)** and **Tulloch et al. (2011)** should be encouraged to enrich inquiry.

## RESOURCES

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## Extra resources<sup>22</sup>

<http://www.ingentaconnect.com/content/tpp/ep>

*Evidence and Policy* is the first peer-reviewed journal dedicated to comprehensive and critical assessment of the relationship between research evidence and the concerns of policy-makers and practitioners, as well as researchers

<https://health-policy-systems.biomedcentral.com/>

*Health Research Policy and Systems* is a journal that covers all aspects of the organization and use of health research – including agenda-setting, building health research capacity and the way research as a whole benefits decision-makers, practitioners in health and related fields, and society at large.

<http://www.who.int/evidence/en/>

The Evidence-Informed Policy Network (EVIPNet) is a network established by WHO to promote the systematic use of research evidence in health policy-making in order to strengthen health systems and get the right programmes, services and drugs to those who need them.

<http://www.who.int/evidence/sure/en/>

Supporting the Use of Research Evidence (*SURE*) for policy in African health systems is a collaborative project that builds on and supports the Evidence-Informed Policy Network (EVIPNet) in Africa and the Region of East Africa Community Health Policy Initiative. The project involves teams of researchers and policy-makers in seven African countries and is supported by research teams in three European countries and Canada. *SURE* is funded by the European Commission's 7<sup>th</sup> Framework Programme (Grant agreement o. 222881).

<https://www.odi.org/our-work/programmes/research-and-policy-development>

The RAPID programme of the Overseas Development Institute, United Kingdom, works with researchers, organizations and governments to improve the integration of local knowledge and research-based evidence into policy-making.

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<sup>22</sup> All websites accessed 31 July 2018.





# C4.

## POLICY IMPLEMENTATION

Marsha Orgill and Lucy Gilson

### INTRODUCTION

As introduced in Part A, policy implementation is a central area of policy analysis thinking and empirical research that is focused broadly on understanding what influences the translation of public policy goals and intentions into practices and, ultimately, societal gains.

In health care, growing recognition of the gap between policy intentions and practices over the last 10–15 years has led to increased research attention being paid to understanding and supporting implementation. The field of “implementation science” has thus developed, with the journal of the same name<sup>23</sup> seeking to publish “evidence regarding methods for promoting the uptake of consolidated research findings into routine health-care practice and health policy”.<sup>24</sup> The policy-implementation gap was also a central driver underlying development of the field of HPSR (Bennett et al., 2018).

Yet very little implementation science or HPSR work explicitly draws on the wider, relevant body of policy implementation theory (Sheikh et al., 2011). Here, we sketch the broad contours of this body of theory to encourage its use in LMIC policy implementation work. Although not a comprehensive review, the references cited in this section and in Part A are an important resource for future research.

Many recognize the 1973 text by Pressman and Wildavsky (*Implementation: How Great Expectations in Washington are Dashed in Oakland*) as a critical milestone in policy analysis work (Hill and Hupe, 2009; Nilsen et al., 2013). Although older public administration, organizational and management literature had already considered the difficulties experienced in executing government decisions before the 1970s, public policy researchers tended to assume that implementation was essentially an uncontested and almost automatic process, in which policies are executed by skilful and compliant bureaucrats (Howlett, 2018; see Part A). The Pressman and Wildavsky text recognized the complexities of policy implementation and heralded an array of more deliberate research undertaken to understand why government programmes were not meeting intended goals and objectives in the United States and Europe (Hill and Hupe, 2009).

The evolution over time of policy implementation research has combined theoretical and methodological development, as well as contestation over the nature of implementation. The first generation of policy implementation research in the 1970s was largely undertaken in the form of a-theoretical single case studies using qualitative data, which supported the generation of hypotheses for wider testing (Saetran, 2014). The second generation emerged during the 1980s and encompassed the development of analytical and theoretical frameworks: Hupe and Saetran (2015) identify Van Meter and Van Horn (1975); Sabatier and Mazmanian (1979); Mazmanian and Sabatier (1981; 1983) as examples. This body of work considered the factors influencing implementation, had a strong empirical focus, included hypothesis testing, introduced quantitative techniques and showed a growth in comparative studies “asking why a policy would ‘succeed’ in one context and ‘fail’ in another” (Hupe and Saetran, 2015; Saetran, 2014). The 1980s also saw the emergence of the long-standing debates between top-down and bottom-up theorists (see below), which has been criticized for stifling conceptual development (Howlett, 2018) and led to calls for a third-generation research paradigm to improve the field scientifically. The papers by Goggin et al. (1990) and Lester et al. (1987), for example, argued that implementation research should employ multiple variables, multiple measures, large sample sizes and embrace multiple policies and longitudinal research of at least five to 10 years. Although some scholars have embraced some of these ideas, Saetran (2014) acknowledges the feasibility challenges to implementing research programmes of this kind.

As noted, debates between top-down and bottom-up thinking have been at the heart of policy implementation thinking over the years.

<sup>23</sup> See <https://implementationscience.biomedcentral.com/>, accessed 31 July 2018.

<sup>24</sup> See [www.https://implementationscience.biomedcentral.com/about](http://www.https://implementationscience.biomedcentral.com/about), accessed 31 July 2018.

## Top-down implementation theory

Pressman and Wildavsky (1973) and Sabatier and Mazmanian (1979) exemplify top-down implementation theory. Taking the perspective of those at the top of bureaucratic hierarchies who are responsible for setting out policy intentions (for example, national government departments), they seek to understand the mechanisms that ensure that implementing agents stick to these intentions as they implement policies (Howlett, 2018). Top-down theorists proposed a set of generally necessary conditions for policies to be successfully implemented. These include that: (1) policies should have clear and consistent objectives providing clarity for evaluation and serving as a resource for implementing officials; (2) policies should incorporate an adequate causal theory of how they would bring about social change and should be implemented by agencies who had high support for them; (3) the implementation process should have a clear legal structure to enhance compliance by implementing officials and target groups (such as sanctions and incentives that could be used to overcome resistance); (4) the long policy process needs the political support of interest groups and key government officials; and (5) there would need to be fairly consistent socioeconomic conditions free from major political upheaval (Sabatier, 1988). Hogwood and Gunn's preconditions for "perfect implementation" added to the above list both perfect communication and coordination and the required combination of resources being available (Hogwood and Gunn, 1984; 1997). In many ways, this top-down perspective reflects the mechanistic view of policy implementation that drove pre-1970s' policy analysis thinking, in which implementation was depicted as just one step in the rational decision-making of the "policy cycle" or "stages heuristic" (see Part A), and policies were seen as being generalizable to multiple contexts (Matland, 1995).

## Bottom-up theories of implementation

However, the top-down implementation perspective has been criticized on the grounds that its assumptions about how implementation occurs are unwarranted. Critics note, for example, that policy is itself a slippery concept, contested and negotiated, making it difficult to see where policy formulation ends and policy implementation begins. Top-level bureaucrats also cannot simply demand compliance from those at lower levels (Hill and Hupe, 2009).

Taking the perspective of those working at the front line of bureaucracies that engage with their clients, bottom-up theorists highlight the many different activities routinely occurring within policy implementation. Often they are emergent, ad hoc and innovative, not necessarily linked to a centrally driven policy and requiring engagement with actors or networks of actors outside the formal chain of bureaucratic command to ensure implementation (Hanf and Scharpf, 1978; Hill and Hupe, 2009). A simple definition of bottom-up implementation is "the process of turning a policy into practice" (Buse et al., 2005:120). From this perspective, implementation involves a series of processes in which formal policy documents and statements are translated into practice through processes and actions, that are themselves influenced by implementing actors' agency, understanding of the world, power, values, knowledge, interests and the context in which they work. Rather than understanding implementation as a linear process of moving from intention to action, Barrett and Fudge (1981:25) conceived of implementation "as a policy/action continuum in which an interactive and negotiative process is taking place over time, between those seeking to put policy into effect and those upon whom action depends". They asserted that "conformance" to top-down policy goals should, then, not be the measure of policy success. Instead, success should be measured by "performance", that is getting something done through processes of negotiation, bargaining and compromise led by implementing actors (Barrett and Fudge, 1981; Howlett, 2018).

Lipsky (1980; 2010) is one of the most well known bottom-up theorists. His work highlights the way in which front-line providers, or street-level bureaucrats, shape clients' experience of policy through their practices, and it provides explanations of what influences their behaviour. He argues that, to cope with the realities of their workplaces (often underresourced settings with heavy, and increasing, workloads), street-level bureaucrats use their discretion in deciding whether and how to implement a new policy. Although these coping behaviours may contradict policy goals, discretionary decision-making can also be appropriately responsive to the needs of clients and providers (Gilson, 2015).

Hjern and Porter (1981), meanwhile, argued that implementation takes place through "implementation structures" rather than through central control. Such structures represent primarily self-selected actors from parts of different organizations in the public and/or private sector from which resources are mobilized; the structure that emerges is then understood as an official administrative entity that can be studied. Actors in "implementation structures" share a common interest in the specific programme being implemented, although their interest levels may differ. Some implementation structures are ad

hoc, with unsettled expectations, while others are more developed, cohesive and routine and so might be “described as networks of relationships in which participants have rather settled expectations about each other’s actions” (Hjern and Porter, 1981:223). These ideas represent the early theoretical foundations for the policy network approaches that have become more widespread in the policy sciences (see below, and sections B3 and C1).

## **Synthesizers**

Over time, public policy scholars have tried to synthesize top-down and bottom-up perspectives within more integrated frameworks, to support thinking about how to manage implementation by drawing on both perspectives (Sabatier, 1988).

One strand of thinking has focused on the features of policy design or content, and their interaction with processes.

Lowi (1964; 1972) first introduced the idea that different types of policy-making and politics play out around four different types of policies – distributive (the distribution of new resources), redistributive (changing the distribution of existing resources), regulatory (the regulation and control of activities) and constituent (the setting up or reorganization of institutions). Ripley and Franklin (1982) then considered the balance of stability and conflict in routines, relationships and ideas likely to play out around policy types. In order to understand the design and implementation of policies, Elmore (1979-80), meanwhile, thought through the steps entailed by both forward mapping (breaking down the goals, objectives, processes and resources available to policy-makers) and backward mapping (starting from the perspective of those at the bottom). Matland (1995), finally, considered how the degree of ambiguity and conflict surrounding any policy is likely to influence the process of implementation. Where there is low ambiguity and high conflict, top-down approaches may be feasible if those at the top provide appropriate structure and have authority to get agents to comply. Where there is high ambiguity and low conflict, bottom-up approaches are important as they allow learning.

A second example of synthesis thinking is the “communications” model devised by Goggin et al. (1990). Based on United States experience, this model sees implementation as a process cutting across the various governance levels within the country. Considering national policy as “federal messages”, the authors identify variables that influence the acceptance or rejection of messages between layers of government and, thus, decision-making by the middle (state) level (Hill and Hupe, 2002; Matland, 1995).

A third strand of synthesizing work has focused on the role of networks. Sabatier’s advocacy coalition theory (1988), for example, is commonly seen as being a synthesis of top-down and bottom-up insights. Kickert et al. (1997; see also Klijn and Koppenjan, 2000, Koppenjan and Klijn, 2004) also see policy-making as involving complex interactions among networks of interdependent actors. Success or failure in policy-making is, then, based on the extent of cooperation achieved, which is in turn shaped by features of network process and structure (Hill and Hupe, 2009:70). Network management, meanwhile, entails managing interactions within networks and changing the institutional arrangements that make up the networks, a very different form of management from that traditionally assumed in top-down models (Hudson and Lowe, 2004).

While some synthesis has taken place, no general implementation theory has so far been developed, and there continues to be debate about the value of further theoretical development (Saetren, 2014). Nonetheless, Howlett (2018), for example, presents a new framework for understanding implementation that is derived explicitly from merging the classical policy cycle with insights from agenda-setting theory (Kingdon, 1984) and from advocacy coalition theory (Sabatier, 1988).

## **Other theories of relevance to health policy implementation**

Beyond the established terrain of policy implementation theory, future LMIC health policy analysis research could also draw on two other areas of theory.

First, innovation theory (Brown and Osborne, 2012; Greenhalgh, 2004; Osborne and Brown, 2005; Rogers, 2003) offers ideas that can enhance understanding of the bottom-up processes of ideas generation and policy implementation; these are specifically relevant to debates about scaling up policy interventions (Gilson and Schneider, 2010; Spicer et al., 2014; Subramanian et al., 2011).

Osborne and Brown (2005:4) define public innovation as “the introduction of new elements into a public service – in the form of new knowledge, a new organization and/or new management or processual skills. It represents discontinuity with the past”. In health care, such innovation is seen as “directed at improving health outcomes, administrative efficiency, cost-effectiveness, or users’

experience” and “implemented by planned and coordinated actions” (Greenhalgh et al., 2004:582). Theory suggests that innovation can be “top-down”, that is, managers implement innovation in public services to meet an existing need in a more efficient way; but also that it can be developed bottom-up, by front-line providers as a local response to need (Osborne and Brown, 2005). Reflecting bottom-up implementation theory, the possible obstacles to innovation in public services include bureaucratic attitudes, coordination problems and failure to reach target groups (Osborne and Brown, 2005). Approaches to spreading and sustaining innovations in health service delivery and organization, then, range from early efforts to communicate information, to consideration of the needs of those who must adopt and implement the innovation (Greenhalgh et al., 2004).

Second, a growing body of empirical HPSR in LMIC recognizes that health systems are complex adaptive systems (Adam, 2014; Adam and de Savigny, 2012). In other words, health systems exhibit properties of emergence, non-linearity, embeddedness within other systems, co-evolution and self-organization (Byrne, 2013; Byrne and Callaghan, 2014). Given these properties, there is an inevitable unpredictability in what may be achieved when implementing policies and programmes, especially as they can themselves exhibit complex properties (Pawson, 2013). Although offering relevant insights and approaches, complex adaptive system thinking has, as yet, rarely been explicitly used specifically to analyse health policy implementation in LMICs (although see e.g. **Gilson et al., 2014**). Such understandings have, however, stimulated the growth of realist evaluation in HPSR, with the aim of generating theory-building accounts of the ways in which multiple interactions among intervention, actors, context and mechanisms influence the implementation experience and explain its outcomes (Marchal et al., 2018; Van Belle et al., 2017).

### **What are the differences between policy implementation theory and implementation science?**

Both areas of work are concerned with how to translate the intentions embedded in health policies and programmes into front-line behaviours and practices.

Implementation science essentially focuses on how to improve the effectiveness of specific health interventions, judged in terms of their original objectives. This is an essentially top-down perspective that Nilsen et al. (2013) argue is rooted in a more reductionist and positivist approach to implementation than policy implementation research. Implementation scientists, then, generally focus on a number of determinants that are causally linked to outputs and outcomes and, often through fixed design and quantitative research, seek to identify the effectiveness of very specific strategies. Where policy actors are considered, the focus is on how to influence the behaviours of the limited number of actors most closely associated with the intervention.

Policy implementation research, meanwhile, addresses multiple health system policy domains (e.g. including health financing and health workforce policies) and considers a wide range of policy actors, across levels of a system, or within policy networks (Sheikh et al., 2011). It is concerned with how these actors’ collective action is sustained or undermined over time, recognizing the interdependence of implementation determinants – including the way in which the context (e.g. front-line provider values and beliefs, legal regulations) influences the policy itself and the implementation strategies employed. While some policy implementation research seeks to test hypotheses and build theory better to understand policy implementation, such research often adopts flexible designs and primarily qualitative or mixed methods research, providing rich description of experiences over time (Nilsen et al., 2013).

## **SELECTED PAPERS**

The 10 papers chosen for this section have been selected because they explicitly draw on policy implementation theory or, in two cases, illustrate the potential of other, relevant bodies of theory in understanding policy implementation. Offering rich accounts of experience, they provide insight into the current body of LMIC health policy implementation research – and offer greater detail around some of the areas of experience highlighted by papers in section C1. The papers also illustrate the application of qualitative, mixed method and case study designs in this research.

The two exemplar papers selected for this section of the Reader are **Erasmus et al., 2014**, which outlines the current scope of work in policy implementation research; and **Walker and Gilson, 2004** who present an in-depth and theoretically framed analysis of policy implementation, combining use of top-down and street-level bureaucracy theory.

Together, the papers illustrate:

- the critical influence of contextual factors over policy implementation, and, more specifically, of organizational and social norms (**Erasmus et al., 2017; Prashanth et al., 2014; Olivier de Sardan et al., 2017**; see also section B2);
- how front-line providers' values and beliefs influence their reactions to the content or design details of policies, as well as their approach to implementation (e.g. **Walker and Gilson, 2004; Aniteye et al., 2013; Erasmus et al., 2017**);
- the exercise of discretionary power by front-line providers (e.g. **Walker and Gilson, 2004; Aniteye et al., 2013**) and the influence of power dynamics in implementation (e.g. **Lencucha et al., 2015; Schneider et al., 2010; Olivier de Sardan et al., 2017**; see also section B1);
- the important influence of mid-level managers over implementation (**Schneider et al., 2010; Walker and Gilson, 2004; Aniteye et al., 2013**);
- that communication and meaning-making is an important managerial activity in implementation (e.g. **Walker and Gilson, 2004; Aniteye et al., 2013; Erasmus et al., 2017; Schneider et al., 2010; Abuya et al., 2010; Meessen et al., 2011**; see also section D1);
- that managerial support for implementation needs to recognize and adapt to key features of local context, such as organizational culture and practical norms (**Erasmus et al., 2017; Prashanth et al., 2014; Walker and Gilson, 2004; Aniteye et al., 2013; Schneider et al., 2010; Abuya et al., 2010; Meessen et al., 2011**); see also section D1);
- how global policy prescriptions are translated during implementation by local actors in local contexts (**Olivier de Sardan et al., 2017; Lencucha et al., 2015**; see also section B3);
- the possible contributions of innovation theory and realist evaluation for policy implementation research (**Abuya et al., 2010; Prashanth et al., 2014**), while recognizing that the focus on power in policy implementation offers value to these other areas of work.

The papers in this section are complemented, in particular, by three papers from section B1 which explicitly address power in implementation: **Dalglish et al., 2015; Gilson et al., 2014; Lehmann and Gilson, 2013**.

We briefly describe each of the papers below, as well as our rationale for selecting them as illustrative examples of the scope of LMIC work on health policy implementation.

The first paper, by **Erasmus et al. (2014)**, presents a *qualitative synthesis of existing LMIC published policy implementation research for the period 1994–2009*. It provides insight into the broad range of policy topics and research questions that have been addressed within this body of work. Over time, decentralization, reproductive health and HIV/AIDS have been the most enduring policy areas considered. Analyses conducted range from broad descriptive accounts of long policy processes (that e.g. consider national policy-makers' changing perceptions over time on contested issues) to the influence that microcontexts (e.g. relationships between people) can have on implementation and service delivery. The paper also provides a summary of the variety of implementation outcomes that researchers have identified in their papers, together with an interpretive synthesis of the implementation improvement strategies represented within them. Finally, the paper considers both the contribution of different disciplines to this area of work and the theoretical frameworks currently applied within it. Overall, the paper illustrates the limited and fragmented nature of this area of work and identifies the importance of improving the process and practice of implementation itself.

Drawing explicitly on insights derived from top-down theoretical perspectives, **Meessen et al. (2011)** present a cross-country synthesis of *experience around policies for the removal of user fees in six sub-Saharan African countries (Burkina Faso, Burundi, Ghana, Liberia, Senegal and Uganda)*. A set of 20 “good practice” hypotheses were developed from a combination of public policy, health policy and health financing policy literature, to evaluate the formulation and implementation of the policies in each country (Hercot et al., 2011). These hypotheses range from considering the preparatory work conducted and policy content details, the sequencing of implementation, communication strategies, technical leadership and support and the rules governing resource transfers for implementation. The analysis shows that many of the countries diverged from these “good practices”, highlighting both the influence of politicians and political pressures over policy implementation and the lack of effort to learn through implementation or ensure effective communication with policy implementors and the public. Overall, the paper provides a range of insights into the bottlenecks and opportunities

around formulating and implementing large-scale reform and draws out lessons for policy design and formulation.

A set of three papers then explore front-line providers' experiences of implementation, drawing on bottom-up perspectives, including Lipsky's theory of street-level bureaucracy (1980; 2010).

**Walker and Gilson (2004)** highlight the central role of nurses and facility managers in *implementing the removal of user fees in South Africa in the mid-1990s*. These authors summarize their qualitative and quantitative data against the key tenets both of top down theory and street-level bureaucracy, to illustrate how these actors experienced the process of policy implementation. This analysis points to the critical influence of implementers' own values and experiences over implementation. It shows how they interpreted and adapted this policy change, one of many policy initiatives being implemented from the top at the same time, in ways that may have led to unexpected outcomes. Rather than concluding that improved planning is critical in strengthening implementation (a top-down perspective), the authors point to the importance of managing meaning in implementation. They suggest this could be done by linking nurses' professional commitments to new policies, as well as by strengthening the role of front-line networks and mid-level managers in an implementation process that demonstrates respect and trust for front-line providers.

**Aniteye et al. (2013)** also show *how provider values and attitudes shape implementation, considering abortion care in Ghana*. They offer detailed insights into obstetricians', midwives' and other health professionals' attitudes and values towards abortion care, using Lipsky's notions of "personal dilemmas" and "social pressures". While Lipsky (1980; 2010) focused on resource constraints as a key influence over provider behaviour, this analysis shows that cultural and religious contexts as well as provider values and attitudes influenced health-care provider practices – although, even in the same context, providers' responses differed. Those who had been more exposed to international declarations and safe abortion practices in other countries were more willing to provide abortion services, while other providers considered such actions morally wrong on religious grounds and some even restricted counselling for all available options. The important influence of mid-level managers over front-line provider experience and implementation is identified as a factor limiting their discretionary power, although doctors and nurses have different sources of power. Suggestions for improving implementation again include managing policy meaning, for example by framing abortion as a health rather than a moral issue and through values clarification workshops that engage providers and their managers, as well as wider advocacy on legal abortion.

Finally, in this set of papers, **Erasmus et al. (2017)** present an analysis of *the implementation of two equity-oriented policies within two South African district hospitals* - a policy on patient's rights and a policy on exemptions set within a wider user fee framework. This study is unusual because it applies a mixed methods and embedded case study design in analysing how organizational contexts, including the values embedded in these contexts, interact with the details of policy content, to influence front-line providers and, through them, policy implementation. Forms of organizational culture and levels of organizational trust are specifically analysed as factors influencing the implementation of policies. The findings illustrate that, in one hospital, which had a clan culture and high levels of organizational trust, it was easier to take explicit steps to implement the patient's rights policy, the content of which challenged provider power. At the same time, in both hospitals, organizational cultures that value order, control and stability supported the implementation of the user fee policy, given clear guidance about patient categories and fee levels, as well as revenue targets. Although this policy did not conflict with implementer's values, revenue generation was prioritized over fee exemptions. The managerial implications of this study include the importance of relationship management and the negotiation of values around policies that challenge front-line providers' status and values, as well as more explicit consideration of how managerial actions shape organizational contexts and hinder or support policy implementation.

The next three papers also present studies of implementation experience that involve cross-case analysis – each drawing on different bodies of theory in seeking to explain why implementation outcomes varied across the cases of focus.

**Abuya et al. (2010)** use innovation theory in analysing the experience of implementing *a novel intervention to improve prompt and effective antimalarial drug use through private medicine retailers, across three districts in Kenya*. They seek to explain differences in the intervention's outcomes (a change in private medicine retailer knowledge and practice) across the three districts, drawing on a combination of insights derived from Greenhalgh et al. (2004), Simmons and Shiffman (2006) and **Walt and Gilson (1994)**. Noting that the use of conceptual frameworks helps guide systematic analysis, they identify the role of communication and relationships between actors up and down the system



and horizontally within partnerships and networks as critical in these experiences. Implementation effectiveness was enhanced when the resource team (from outside the district, providing technical support for implementation) had experience, was trusted by the user organization and had wider networks, when the user organization (the district health managers) benefited from leadership stability and when the relationship between them was underpinned by transparent and agreed principles. In addition, flexible management and budgetary systems within the user organization enabled programme adaptation in response to experience, thereby enhancing effectiveness. These insights point to lessons about ways to support the implementation and scale-up of public health innovations in other settings.

**Prashanth et al. (2014)** then draw on a realist evaluation approach and use mixed methods to explain how a *capacity-building intervention for health managers implemented in two different sites in Tamkur district, India*, generated different outcomes. As health systems exhibit characteristics of complex adaptive systems, the way people or systems respond to “new knowledge, skills or ideas is neither straightforward nor easily predictable” (**Prashanth et al., 2014:2**). Realist evaluation uses iterative enquiry to provide plausible explanations of change through exploring the pathways, mechanisms and contextual factors that influence the observed outcomes of an intervention. In this paper, the outcomes of the capacity-building intervention were found to be affected by each site’s unique organizational context rather than primarily by the availability and motivation of individual staff to participate in training. Implementation of managerial development programmes must then take account of the particular organizational contexts in which individuals work, seeking to align existing relationships between the internal (individual and organizational) and external (policy and sociopolitical environment) attributes of the organizations to support overall performance gains.

**Schneider et al. (2010)**, the last paper in this group, seek to explain how operational and strategic management influenced the different antiretroviral coverage levels achieved across three provinces in *the early years of antiretroviral roll-out in South Africa (2004–2007)*. In a mixed methods study, applying ideas derived from Brinkerhoff and Crosby (2002), they identify strategic management differences between the three provinces as key explanations of the different outcomes achieved. These included the different political circumstances of the three provinces within the overarching quasi-federal system, as well as differences in programme design, partnerships and bottom-up leadership to support the roll-out. The authors conclude that scaling up public health interventions is not exclusively an issue of “system capacity”, financial and human resourcing, as commonly understood. Instead it is an implementation process that needs to be actively managed, taking account of local contexts. Strategic management skills that aided antiretroviral roll-out included the ability and willingness of political leaders to assert a clear direction, to acquire additional resources and to govern key knowledge and implementation partnerships. Also important was flexibility in implementation to enable local innovation and build on prior learning and tacit knowledge.

Although the ideas, interests and institutions that permeate national health systems are increasingly global in nature, the last two papers illustrate how local social and organizational contexts influence the implementation of global policies (see also section B3).

**Olivier de Sardan et al. (2017)** reflect on 15 years of ethnographic research in West Africa to consider why the “travelling models” of *maternal health policy* confront challenges when implemented in new settings. These “travelling models” (e.g. the partogram, focused antenatal care, the prevention of mother-to-child transmission of HIV or performance-based payment) are defined as standardized interventions that seek to change the behaviour of one or more actors through embedded mechanisms that are assumed to have similar effects across implementation contexts. Using empirical examples and reflecting the insights of bottom-up policy theory, the authors argue that these interventions are operationalized by social actors working within pre-existing routines, norms and organizational cultures. As the social and pragmatic norms of patients and providers differ from the norms embedded in the policies, the implementation gap between policy intention and practice is inevitable. They conclude that implementation towards policy goals requires the adaptation of existing pragmatic norms and that this is best undertaken by “reformer health personnel”, who are working to transform professional cultures from inside, or by local organizations exploring innovative approaches based on local realities. Overall, this paper presents an important critique of global public health practice, including the application of randomized controlled trial study designs, recognizing the power of global experts and the global dynamics at play across development sectors.

Finally, **Lencucha et al. (2015)** provide a detailed account of *national-level policy contestation around implementing the global WHO Framework Convention on Tobacco Control (WHO FCTC) in the Philippines*. The paper illustrates how national-level discourse, ideas, institutional arrangements

and laws matter when trying to implement global public health goals. Although the Department of Health seeks to implement measures in alignment with the WHO FCTC, the Philippines Tobacco Regulation Act of 2003 (RA 9211) undermines its ability to do so. This national policy gives power to the Department of Trade and Industry to chair policy spaces where decisions are made regarding tobacco control, and also makes allowances to include a tobacco industry representative in these spaces. Thus, while the goals of the WHO FCTC are clear and the Philippines Department of Health agrees with these goals, the implementation of this policy is contested within the country – there is contestation between health and commercial interests among government departments, and private sector interests are not aligned with public health interests. Implementation of global health goals can be either enabled or constrained by the power of country-level actors, while the institutional arrangements established to support whole-of-government decision-making have particular influence over policy action on noncommunicable diseases.

## **FUTURE RESEARCH**

The papers selected show that very little of the wider body of policy implementation theory is commonly used in LMIC research. Street-level bureaucracy is, perhaps, the most often used theory, but there is little indication of a consistent and coherent effort to test and develop any particular set of theoretical ideas.

Future research could, then:

- include more detailed syntheses of existing research to consolidate knowledge, using a range of synthesis approaches (Erasmus, 2014 uses meta-ethnography, for example);
- proactively set out to test and develop bodies of relevant theory in LMIC settings (for example, a deliberate and sustained programme of work around street-level bureaucracy could generate adaptations appropriate to LMIC settings).

In addition, future research could draw on theory in identifying and investigating the many relevant questions currently overlooked, of which some are:

- the nature and role of actor networks and self-organized structures in implementation;
- how implementation varies across policy types;
- the role of ideas, framing and reframing, and communication in implementation (see Part A);
- how broader political dynamics, including contestation in agenda-setting and policy formulation influences implementation (see e.g. Howlett, 2018);
- how multilevel governance influences implementation, e.g. the implementation opportunities and challenges under centralized versus federal governance structures (Hill and Hupe, 2009);
- the management and leadership styles and practices needed to support implementation, considering different policies and contexts;
- innovation as an implementation issue.

Current research also points to the importance of more explicitly considering the exercise of power and power dynamics in future implementation work (see section B1), as well as paying closer attention to national and local contexts (see section B2), and to global actors, their influence, and resistance to them (see section B3). Organizational theory may offer particular value for deeper inquiry into the organizational settings of implementation and innovation.

Policy implementation theory and questions, and concern for power, could, meanwhile, be infused into wider evaluation work.

From a methodological perspective, the complexity of implementation phenomena suggest that flexible study designs using primarily qualitative methods and ethnography are likely to remain important. The papers presented here also show the value of cross-case comparative analysis in explaining differences in implementation outcomes and in developing analytical generalizations and plausible theory for continued knowledge development. Longitudinal work is also likely to offer value, given the long time frames of implementation. Finally, as rarely used, there would be value in exploring the use of mixed method study designs and quantitative analyses in understanding policy implementation.



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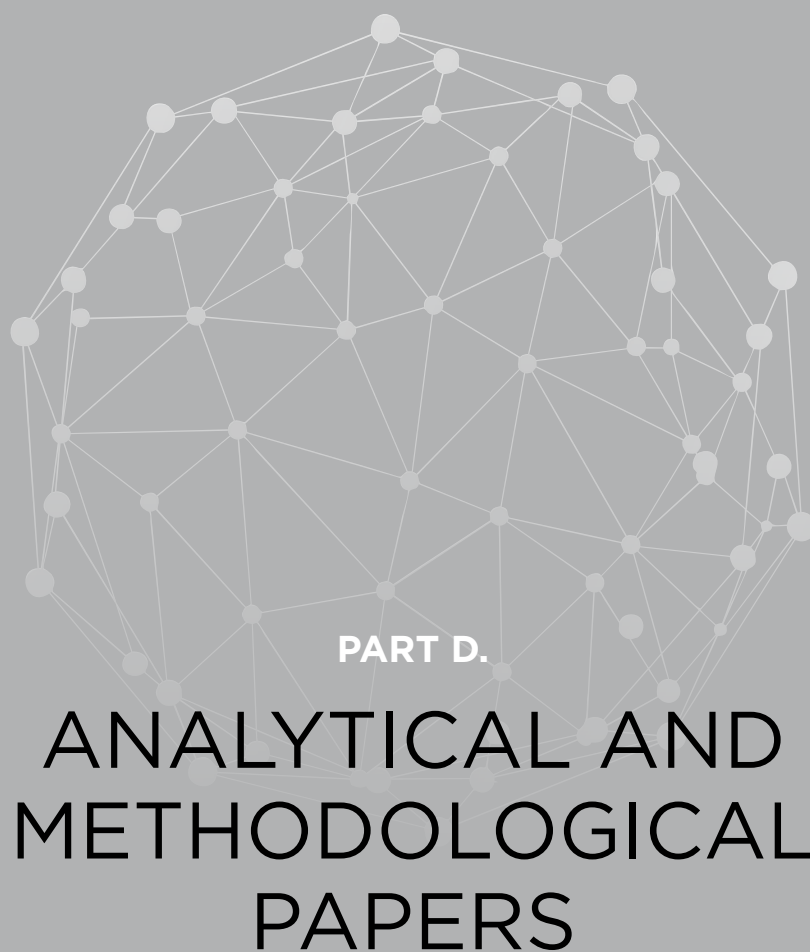
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<b>D1. Using health policy analysis prospectively to influence policy change .....</b>	<b>95</b>
<b>D2. Methodological issues in health policy analysis research .....</b>	<b>101</b>



# D1.

# USING HEALTH POLICY ANALYSIS PROSPECTIVELY TO INFLUENCE POLICY CHANGE

Marsha Orgill and Lucy Gilson

## INTRODUCTION

As highlighted in Part A, over 20 years ago Gill Walt noted that “if we as health workers, or as teachers, or students, or civil servants, do not feel that we, and the groups or organisations which we belong to, have some power to alter the policy that affects our lives, or the lives of those around us, why get up in the morning?” (1994:10).

From this perspective, health policy analysis is important not only because it illuminates the politics of policy change, but also because it can be used to inform action aimed at bringing about health and societal change. It can, then, not only be used retrospectively, to understand past policy failures and experiences, but also, prospectively, to support change (**Walt et al., 2008**).

Kent Buse (2008) has also written persuasively about the value of prospective policy analysis. He notes both that “to be prepared entails some understanding of the political dimensions of the policy in question” (Buse, 2008:352) and that this requires “*analysis which seeks to understand the unfolding political-economy environment of policy change to support stakeholders to more effectively engage in policy processes*” (Buse, 2008:351, emphasis added). Such analysis includes work that is forward-looking, with real-time documentation, immediate lesson-learning (analysis) and feedback into action. By leveraging windows of opportunity, policy reformers or advocates might hope for major changes in policy documents or directions, but the influence achieved “may be as subtle as a shift in perceptions of an issue that sets the stage for more apparent and tangible change at a future date” (Buse, 2008:356).

This section seeks to introduce various ways in which health policy analysis frameworks and tools can be used prospectively to understand and engage with the political dimensions of policy processes. It seeks to support practical thinking about the use of prospective health policy analysis to influence policy change as an insider or outsider and in the everyday practice of managers, policy-makers, advocates and researchers.

## SELECTED PAPERS

In practice, not many published papers report prospective policy analysis. From the limited available pool, 10 papers were thus selected to present both theoretical or analytical ideas that support stakeholders to engage proactively in policy processes and papers that report real-world experience of such action. These 10 papers also address the various target audiences for whom prospective policy analysis may be useful, including researchers, policy-makers, managers, civil servants and donors. The two exemplar papers included, **Buse et al. (2009)** and **Makan et al. (2015)** offer real-world examples of prospective policy analysis addressing policy-makers and researchers, respectively.

We briefly describe each of the papers selected as well as our rationale for selecting them as illustrative examples of this underreported area of LMIC health policy analysis work.

The paper by **Weible et al. (2012)** sets the scene for this section, drawing from policy sciences theory. The authors identify, first, *critical components in the political-economy environment that are important to consider before taking action*. These include identifying the actors within and boundaries of policy subsystems, working on a policy issue in a particular geographical area, understanding the macrosystem or broader rules in which the subsystems are nested, such as the political system and the culture of a society, and understanding the different paths that could lead to minor and major change, including major events that stimulate action (e.g. a crisis), learning that alters values and

attitudes and the nature of negotiation and cooperation between actors. Second, *key strategies for effectively engaging in the policy process* are identified. Developing deep knowledge of the belief systems and ways in which participants understand and reason in the world is important, as well as building networks and cooperating with others in the particular policy subsystem of focus, to overcome obstacles and leverage opportunities. The authors recommend spending long periods of time within this subsystem to develop relevant understanding and to be ready for action. Policy processes can take years to unfold, and being around at opportune moments is important in bringing about change.

Five papers are linked to understanding how policy actors respond to and engage in policy processes, and present ideas about the types of prospective analysis that can inform the development of strategies to influence policy actors and policy change processes. These papers offer additional insights to other stakeholder analysis papers presented in section B1 and C1.

An interesting and clear example of how to gather relevant information on key actor perceptions before implementing new policy interventions is provided by **Buse et al. (2009)**, considering five *evidence-based HIV interventions in Pakistan* (where the epidemic is small and concentrated among people with specific risk behaviours). The paper reports work to *assess prospectively the political feasibility of scaling up these interventions*, considering the potential opportunities and threats to implementation as expressed through the perceptions of stakeholders (mostly policy elites) in questionnaires and interviews. Although all the interventions were understood as evidence-based, there were differences in perceptions around, for example, ease of explanation. As some interventions challenged socially conservative values, they would likely be difficult to implement at scale. The information was used to think of ways to increase the demand for the interventions, for example through the development of constituencies and advocacy coalitions over the longer term to represent marginalized groups. The authors conclude that this prospective policy analysis supported realistic thinking about the future implementation of pro-poor reform.

**Gilson et al. (2012)** then outline how to conduct a stakeholder analysis and illustrate the critical importance of interpreting the results with an understanding of the broader political economy context (see also section B2). The paper draws on work undertaken in South Africa and Tanzania to consider *the political feasibility of policy options for achieving universal health coverage* in these countries. Stakeholder analyses in each country helped to identify policy actor interests in relation to different policy design options and showed how their interests and preferences differed within and across country settings (see also **Varvasovszky and Brugha, 2000**, section D2). These analyses were then used to consider how and why stakeholders might react to a range of alternative policy proposals. Prospectively, stakeholder analysis can then be used to:

- generate ideas about how to change policy design in ways that address actors' concerns and/or areas of contestation;
- help describe reasons for differences and provide a basis for addressing them during policy negotiations;
- develop actor management strategies (see **Reich, 2002**, below).

**Reich's (2002)** analytical note on *the political analysis of actors* emphasizes the importance of assessing the distribution of political costs and benefits among policy actors through a stakeholder analysis. He argues that for those managing reform processes, this analysis provides a foundation for the development of political strategies to help shift the balance of power among policy actors to support reform. These include strategies for: mobilizing and increasing the number of actors in the reform process who support the reformers' goals; reshaping the distribution of power between actors; shifting actors from oppositional to supportive positions; and reframing how policy problems and solutions are perceived by actors.

Addressing global health issues, **Bump et al. (2013)** consider the *level of political priority given to the control of diarrhoeal disease in the global policy agenda* over the last few decades, drawing on a framework developed from political science theory. Recognizing a decline in the priority given to diarrhoeal disease control over time, they use the PolicyMaker software to determine which global institutions have most influence in this policy area and what positions they hold, as well as to suggest political strategies for promoting its priority on the global health agenda. Framing is identified as the most influential future strategy; and one option includes framing the control of diarrhoeal disease within the primary health care movement, essentially locating the control of diarrhoeal disease within existing efforts to mobilize primary health care. In this analysis these authors show the value of understanding components of the global political-economy environment before planning action in support of policy change, and their priority-setting framework could be usefully applied more



widely. The focus on framing as a strategy picks up one of **Reich's (2002)** strategy ideas and reflects other analyses that identify and consider the power of ideas and discourse (see sections C1–C4).

The last paper in this group focuses, unusually, on the political-economy environment at the micro level, arguing that prospective health policy analysis tools can be applied in *everyday leadership by health system managers* (**Gilson, 2016**). The paper illustrates the routine challenges faced by front-line health managers, including staff shortages, unscheduled meetings, limited budgets and poor staff attitudes in facilities. Within these contexts, the paper argues that everyday political leadership is needed to balance multiple relationships, maintain services and ensure good quality of care. Health policy analysis tools, including stakeholder analysis, can then be used prospectively, both to allow leaders to reflect on their own use of power and to consider how to manage the power dynamics of everyday settings. The paper recognizes front-line power dynamics (section B1) and contexts (section B2) and complements analyses of policy implementation (section C4).

Two papers then add to the discussion of the research/policy interface, discussed in section C3.

**Makan et al. (2015)** report work undertaken to support *strategy development for research uptake* within a multicountry research programme called PRIME (the Programme for Improving Mental Health CarE). This programme focused on researching the best ways to integrate and scale up mental health into maternal and primary health-care systems in Ethiopia, India, Nepal, South Africa and Uganda. The paper reports on the use of a prospective stakeholder analysis as a descriptive tool to understand the landscape of actors involved in the new research consortium (see also **Varvasovszky and Brugha, 2000**, section D2). In addition, as a political analysis tool, the stakeholder analysis was useful in identifying a range of relevant stakeholders at multiple levels of the health system across countries, as well as non-health policy actors who could support research uptake and implementation. By considering these actors' levels of support, interests and power the research teams were able to think strategically about opportunities for increased stakeholder engagement, and whom they should prioritize, as well as in recognizing additional stakeholders to target in further research uptake activities.

A very different kind of paper focuses on *how to design policy dialogues*, an intervention widely promoted as a means of bringing research and evidence into policy decision-making. **Lavis et al. (2009)** discuss how to create an enabling space, bringing together multiple actors to discuss their views and experiences and so facilitate the use of evidence in decision-making. Policy dialogue goals can include information-sharing, networking, action planning and developing a consensus statement (if not consensus achievement). The key issues identified as important in planning such a policy dialogue include how to focus, structure and facilitate it, what preparation is needed, ensuring fair representation among those who will be involved in, or affected by, future decisions related to the issue, and what outputs will be generated and follow-up action taken. **Mwisongo et al. (2016)**, section B1, offer insights into the real-world power dynamics within policy dialogues.

The last two papers selected focus on the way health policy analysis can support advocacy, complementing the papers presented in section C2.

**Harris et al. (2017)** present, first, a rich description of the policy and regulatory environment for infant and young child feeding and nutrition in Bangladesh, Ethiopia and Viet Nam; and, second, a *description and evaluation of a targeted advocacy intervention* implemented by Alive and Thrive (A&T – an initiative to promote and support optimal maternal nutrition, breastfeeding and complementary feeding practices), to influence and strengthen this policy environment (2009–2014). The paper provides a conceptual framework (applying key health policy analysis concepts) that can be used prospectively to influence the design of, and monitor and evaluate the contribution of, advocacy interventions in complex political-economy environments. The study tracks changes in this environment over a four-year period as part of evaluating the potential contribution of A&T to shifts within it. The advocacy strategies employed by A&T included working to set national agendas, framing the discourse on infant and young child feeding, popularizing this discourse in the media, gathering and sharing evidence and creating policy windows together with active policy entrepreneurs. The study found that a well planned and well implemented advocacy strategy can successfully contribute to changing the policy environment in favour of better nutrition, including the replacement and/or revision of key national policies and regulations affecting infant and young child feeding across the countries. The role of A&T, the political context, the framing of ideas and the commitment of stakeholders throughout the policy cycle were key factors influencing change.

**Chapman and Fisher (2000)**, finally, illustrate the power of *effective nongovernmental organization campaigns* as a tool for policy influence and advocacy across international, national and local policy environments (reflecting some of the lessons of Gaventa's powercube, see section B1). The paper presents details on a successful campaign to promote breastfeeding in Ghana and a campaign against the use of child labour in the carpet industry in India, highlighting the complex intersection of the campaigns with grass-roots activism, global politics and the public and private sector. The paper provides practical insights that can be used prospectively to plan a successful campaign. These include working across international, national and local levels in different decision spaces, collaboration with others, making efforts to legitimize campaign work, harnessing the power of passionate individuals or champions, mobilizing people in communities as well as giving them active roles and recognizing their contributions. The authors conclude that there is not always one defining moment in a campaign. Success accumulates over time through incremental steps, given both the opportunities and barriers that arise, and different campaign strategies are needed in different times. National champions may sometimes be useful to motivate others, for example, but at other times, mobilizing mass support from people may be required to influence change.

## FUTURE RESEARCH

Few published papers reporting experience of prospective policy analysis are currently available, likely because those involved in doing this work (e.g. advocates, policy strategists) do not seek to write academic papers. However, there is huge potential for both practitioners and researchers to learn from such experience, as the empirical papers presented here illustrate. Such learning could also be used within global health teaching, including health leadership training and development.

Perhaps such experience could be collated and documented in various ways – through peer learning processes among different groups, by embedding researchers and research within policy-making organizations or advocacy groups or by adding a focus on policy change processes to other prospective evaluative work.

**Weible et al. (2012)** note, however, that to learn about strategies for influencing policy change within and across contexts, “what is needed is an empirical effort towards the actual testing and refinement of our strategies and other strategies [for influencing policy processes] in empirical settings”. They argue that this sort of work demands a rigorous methodological approach over the long term, even while drawing out current lessons for practitioners.

## RESOURCES

### List of selected papers<sup>27</sup>

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### Extra resources<sup>29</sup>

There is a wide range of resources available to support various forms of prospective analysis Here we simply highlight a few – but encourage you to dig further!

1. PolicyMaker, a software application for computer-assisted political analysis, can be used to conduct stakeholder analysis and develop political strategies (Reich and Cooper, 1995-2004). The political mapping feature allows for an analysis of the policy environment based on assessments of players, positions and power. The software is available at:  
<http://www.polimap.com/default.html>.
2. In addition to the examples of strategies for stakeholder management outlined in the selected papers, the following books also provide useful ideas:  
Brinkerhoff DW, Crosby B (2002). Managing policy reform: concepts and tools for decision-makers in developing and transitioning countries. Bloomfield: Kumarian Press  
Roberts M, Hsiao W, Berman P, Reich M (2008). Getting health reform right: a guide to improving performance and equity. New York: Oxford University Press.
3. The United Kingdom Overseas Development Institute has developed a RAPID Outcome Mapping Approach (ROMA), which is a guide to understanding, engaging with and influencing policy at any stage in the policy process. It includes a focus on collaborative ways of diagnosing problems,

<sup>28</sup> All websites accessed 31 July 2018.

<sup>29</sup> All websites accessed 31 July 2018.

development of a range of strategies to influence the policy process and ways of monitoring and learning over time from work undertaken in the policy process.

PDF guide: <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/9011.pdf>

Online guide: <https://www.odi.org/features/roma/what-is-roma>.

4. The Overseas Development Institute has also developed a manual which includes (a) approaches and frameworks for understanding policy influence and (b) methods and tools for monitoring and evaluating policy influence and advocacy

PDF guide: <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/8928.pdf>.

5. *An Introduction to Advocacy*: a training guide, by Ritu Sharma:

PDF guide: <https://resourcecentre.savethechildren.net/sites/default/files/documents/1981.pdf>.

6. The full set of SUPPORT tools provide an insight into strategies focusing primarily on ways of promoting the use of evidence in policy processes and decision-making. The tools can be found at: <https://health-policy-systems.biomedcentral.com/articles/supplements/volume-7-supplement-1>.

# D2.

## METHODOLOGICAL ISSUES IN HEALTH POLICY ANALYSIS RESEARCH

*Lucy Gilson and Marsha Orgill*

### INTRODUCTION

In each section of this Reader, some key methodological points for future research have been identified from review of the papers selected. Taken together these points highlight the value for future health policy analysis research of:

- ethnography and discourse analysis, and compelling narratives of policy change;
- insider-researcher accounts of experience;
- tracing policy change over time through historical or prospective work;
- specific analytical techniques such as stakeholder and social network analysis;
- deliberately using conceptual or theoretical frameworks to deepen analysis;
- conducting synthesis of current empirical literature to generate new frameworks for use in future work (as well as to highlight research gaps in the current literature);
- in single case study work, using multiple frameworks to deepen analysis;
- conducting comparative work across countries, subnational areas or policies, to enable deeper inquiry into the central issues of focus through cross-case analysis, perhaps in combination with theory-driven analysis;
  - selecting country or geographical cases to allow, for example, the influence of critical features of the political and administrative context to be assessed, or to allow comparison between more and less successful policy outcomes;
- exploring the use of large-scale quantitative data and mixed methods studies.

Some of these points are considered further in the papers included in this section.

In addition, the HPSR Reader (Gilson, 2012) offers research and study design insights of relevance to health policy analysis. For example, it specifically considers approaches to case study research. Empirical examples of such research, meanwhile, include **Erasmus et al., 2017** (section C4), **Gómez and Harris, 2015** (section B2) and **Shearer et al., 2016** (section C1).

There are also many available methodological texts of relevance to health policy analysis, from political science, international relations or organizational studies, among others. Papers included here point to some of the relevant journals. As many policy analysis texts focus on the content of the area and not research methodology, health policy analysts are encouraged to look beyond the health field for methodological texts and papers.

For case study guidance, for example, see George and Bennett (2005). Also, see Collier (2011) and Kay and Baker (2015) for insights on the method of process tracing – which is widely used in broader policy and organizational case study work to explore causal processes and analyse complex decision-making, and for testing or building theory (see e.g. **Shiffman et al., 2002**, section C2 and **Smith, 2014**, section B2). Costley et al. (2010), meanwhile, specifically consider the approach of insider research.

Finally, a special edition of the journal *Health Policy and Planning* (2014 Sep; 29(Suppl 3): 178) offers insight into the opportunities and challenges of health policy analysis synthesis work (Gilson, 2014), and some of its papers are included in this Reader.

## SELECTED PAPERS

The 10 papers selected for this section address some of the methodological issues summarized above, as well as additional issues. The two exemplar papers included for this section include an overview paper (**Walt et al., 2008**) and a paper on document review, specifically (**Bowen, 2009**).

**Walt et al. (2008)** present a short account of *key issues to address in doing health policy analysis work in LMICs*. It starts by considering the nature of the health policy environment, and some of the challenges to researching the highly complex phenomenon of health policy change. Recognizing differences between contexts, the paper also notes the greater range of actors engaged in policy processes across contexts, and the way policies are influenced by global decisions as well as domestic ones, and by global networks. The challenges of doing health policy analysis are considered; and to support its call for more theory-driven work, some relevant conceptual frameworks and theories are described. Case study research design is then discussed in some detail, given the value of comparative work, as well as the need for, but challenges of, tracing policy change over long time horizons. Finally, the importance of paying attention to researcher positionality, and what this means in practice, is discussed.

**Bowen (2009)** provides concrete and practical advice about *how to do document analysis*. Although widely used in health policy analysis work, novice researchers are often unsure exactly how to go about doing such analysis. This paper explains the rationale for this work, considers how documents can be useful and the pros and cons of working with them, sets out the steps of analysis, and provides pointers about how to approach documents critically. It also includes a worked example of such analysis focused on the Jamaican Social Fund, an experience relevant to health policy change.

Two papers specifically consider the analysis of power in health policy analysis work (see also section B1 and D1).

**Erasmus and Gilson (2008)** address the issue of *how to investigate power*, with a particular focus on policy implementation. The paper begins by describing some concrete examples that show the exercise of power, including the labels and understandings given to policies, and the use of humour. The intention is to encourage researchers to think about how they might see the exercise of power, as it is often hidden. The paper then provides practical ideas about how to conduct observation, conduct interviews and use document reviews to collect data on power. Finally, it discusses how to go about making the interpretive judgements that are inevitable when assessing power.

**Varvasovszky and Brugha (2000)** is perhaps one of the most widely used guides in health policy analysis work, covering *stakeholder analysis*. It outlines issues to be considered before undertaking such analysis – such as the purpose and time dimensions of interest, the time frame and the context in which the analysis will be conducted. It discusses the advantages and disadvantages of an individual or team approach, and of the use of insiders and outsiders for the analysis. It describes how to identify and approach stakeholders and considers the use of qualitative or quantitative data collection methods for estimating stakeholder positions, levels of interest and influence around an issue. A key message is that the process of data collection and analysis needs to be iterative; the analyst needs to revise and deepen earlier levels of the analysis, as new data are obtained. Different examples of ways of analysing, presenting and illustrating the information are provided. It complements papers using stakeholder analysis presented in sections B1 (**Abihiro and McIntyre, 2013**); and C1 (**Onoka et al., 2014**), as well as the discussion of this form of analysis for prospective health policy analysis work (section D1, **Makan et al., 2015**).

Five papers address a range of methodologies and analytical approaches, and consider further the issue of researcher positionality.

**Lancaster (2017)** considers the challenges of *elite interviewing*, a staple method of policy analysis research. Drawing examples from a study of Australian drug policy, the author reflects on strategies for gaining access to respondents, conducting interviews and post-interview analysis and reporting. The dynamics of power and vulnerability between researcher and respondent is considered, and how it changes over time during and after the interview; as well as the importance and difficulties of maintaining confidentiality and anonymity within a small policy community. This paper again demonstrates the value of a reflexive account of policy research.

**Akintola et al. (2015)** report a study that *analyses print media coverage* of primary care and related research evidence in South Africa. The paper outlines the rationale for conducting media analysis work to understand policy decision-making, and its careful methods section provides important pointers for this type of study. It addresses where to source media reports, developing a search and



selection strategy for papers, a search strategy for stories and a selection and analysis strategy for the stories. Its detailed findings section then provides ideas about how to present the data collected. The analysis highlights the health issues covered in the media and those not addressed, and raises questions about what is influencing what is covered. These issues are clearly relevant to understanding policy change. See also Paalman, 1997.

**Abereso-Ako (2017)** considers the challenges of *doing ethnographic work*, drawing from the experience of conducting a hospital-based Ghanaian study. Ethnographic work is itself important in health policy analysis, and the paper is also relevant to thinking about the challenges of insider research. Very helpfully, it prompts consideration about positionality and its place in health policy analysis work. As the author notes: “Negotiating my multiple identities between trust and distrust relations as well as cooperation and lack of cooperation from research participants were important sources of data, as they enabled me to gain knowledge and a better understanding of determiners of worker motivation” (**Abereso-Ako, 2017:17**).

**Hendriks (2007)** reflects on her personal experience of *doing interpretive research*, that is, considering the meanings of policy events, actions, texts, stories and objects in their particular human and historical context. The author outlines some principles for researchers (researcher reflexivity, being flexible and adaptive when conducting research, being an advocate), and considers the details of the research process through the worked example of research on deliberative governance. Finally, she offers six sets of reflections – about the use of comparison in interpretive research, the balance of induction and deduction, balancing multiple roles, how researchers’ presence affects the research, the skills needed for interpretive research and how interpretive researchers evaluate the policy world they observe. Although this form of analysis is specifically linked to the argumentative turn in policy analysis, the paper offers insights of relevance to all policy analysts.

**Harmer (2011)** presents a comprehensive worked example of *discourse analysis*, one type of interpretive research. The analysis considers the radical shift in how public and private global health actors work together – from international public and private interactions to global health partnerships. The author clearly outlines the analytical approach used in identifying the discourses underlying this shift, and illustrates how they justified, legitimized, communicated and coordinated ideas about the practice of global health partnerships. Discourse, in other words, made change possible. It is complemented by papers in other sections (e.g. **Parkhurst et al., 2015**, section B2).

Finally, **Ridde (2009)** provides a worked health policy analysis example of *one approach to using theory in analysis*. He applies Kingdon’s multiple streams theory in analysis of the implementation of the Bamako Initiative in Burkina Faso. He first describes the experience through the lens of the key elements of the theory (considering the three streams, the window of opportunity and policy entrepreneurs), and then tests three propositions about why there was a policy implementation gap. For other empirical examples of how to use theory in policy analysis work, see section C2 (**Shiffman et al., 2002; Parkhurst and Vulimiri, 2013**) and for an in-principle discussion of different approaches to using theory in policy analysis work, see Cairney (2013).

## RESOURCES

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## The politics of health sector reform in developing countries: three cases of pharmaceutical policy

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### Abstract

This paper examines the political dynamics of health sector reform in poor countries, through a comparative study of pharmaceutical policy reform in Sri Lanka, Bangladesh, and the Philippines. The paper first reviews five reasons why policy reform is political. It then presents three political economic models of the policy reform process: the political will, political factions, and political survival models. Next, the paper describes the three cases of national pharmaceutical policy reform, and identifies common conditions that made these reforms politically feasible. The paper's analysis suggests that health sector reform is feasible at certain definable, and perhaps predictable, political moments, especially in the early periods of new regimes. The most important and manipulable political factors are: political timing, which provides opportunities for policy entrepreneurs to introduce their ideas into public debate, and political management of group competition, which allows leaders to control the political effects of distributional consequences and protect the regime's stability. A strong and narrow political coalition improves the capacity of political leaders to resist the pressures of concentrated economic costs (both inside and outside national boundaries). The paper argues that for reform to succeed, policy-makers need effective methods to analyze relevant political conditions and shape key political factors in favor of policy reform. The method of Political Mapping is briefly introduced as a technique that can help policy-makers in analyzing and managing the political dimensions of policy reform and in improving the political feasibility of reform.

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## Review article

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# Reforming the health sector in developing countries: the central role of policy analysis

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

This paper argues that much health policy wrongly focuses attention on the *content* of reform, and neglects the *actors* involved in policy reform (at the international, national and sub-national levels), the *processes* contingent on developing and implementing change and the *context* within which policy is developed. Focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge. The paper is organized in 4 sections. The first sets the scene, demonstrating how the shift from consensus to conflict in health policy established the need for a greater emphasis on policy analysis. The second section explores what is meant by policy analysis. The third investigates what other disciplines have written that help to develop a framework of analysis. And the final section suggests how policy analysis can be used not only to analyze the policy process, but also to plan.

## Introduction

Policy analysis is an established research and academic discipline in the industrialized world, yet its application to developing countries has been limited, and the health sector in particular appears to have been neglected.

This is all the more surprising because of the growing crisis in health systems. The initial optimism of the Primary Health Care (PHC) revolution of the late 1970s has been challenged by a number of trends: escalating costs but lower public health budgets because of economic recession; the emergence of AIDS; the increase in the number of large-scale and complex disasters; the prevalence of chronic diseases side by side with persisting communicable diseases; worsening inequities in access to services; demoralized health

staff; emerging drug resistance to some diseases. In the face of severe economic constraints and shifts towards neo-liberal values, many countries have introduced structural adjustment programmes which have led to cuts in public health services, introduction of, or increased, charges for health care, and liberalization of the health sector to promote private sector development. The effects of such economic reform programmes have been harsh. Zimbabweans dubbed their Economic Structural Adjustment Programme (ESAP) the Extreme Suffering of the African People (Woodroffe 1993). Gains in health status achieved up to the 1970s are being eroded, and evidence is growing of the negative effects of health reforms on health status, especially on the vulnerable (Kanji and Jazdowska 1993; Messkoub 1992; Pinstrup-Anderson 1993).<sup>1</sup>

# Power and pro-poor policies: the case of iCCM in Niger

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## Abstract

Analyses of health policy in low- and middle-income countries frequently mention but rarely adequately explore power dynamics, whether or not the policy in question targets the poor. We present a case study in Niger of integrated community case management (iCCM), a policy to provide basic care for poor rural children sick with malaria, diarrhoea and pneumonia, which has contributed to measurable reductions in child mortality. We focus on the three dimensions of power in policymaking: political authority, financial resources and technical expertise. Data collection took place March to August 2012 and included semi-structured interviews with policy actors ( $N=32$ ), a document review ( $N=103$ ) and contextual analysis. Preliminary data analysis relied on process tracing methodology to examine why iCCM was prioritized and identify dimensions of power most relevant to the Nigerien case; we then applied theoretical categories deductively to our data. We find that political authorities, namely President Mamadou Tandja, created the underlying health infrastructure for the policy ('health huts') as a way to distribute rents from development aid through client networks while claiming the mantle of political legitimacy. Conditional influxes of financial resources created an incentive to declare fee exemptions for children below 5 years, a key condition for the policy's success. Technical expertise was concentrated among international actors from multi-lateral and bilateral agencies who packaged and delivered scientific arguments in support of iCCM to Nigerien policymakers, whose input was limited mainly to operational decisions. The Nigerien case sheds light on the dimensions of power in health policymaking, particularly in neo-patrimonial African regimes, and provides insights on how external actors can work within these contexts to promote pro-poor policies.

**Key words:** Africa, child mortality, health policy, power, rural health

# Practice and power: a review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers

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Tackling the implementation gap is a health policy concern in low- and middle-income countries (LMICs). Limited attention has so far been paid to the influence of power relations over this gap. This article presents, therefore, an interpretive synthesis of qualitative health policy articles addressing the question: how do actors at the front line of health policy implementation exercise discretionary power, with what consequences and why? The article also demonstrates the particular approach of thematic synthesis and contributes to discussion of how such work can inform future health policy research. The synthesis drew from a broader review of published research on any aspect of policy implementation in LMICs for the period 1994–2009. From an initial set of 50 articles identified as relevant to the specific review question, a sample of 16 articles were included in this review. Nine report experience around decentralization, a system-level change, and seven present experience of implementing a range of reproductive health (RH) policies (new forms of service delivery). Three reviewers were involved in a systematic process of data extraction, coding, analysis, synthesis and article writing. The review findings identify: the practices of power exercised by front-line health workers and their managers; their consequences for policy implementation and health system performance; the sources of this power and health workers' reasons for exercising power. These findings also provide the basis for an overarching synthesis of experience, highlighting the importance of actors, power relations and multiple, embedded contextual elements as dimensions of health system complexity. The significance of this synthesis lies in its insights about: the micropractices of power exercised by front-line providers; how to manage this power through local level strategies both to influence and empower providers to act in support of policy goals; and the focus and nature of future research on these issues.

**Keywords** Front-line providers, interpretive synthesis, local managers, LMICs, policy implementation, power, thematic synthesis

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## ***Democratic demands and social policies: the politics of health reform in Ghana\****

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### ABSTRACT

It is commonly assumed that the advent of democracy tends to bring about social welfare improvements. Few studies, however, have examined empirically the impact of third-wave democratisation processes on social policies in developing countries, particularly in sub-Saharan Africa. Through a diachronic comparison, this paper examines the effects of Ghana's democratisation process on the evolution of its health policy. It shows that the emergence of democratic competition played an important role in the recent adoption of a crucial health reform. A policy feedback effect on politics and a process of international policy diffusion were additional but secondary factors.

### INTRODUCTION: THE DEMOCRATIC PROCESS AND SOCIAL WELFARE POLICIES

The late twentieth-century proliferation of new democracies provides a remarkable opportunity for investigating the effects of democratisation processes on social welfare development. Yet few studies have examined empirically the impact of third-wave democratisation processes on social welfare systems in developing countries. This is particularly true for Africa, a continent in desperate need of measures that could help tackle widespread economic and social hardship. Very limited research, in particular, has been carried out on whether the democratic reforms

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# The Eight Modes of Local Governance in West Africa

Jean-Pierre Olivier de Sardan

**Abstract** Used in an analytical and non-normative way, the concept of governance may be taken to refer to any organised method of delivering public or collective services and goods according to specific logics and norms, and to specific forms of authority. This article applies the concept to analysis of local arenas in which public goods and services are delivered or co-delivered in Niger and other countries of West Africa. The analysis proposes eight 'modes of local governance' and describes their main characteristics drawing on fieldwork evidence collected over an extended period. Chiefly, associational, municipal (municipal council), project-based, bureaucratic, sponsorship-based, religious and merchant modes of governance are distinguished. The article concludes by defining and delimiting a concept of local political culture, referring to a set of shared modern practices and representations relating to the practical operation of modes of local governance in specific local arenas.

## 1 Introduction: governance and the delivery of public goods and services

'Governance' is a very plurivalent term, used at a number of different levels and covering objects of a variety of types.<sup>1</sup> It is not universally recognised in the social sciences. Many commentators have criticised the notion of governance for being 'polluted' by its normative definitions (developed in particular by the World Bank, a disciple of 'good governance' strongly tinted with neoliberal ideology),<sup>2</sup> and/or to mask a 'depoliticisation' of public affairs to the benefit of a purely technocratic vision, which is either illusory or misleading (Abrahamsen 2002; Hermet *et al.* 2005). But governance may be conceived in a radically different way, without normative or ideological judgements, as associating the managerial as well as the political dimensions of public or collective actions (Blundo and Le Meur 2009).

Taking the concept of governance in a purely descriptive and analytical sense, we can define it as any organised method of delivering public or collective services and goods according to specific logics and norms, and to specific forms of authority. Any organised form of this delivery, operating according to specific norms, and implementing specific logics, can then be considered to be a mode of governance.

Our definition focuses on a *specific function* of collective action, authority or regulation which for a long time was associated with the state, but which today can be implemented by other types of players and institutions. The delivery of public or collective services and goods can be carried out in a liberal or bureaucratic manner, centralised or decentralised, clientelist or despotic, formal or informal, and driven by the market or by the state. It can be either efficient or not, delivering high-quality goods or services or not. It may involve any level of society and the state. Furthermore, the players (or organisations) which deliver public or collective services and goods are more and more numerous, particularly in Africa. The modes of governance there have become very varied, which opens up the scope of analysis even more: 'There is no longer any public service in Africa whose delivery does not include the greater or lesser involvement of the four following instances: the state administrative services, the development administration (NGOs and international agencies), the "community-type" organizations (from associations to the municipal council), and private operators' (Blundo and Le Meur 2009).

Our definition of governance enables us, therefore, to complement traditional

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## **A Corporate Veto on Health Policy? Global Constitutionalism and Investor–State Dispute Settlement**

**Benjamin Hawkins**

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**Chris Holden**

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**Abstract** The importance of trade and investment agreements for health is now widely acknowledged in the literature, with much attention now focused on the impact of investor–state dispute settlement (ISDS) mechanisms. However, much of the analysis of such agreements in the health field remains largely descriptive. We theorize the implications of ISDS mechanisms for health policy by integrating the concept of global constitutionalism with veto point theory. It is argued that attempts to *constitutionalize* investment law, through a proliferation of International Investment Agreements (IIAs), has created a series of new veto points at which corporations may seek to block new policies aimed at protecting or enhancing public health. The multiplicity of new veto points in this global “spaghetti bowl” of IIAs creates opportunities for corporations to venue shop; that is, to exploit the agreements, and associated veto points, through which they are most likely to succeed in blocking or deterring new regulation. These concepts are illustrated with reference to two case studies of investor–state disputes involving a transnational tobacco company, but the implications of the analysis are of equal relevance for a range of other industries and health issues.

**Keywords** investor–state dispute settlement; bilateral investment treaties; tobacco control; tobacco industry; veto points; veto players; global constitutionalism

### **Introduction**

The importance of international trade and investment for health is now widely acknowledged (McGrady 2011; Voon et al. 2014: 109–36; Alemanno

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## The politics of 'branding' in policy transfer: the case of DOTS for tuberculosis control

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### Abstract

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

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**Keywords:** Policy transfer; Tuberculosis; DOTS; Policy communities; Agenda setting; Public policy formulation

### Introduction

How and why policies are transferred between countries has attracted considerable interest from scholars of public policy over the last decade. Defined as *'the occurrence of, and processes involved in, the development of programmes, policies, institutions etc. within one political and/or social system which are based upon the ideas, institutions, programmes and policies emanating from other political and/or social systems'* (Dolowitz, 2000, p. 3), policy transfer overlaps with a

series of other similar concepts, from active lesson drawing (Rose, 1993), to more passive notions of policy convergence (Bennett, 1991). One of the driving questions in the policy transfer literature is how far policies are transferred voluntarily (policy makers learn about experiences elsewhere, and choose to adapt them to their own environments) or coercively (policies are imposed on government policy makers by international organisations tying loans to policy conditions). This last question is of importance in low-income developing countries, which may be particularly dependent on external agencies for financial and technical assistance. Understanding how policies are transferred is important for a number of reasons (Stone, 1999), not least because transfer without 'ownership' may lead to deficits or failures in implementation.

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# The bit in the middle: a synthesis of global health literature on policy formulation and adoption

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Policy formulation and adoption are poorly understood phases of the health policy process. We conducted a narrative synthesis of 28 articles on health policy in low- and middle-income countries to provide insight on what kinds of activities take place in these phases, the actors crafting policies and the institutions in which policy making occurs. The narrative synthesis involved an inductive process to identify relevant articles, extract relevant data from text and reach new understandings. We find that actors exercising decision-making power include not just various governmental entities, but also civil society, commissioners, nongovernmental organizations and even clergy. We also find that most articles identified two or more distinct institutions in which policy formulation and adoption occurred. Finally, we identify seven distinct activities inherent in policy formulation and adoption: generation of policy alternatives, deliberation and/or consultation, advocacy of specific policy alternatives, lobbying for specific alternatives, negotiation of policy decisions, drafting or enacting policy and guidance/influence on implementation development. Health policy researchers can draw on these categories to deepen their understanding of how policy formulation and adoption unfolds.

**Keywords** Policy adoption, policy formulation, policy process

## KEY MESSAGES

- Processes surrounding policy formulation and adoption in global health are poorly understood, under-theorized and under-researched.
- We identify seven distinct groups of activities that may occur during policy formulation and adoption, including drafting of alternatives, lobbying and providing guidance on implementation.
- These seven sets of activities provide a foundation for advancing research on this stage of the policy process.

## Introduction

In this article, we synthesize literature focusing on health policy change in low- and middle-income countries (LMICs) to provide greater analytical clarity around the phase of the policy process bridging agenda setting and implementation.

This phase, which we term ‘the bit in the middle’, is commonly referred to as policy formulation, -adoption, -making or -diffusion. In addition, we use this synthesis to create a map of scholarly articles describing such processes and develop

# Why do policies change? Institutions, interests, ideas and networks in three cases of policy reform

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## Abstract

Policy researchers have used various categories of variables to explain why policies change, including those related to institutions, interests and ideas. Recent research has paid growing attention to the role of policy networks—the actors involved in policy-making, their relationships with each other, and the structure formed by those relationships—in policy reform across settings and issues; however, this literature has largely ignored the theoretical integration of networks with other policy theories, including the ‘3Is’ of institutions, interests and ideas. This article proposes a conceptual framework integrating these variables and tests it on three cases of policy change in Burkina Faso, addressing the need for theoretical integration with networks as well as the broader aim of theory-driven health policy analysis research in low- and middle-income countries. We use historical process tracing, a type of comparative case study, to interpret and compare documents and in-depth interview data within and between cases. We found that while network changes were indeed associated with policy reform, this relationship was mediated by one or more of institutions, interests and ideas. In a context of high donor dependency, new donor rules affected the composition and structure of actors in the networks, which enabled the entry and dissemination of new ideas and shifts in the overall balance of interest power ultimately leading to policy change. The case of strategic networking occurred in only one case, by civil society actors, suggesting that network change is rarely the spark that initiates the process towards policy change. This analysis highlights the important role of changes in institutions and ideas to drive policymaking, but hints that network change is a necessary intermediate step in these processes.

**Key words:** Health policy, policy making, Burkina Faso

## Introduction

Understanding the drivers of policy change is a pursuit that has captured the imaginations of researchers and practitioners alike (Walt 1994; Walt and Gilson 1994; Gilson and Raphaely 2008). While theory-driven health policy analysis continues to grow in low- and middle-income countries (LMIC), the complexity of the contexts and issues studied calls for greater integration of multiple policy theories for a given case of policy change (Agyepong and Adjei 2008;

Smith 2014; Walt and Gilson 2014). Our field does not suffer from the same disagreements that prevent theoretical integration in the industrialized world—namely, the stalemate between behaviouralist and structuralist paradigms (Skocpol 1985).

In this article, we hope to shed light on the relative influence and temporal ordering of various factors from a range of theoretical perspectives to understand why policies change. Existing policy change frameworks can be distilled into three key elements, or explanatory variables: institutions (processes, context); interests (actors, power)

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# The emergence of political priority for safe motherhood in Honduras

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Each year an estimated 500 000 to 600 000 women die due to complications from childbirth, making this one of the leading causes of death globally for women in their reproductive years. In 1987 a global initiative was launched to address the problem, but few developing countries since then have experienced a documented significant decline in maternal mortality levels.

Honduras represents an exception. Between 1990 and 1997 the country's maternal mortality ratio – the number of deaths due to complications during pregnancy, childbirth and the postpartum period per 100 000 live births – declined 40% from 182 to 108, one of the largest reductions ever documented in such a short time span in the developing world.

This paper draws on three political science literatures – constructivist international relations theory, policy transfer and agenda-setting – to explain how political priority for safe motherhood emerged in Honduras, a factor that underpinned the decline. Central to the explanation is the unusually cooperative relationship that developed between international donors and national health officials, resulting in effective transfer of policy and institutionalization of the cause within the domestic political system. The paper draws out implications of the case for understanding the political dynamics of health priority generation in developing countries.

**Key words:** policy transfer, agenda setting, constructivism, safe motherhood, maternal mortality, Honduras

## Introduction

Each year developing world health ministries accept financial and technical assistance from dozens of international health policy networks promoting causes such as AIDS prevention, polio eradication, reproductive health, safe motherhood and health sector reform. Despite the resources they offer, these networks must compete for the attention of ministries, since limited health systems capacities prevent governments from giving implementation priority to more than a handful of causes.

Scholars of developing world health policy have analyzed the emergence and forms of these networks (Reich 2000; Walt 2001; Ogden et al. 2003; Widdus 2003), and the structure and effectiveness of health ministries (Berman 1995; Bossert et al. 1998; Olsen 1998). With only a few exceptions (Okunzi and Macrae 1995; Buse and Gwin 1998; Walt et al. 1999; Walt et al. 2004), they have given little systematic attention to the interactions between the two. Understanding the nature and quality of these interactions is crucial since these have bearing on why developing world governments may prioritize some health causes and neglect others.

This paper investigates network–ministry interactions and their impact on health priority setting through a study of safe motherhood in Honduras in the 1990s. The case is revealing because international officials concerned with safe motherhood interacted repeatedly with Honduran health

bureaucrats throughout the decade, and because these interactions resulted in successful policy transfer, implementation and impact. In the 1990s the Honduran state made safe motherhood among its foremost priorities, and the country experienced one of the most dramatic declines in maternal mortality ever documented in such a short time span in the developing world. Between 1990 and 1997 the Honduran maternal mortality ratio declined from 182 to 108 maternal deaths per 100 000 live births (Castellanos et al. 1990; Meléndez et al. 1999). Both the 1990 and 1997 figures are highly reliable, as they are based on Reproductive Age Mortality Surveys (RAMOS), the gold standard in maternal mortality investigations that examine every maternal death in a country over the course of a year and generate statistics for the entire population, rather than sample-based estimates with wide confidence intervals. There have been other cases of documented decline in such a short period of time, but they are few and far between.<sup>1</sup>

Danel (1998) has analyzed the medical and technical interventions associated with the Honduran maternal mortality decline. In this paper, we investigate how political priority emerged for the cause. We employ concepts from three political science literatures – constructivist international relations theory, policy transfer and agenda setting – to examine why successful policy transfer and implementation occurred and to highlight the case's significance for understanding network–ministry interactions and health priority formation in developing countries.



# Can frameworks inform knowledge about health policy processes? Reviewing health policy papers on agenda setting and testing them against a specific priority-setting framework

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This article systematically reviews a set of health policy papers on agenda setting and tests them against a specific priority-setting framework. The article applies the Shiffman and Smith framework in extracting and synthesizing data from an existing set of papers, purposively identified for their relevance and systematically reviewed. Its primary aim is to assess how far the component parts of the framework help to identify the factors that influence the agenda setting stage of the policy process at global and national levels. It seeks to advance the field and inform the development of theory in health policy by examining the extent to which the framework offers a useful approach for organizing and analysing data. Applying the framework retrospectively to the selected set of papers, it aims to explore influences on priority setting and to assess how far the framework might gain from further refinement or adaptation, if used prospectively. In pursuing its primary aim, the article also demonstrates how the approach of framework synthesis can be used in health policy analysis research.

**Keywords** National and global agenda setting, policy analysis, policy framework, priority setting, qualitative synthesis

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## KEY MESSAGES

- The Shiffman and Smith framework offers huge value in guiding cross-national as well as cross-policy research and analysis in a field that has been neglected and under-developed. The analysis demonstrates that comparative qualitative studies would be more rigorous if such frameworks were utilized prospectively.
- The framework would be enhanced by a few adjustments and conceptual refinements. For example, contestability or conflict is missing, and should be considered as one of the characteristics of the problem being considered. And the notion of ‘guiding institutions’ would benefit from being separated into two concepts: guiding organizations, under actor power, and the formal and informal norms and rules that make up judicial and legal institutions under political context.
- Framework synthesis offers a feasible, deductive approach to qualitative synthesis for health policy analysis research.

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## debate

### The ‘good governance’ of evidence in health policy

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Calls for evidence-based policy often fail to recognise the fundamentally political nature of policy making. Policy makers must identify, evaluate and utilise evidence to solve policy problems in the face of competing priorities and political agendas. Evidence should inform but cannot determine policy choices. This paper draws on theories of ‘good governance’ to develop a framework for analysing and evaluating processes of evidence-informed policy making. ‘Good governance’ requires the use of appropriate bodies of high-quality evidence to inform policy and promotes decision-making processes that are transparent, accountable and open to contestation by the populations they govern.

**key words** evidence-informed policy • good governance • knowledge translation

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#### Introduction

Evidence-based policy making (EBPM) remains an ideal for which many actors in the field of health policy strive. Motivated by a commitment to alleviate human suffering, some have expressed frustration at the inability of policy makers to respond to advances in scientific knowledge which they claim point to effective policy interventions (cf Lee, 2003; Garner et al, 1998; Thamlikitkul, 2006; Feldman et al, 2001). Framing the issue in these terms, critics identify two main barriers to evidence-based policy. Either research evidence does not find its way into the hands of decision makers in forms which are accessible to them, or this evidence is ignored for political or ideological reasons. Politics is thus viewed as an impediment to effective policy, which must be overcome.

Within this paradigm, the solutions offered to overcome the barriers to evidence use are more effective knowledge transfer, exchange or translation (from here on referred to collectively as knowledge translation) (cf Shaxson et al, 2012), and advocacy of EBPM as a political objective. This approach is manifested in a number of international initiatives which aim to improve the understanding, uptake, and utilisation of evidence



# Assessing the influence of knowledge translation platforms on health system policy processes to achieve the health millennium development goals in Cameroon and Uganda: a comparative case study

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## Abstract

There is a scarcity of empirical data on the influence of initiatives supporting evidence-informed health system policy-making (EIHSP), such as the knowledge translation platforms (KTPs) operating in Africa. To assess whether and how two KTPs housed in government-affiliated institutions in Cameroon and Uganda have influenced: (1) health system policy-making processes and decisions aiming at supporting achievement of the health millennium development goals (MDGs); and (2) the general climate for EIHSP. We conducted an embedded comparative case study of four policy processes in which Evidence Informed Policy Network (EVIPNet) Cameroon and Regional East African Community Health Policy Initiative (REACH-PI) Uganda were involved between 2009 and 2011. We combined a documentary review and semi structured interviews of 54 stakeholders. A framework-guided thematic analysis, inspired by scholarship in health policy analysis and knowledge utilization was used. EVIPNet Cameroon and REACH-PI Uganda have had direct influence on health system policy decisions. The coproduction of evidence briefs combined with tacit knowledge gathered during inclusive evidence-informed stakeholder dialogues helped to reframe health system problems, unveil sources of conflicts, open grounds for consensus and align viable and affordable options for achieving the health MDGs thus leading to decisions. New policy issue networks have emerged. The KTPs indirectly influenced health policy processes by changing how interests interact with one another and by introducing safe-harbour deliberations and intersected with contextual ideational factors by improving access to policy-relevant evidence. KTPs were perceived as change agents with positive impact on the understanding, acceptance and adoption of EIHSP because of their complementary work in relation to capacity building, rapid evidence syntheses and clearinghouse of policy-relevant evidence. This embedded case study illustrates how two KTPs influenced policy decisions through pathways involving policy issue networks, interest groups interaction and evidence-supported ideas and how they influenced the general climate for EIHSP.

# Mapping the existing body of health policy implementation research in lower income settings: what is covered and what are the gaps?

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This article uses 85 peer-reviewed articles published between 1994 and 2009 to characterize and synthesize aspects of the health policy analysis literature focusing on policy implementation in low- and middle-income countries (LMICs). It seeks to contribute, first, to strengthening the field of LMIC health policy analysis by highlighting gaps in the literature and generating ideas for a future research agenda and, second, to thinking about the value and applicability of qualitative synthesis approaches to the health policy analysis field. Overall, the article considers the disciplinary perspectives from which LMIC health policy implementation is studied and the extent to which the focus is on systems or programme issues. It then works with the more specific themes of the key thrusts of the reviewed articles, the implementation outcomes studied, implementation improvement recommendations made and the theories used in the reviewed articles. With respect to these more specific themes, the article includes explorations of patterns within the themes themselves, the contributions of specific disciplinary perspectives and differences between systems and programme articles. It concludes, among other things, that the literature remains small, fragmented, of limited depth and quite diverse, reflecting a wide spectrum of health system dimensions studied and many different suggestions for improving policy implementation. However, a range of issues beyond traditional ‘hardware’ health system concerns, such as funding and organizational structure, are understood to influence policy implementation, including many ‘software’ issues such as the understandings of policy actors and the need for better communication and actor relationships. Looking to the future, there is a need, given the fragmentation in the literature, to consolidate the existing body of work where possible and, given the often broad nature of the work and its limited depth, to draw more explicitly on theoretical frames and concepts to deepen work by sharpening and focusing concerns and questions.

**Keywords** Health policy analysis, LMIC, policy implementation, synthesis

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## 'We are bitter but we are satisfied': nurses as street-level bureaucrats in South Africa

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### Abstract

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

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**Keywords:** Policy implementation; User fees; Nurses; South Africa; Street-level bureaucrat

### Introduction

How are policies implemented, what factors affect implementation and how can policy implementation be strengthened? Policy analysis theory offers two main theoretical approaches for considering these questions: top-down and bottom-up perspectives. Top-down approaches see implementation as a rational process that can be pre-planned and controlled by the central planners responsible for developing policies. The requirements of implementation are presented as a generalised list of conditions, which if met, will enable effective implementation (Hogwood & Gunn, 1984; Sabatier & Mazmanian, 1979). Implementation failure,

seen in the gap between policy objectives and achievements, is, therefore, the result of failing to plan adequately for implementation.

The bottom-up perspective (Hjern & Porter, 1981), however, sees policy change as a much more dynamic and interactive process. This perspective emphasises the need to understand implementation systems and the actors responsible for implementation in order to understand why policies do not achieve expected outcomes. For some, the gap between objectives and outcomes is a demonstration of how policy is recreated through the process of implementation, rather than an implementation failure (Hill, 1997). Others suggest that developing inter-personal competence and trust within organisations is necessary to strengthen implementation (Elmore, 1978; Fox, 1974).

Bottom-up theories are generally judged to have particular relevance to the delivery of social services,

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# Political feasibility of scaling-up five evidence-informed HIV interventions in Pakistan: a policy analysis

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## ABSTRACT

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

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

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

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

It is now widely accepted that evidence rarely feeds directly into policy and, moreover, that policy is not always implemented in such a way to achieve the impact desired.<sup>1,2</sup> What determines the implementation of evidence-informed policy and what prospects are there that recent research pointing to evidence-based interventions will be widely rolled out across Pakistan to curb the HIV epidemic? This paper addresses both of these questions but, first, what is policy analysis and how can it help?

Policy and policy change are thought to result from complex interactions among *institutions* (the formal and informal norms governing how decisions are made), *interest groups* that stand to gain or lose from the policy and *ideas* (discourse, persuasion and advocacy for or against particular policies based on

argument and, sometimes, evidence).<sup>3</sup> Making sense of this complexity is the field of policy analysis.

Policy analysis can help to explain why some issues, problems or solutions receive the attention of policymakers. An analysis of the political dimensions of an issue, famously described as “who gets what, when, how”,<sup>4</sup> can also identify which stakeholders are supportive or resistant and can therefore be used to develop strategies and tactics to change the political landscape. Policy analysis can assist in identifying and addressing obstacles to the implementation of policies and may establish more realistic expectations of pro-poor reform. Policy analysis can also improve the prospects that technical advice is considered during policy formulation, thus increasing the possibility of implementing evidence-informed policy.<sup>5</sup>

Our approach to assessing political feasibility involved a consideration of the institutions, interests and ideas presently prevailing in Pakistan with respect to HIV and the specific interventions. In particular, we drew from the mainstream policy agenda-setting, formulation and implementation theories to distil the key determinants of political feasibility.

What decision-makers are paying attention to at any one time depends on the convergence of three separate “streams” of ongoing activities—problem, policy solutions and politics.<sup>6</sup> “Policy entrepreneurs” affect the coming together of the streams or take advantage of agenda-setting opportunities when the streams converge (ie, all the conditions are met including that a problem is widely recognised, a technically feasible solution exists and there is sufficient political support).

Once decision-makers have decided to act, the processes of policy formulation and decision-making commence. This involves assessing alternative courses of action proposed by interest groups and technical experts, weighing up their pros and cons, and bargaining and negotiating over which policy option to adopt. Some of the important considerations related to the role of evidence in decision-making include the background and training of the decision-maker and exposure to the research process.<sup>7</sup>

Hill and Hupe identify seven factors that affect policy implementation.<sup>8</sup> These include the manner in which the proposed intervention will affect frontline service staff (but also their moral approaches to the problem and their understanding of the policy) and intended beneficiaries. While acknowledging the complexity and serendipity of the policy process, certain features of the policy-making process, the content of policy and context



## RESEARCH

## Open Access



# Stakeholder analysis of the Programme for Improving Mental health carE (PRIME): baseline findings

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## Abstract

**Background:** The knowledge generated from evidence-based interventions in mental health systems research is seldom translated into policy and practice in low and middle-income countries (LMIC). Stakeholder analysis is a potentially useful tool in health policy and systems research to improve understanding of policy stakeholders and increase the likelihood of knowledge translation into policy and practice. The aim of this study was to conduct stakeholder analyses in the five countries participating in the Programme for Improving Mental health carE (PRIME); evaluate a template used for cross-country comparison of stakeholder analyses; and assess the utility of stakeholder analysis for future use in mental health policy and systems research in LMIC.

**Methods:** Using an adapted stakeholder analysis instrument, PRIME country teams in Ethiopia, India, Nepal, South Africa and Uganda identified and characterised stakeholders in relation to the proposed action: scaling-up mental health services. Qualitative content analysis was conducted for stakeholder groups across countries, and a force field analysis was applied to the data.

**Results:** Stakeholder analysis of PRIME has identified policy makers (WHO, Ministries of Health, non-health sector Ministries and Parliament), donors (DFID UK, DFID country offices and other donor agencies), mental health specialists, the media (national and district) and universities as the most powerful, and most supportive actors for scaling up mental health care in the respective PRIME countries. Force field analysis provided a means of evaluating cross-country stakeholder power and positions, particularly for prioritising potential stakeholder engagement in the programme.

**Conclusion:** Stakeholder analysis has been helpful as a research uptake management tool to identify targeted and acceptable strategies for stimulating the demand for research amongst knowledge users, including policymakers and practitioners. Implementing these strategies amongst stakeholders at a country level will hopefully reduce the knowledge gap between research and policy, and improve health system outcomes for the programme.

**Keywords:** Stakeholder analysis, Health policy and systems research, Knowledge translation, Research uptake, Mental health

## Background

The use of stakeholder analysis (SHA) as a systematic technique for gathering insights relating to a proposed action or reform is not new, and has commonly been

used in business, change management, public policy, health care management and development. SHA gathers these insights by identifying, categorising and analysing individuals or groups that are likely to have a 'stake' (be affected by, or have an interest in) a proposed action [1–3].

More recently, the utility of this approach has been reiterated amongst scholars of Health Policy and Systems Research (HPSR) [4–6]. HPSR has evolved into an

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# Document Analysis as a Qualitative Research Method

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## ABSTRACT

This article examines the function of documents as a data source in qualitative research and discusses document analysis procedure in the context of actual research experiences. Targeted to research novices, the article takes a nuts-and-bolts approach to document analysis. It describes the nature and forms of documents, outlines the advantages and limitations of document analysis, and offers specific examples of the use of documents in the research process. The application of document analysis to a grounded theory study is illustrated.

**Keywords:** Content analysis, documents, grounded theory, thematic analysis, triangulation.

Organisational and institutional documents have been a staple in qualitative research for many years. In recent years, there has been an increase in the number of research reports and journal articles that mention document analysis as part of the methodology. What has been rather glaring is the absence of sufficient detail in most reports found in the reviewed literature, regarding the procedure followed and the outcomes of the analyses of documents. Moreover, there is some indication that document analysis has not always been used effectively in the research process, even by experienced researchers.

This article examines the place and function of documents in qualitative research. Written mainly for research novices, the article describes the nature and forms of documents, outlines the strengths and weaknesses of document analysis, and offers specific examples of the use of documents in the research process. Suggestions for doing document analysis are included. The fundamental purpose of this article is to increase knowledge and understanding of document analysis as a qualitative research method with a view to promoting its effective use.

## DEFINING DOCUMENT ANALYSIS

Document analysis is a systematic procedure for reviewing or evaluating documents—both printed and electronic (computer-based and Internet-transmitted) material. Like other analytical methods in qualitative research, document analysis requires that data be examined and interpreted in order to elicit meaning, gain understanding, and develop empirical knowledge (Corbin & Strauss, 2008; see also Rapley, 2007). Documents contain text (words) and images that have been recorded without a researcher's intervention. For the purposes of this discussion, other mute or trace evidence, such as cultural artifacts, is not included. Atkinson and Coffey (1997) refer to documents as 'social facts', which are produced, shared, and used in socially organised ways (p. 47).

Documents that may be used for systematic evaluation as part of a study take a variety of forms. They include advertisements; agendas, attendance registers, and minutes of meetings; manuals; background papers; books and brochures; diaries and journals; event programs (i.e., printed outlines); letters and memoranda; maps and charts; newspapers (clippings/art-

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# 'Doing' health policy analysis: methodological and conceptual reflections and challenges

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

**Keywords** Policy analysis, methodology, process, health policy

## KEY MESSAGES

- Little guidance exists on how to do health policy analysis, concerning low and middle income countries. This paper explores ways of developing this field.
- To advance health policy analysis, researchers will need to use existing frameworks and theories of the public policy process more extensively, make research design an explicit concern in their studies, and pay greater attention to how their own power and positions influence the knowledge they generate.

## Introduction

Health policy analysis is a multi-disciplinary approach to public policy that aims to explain the interaction between institutions, interests and ideas in the policy process. It is useful both

retrospectively and prospectively, to understand past policy failures and successes and to plan for future policy implementation. The case for undertaking policy analysis has been made by a number of scholars (Parsons 1995) and 15 years ago, in this journal, Walt and Gilson (1994) argued it was central to health reforms. However, there has been much less attention given to *how* to do policy analysis, what research designs, theories or methods best inform policy analysis. Reich and Cooper (1996) designed and have updated a software tool to help researchers and policy-makers analyse the political dimensions of public policies. Others, such as Varvasovszky and Brugha (2000), have designed guidelines for undertaking stakeholder analysis, as a part of health policy analysis. Bossert (1998) developed an approach to analyse choices for the decentralization of health sectors. Sabatier (1999, 2007) has explored different theoretical frameworks of the policy process

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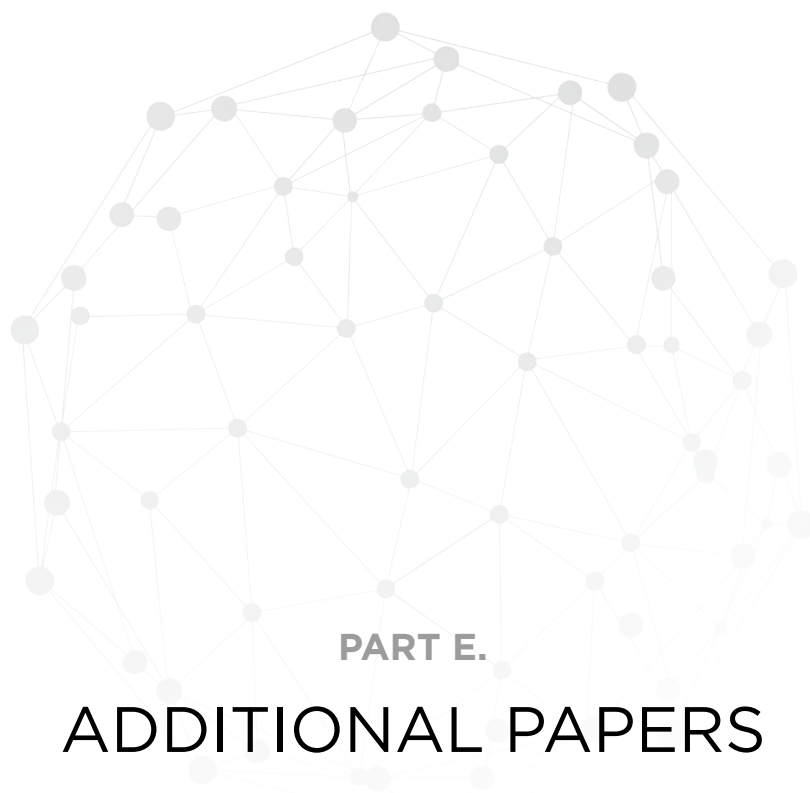
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**Policy makers, policy choices, and policy outcomes:**  
*The political economy of reform in developing countries*

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**Abstract.** This article presents an analytic model for understanding the role of decision makers in bringing about significant policy and institutional changes and in understanding how processes of agenda setting, decision making, and implementation shape the content, timing, and sustainability of reform initiatives. Central to the model is the assertion that policy elites and the policy making process are important determinants of reform. The framework indicates that circumstances surrounding issue formation, the criteria that decision makers use to select among options, and the characteristics of specific policies are analytic categories that explain a considerable amount about reform outcomes. The model is based on cases developed by participants in twelve initiatives to bring about policy and institutional change in a variety of developing countries.

The development message of the 1980s is clear: for a large number of countries, little can be accomplished to enhance growth and welfare unless major policy and institutional reforms are undertaken and sustained by developing country governments. The bearers of this message – many development specialists, international aid and lending agencies, development advisors, academic specialists, and industrial country governments – have become increasingly convinced of: 1) the importance of establishing a macro-policy climate to improve economic performance; 2) the need for adjusting sectoral policies to encourage efficiency and responsiveness to market forces; and 3) the imperative to lessen bureaucratic constraints on economic interactions. The debt crisis in Latin America and the food crisis and apparent failure of two decades of development in many African countries, contrasted with the apparent success of a number of Asian countries in achieving and sustaining high rates of growth, have helped focus extensive attention on the issue of appropriate macroeconomic, sectoral, and institutional contexts for development.<sup>1</sup>

Nevertheless, in the 1980s, the ranks of opposition to reform were full: economic elites supported by existing policies; ethnic, regional, and religious groups favored in allocative decision making; bureaucrats and bureaucratic agencies wielding regulatory power; policy elites sustained through patronage and clientele networks; military organizations accustomed to spending generous budgets with few questions asked. Moreover, decision makers, even those convinced of the economic need for the reforms, could not escape considering the political wisdom of adopting and pursuing them; in the name of efficiency and development, most changes implied a significant decentraliza-

# Beyond Governance: Bringing Power into Policy Analysis

## Abstract

This article discusses how power may be fruitfully brought into policy analysis in order to make efforts to support development and poverty alleviation in developing countries. It begins by asking why power has been left out of development policy analysis for such a long time and proceeds by discussing what a power analysis entails. The third section provides a framework for how power can be brought into policy analysis as an independent and dependent variable. It concludes by demonstrating the usefulness of this approach and discussing the implications it has for the kind of data needed for development analysis and the kind of approach to adopt. This approach is shown to transcend the limitations of conventional diplomatic reporting on politics and regular macro-economic analysis, which is based largely on questionable national statistical information.

*Keywords:*

## 1. Introduction

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There is a growing recognition in both academic and policy circles that politics in African countries is as much part of the problem as the solution. The academic literature is full of references to the weakness and fragility of the state (see, for example, Villalon and Huxtable, 1998; Herbst, 2000; Forrest, 2003), its inability to project power over society (Herbst, 2000) and the prevalence of informal over formal institutions, reducing its ability to make society 'legible' (Hydén, 2006). Evaluation reports sponsored by the donor community in recent years tend to attribute lack of success in development performance to lack of political will, or state that 'politics is the determining factor'. This rather belated recognition of the significance of political factors in development comes after more than a



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# 'The one with the purse makes policy': Power, problem definition, framing and maternal health policies and programmes evolution in national level institutionalised policy making processes in Ghana

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## ABSTRACT

This paper seeks to advance our understanding of health policy agenda setting and formulation processes in a lower middle income country, Ghana, by exploring how and why maternal health policies and programmes appeared and evolved on the health sector programme of work agenda between 2002 and 2012. We theorized that the appearance of a policy or programme on the agenda and its fate within the programme of work is predominately influenced by how national level decision makers use their sources of power to define maternal health problems and frame their policy narratives. National level decision makers used their power sources as negotiation tools to frame maternal health issues and design maternal health policies and programmes within the framework of the national health sector programme of work. The power sources identified included legal and structural authority; access to authority by way of political influence; control over and access to resources (mainly financial); access to evidence in the form of health sector performance reviews and demographic health surveys; and knowledge of national plans such as Ghana Poverty Reduction Strategy. Understanding of power sources and their use as negotiation tools in policy development should not be ignored in the pursuit of transformative change and sustained improvement in health systems in low- and middle income countries (LMIC).

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## 1. Introduction

Gaining insights into why some policy issues get on the agenda and move into programme formulation while others disappear is important. This is because part of the process of transformative change and improvement in health systems and outcomes is getting, formulating and maintaining priority policy issues on the agenda.

Problem definition shapes what issues get on the agenda, and what specific course of action is taken and maintained or not. How policy actors interpret current and past events shape their problem definition (Rocheffort and Cobb, 1994) and help to frame and label issues for decisions. Labelling an issue dictates the kind of attention

the issue attracts and sets the stage for decision making (Peters, 2005). Therefore, what is usually more urgent and practical in influencing policy agenda setting and formulation is control over the interpretation of events (Mosse, 2005), and subsequent issue labelling. Different policy actors present different explanations for the nature of a particular problem (Portz, 1996) and use different negotiation tools such as the control over a resource or access to information to make a case and persuade others. Despite the importance of understanding agenda setting and the use of power to frame agenda issues, there is still limited literature on the examination of power in health policy in LMICs (Gilson and Raphaely, 2008). There are however papers on political agenda setting for safe motherhood in Nigeria (Shiffman and Okonofua, 2007), and actors practice of power in a South African community health programme (Lehmann and Gilson, 2013).

Reasons proposed for why some issues are considered and specific course of actions formulated and why others fail are wide

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# Political contexts and maternal health policy: Insights from a comparison of south Indian states



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## ABSTRACT

Nearly 300,000 women die from pregnancy-related complications each year. One-fifth of these deaths occur in India. Maternal survival rose on India's national policy agenda in the mid-2000s, but responsibility for health policy and implementation in the federal system is largely devolved to the state level where priority for the issue and maternal health outcomes vary. This study investigates sources of variation in maternal health policy and implementation sub-nationally in India. The study is guided by four analytical categories drawn from policy process literature: constitutional, governing and social structures; political contexts; actors and ideas. The experiences of two south Indian states—Tamil Nadu a leader and Karnataka a relatively slow mover—are examined. Process-tracing, a case study methodology that helps to identify roles of complex historical events in causal processes, was employed to investigate the research question in each state. The study is informed by interviews with public health policy experts and service delivery professionals, observation of implementation sites and archival document analysis. Historical legacies—Tamil Nadu's non-Brahmin social movement and Karnataka's developmental disparities combined with decentralization—shape the states' political contexts, affecting variation in maternal health policy and implementation. Competition to advance consistent political priorities across regimes in Tamil Nadu offers fertile ground for policy entrepreneurship and strong public health system administration facilitates progress. Inconsistent political priorities and relatively weak public health system administration frustrate progress in Karnataka. These variations offer insights to the ways in which sub-national political and administrative contexts shape health policy and implementation.

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## Introduction

India's *Janani Suraksha Yojana* (JSY) and other programs devised to increase the use of skilled maternal health services among women from lower socio-economic groups have drawn a great deal of attention for their potential to reduce the global burden of maternal deaths (Lim et al., 2010). India's success is crucial: the country accounts for the largest number of maternal deaths in the world, approximately 56,000 (19 percent) of an estimated 287,000 worldwide in 2010 (WHO, 2012). Maternal survival rose on India's policy agenda with the 2004 national election (Shiffman & Ved, 2007) and has stayed there (Government of India Planning Commission, 2011), the JSY program its most visible policy solution. But India's maternal survival policy story is much more complex. India is a vast and diverse nation made up of 35 states and union territories (Government of India, 2011)—a federal system in which sub-national governments feature their own policy

priorities, public health systems and mix of social, political and administrative influences on policymaking. These conditions contribute to varying maternal health policy, implementation and outcomes sub-nationally.

This study investigates sources of variation in maternal health policy and implementation sub-nationally in India. The experiences of two south Indian states (Tamil Nadu and Karnataka) are examined. Four analytical categories drawn from the policy process literature guide the study: constitutional, governing and social structures; political contexts; actors and ideas. Process-tracing, a case study methodology that helps to identify roles of complex historical events in causal processes, was employed to investigate the research question in each state. The study is informed by interviews with public health policy experts and service delivery professionals, observation of implementation sites and archival document analysis.

Case selection was based upon: comparability in terms of relative social progressivity among south Indian states and poverty rates; Tamil Nadu's leadership on maternal health policy (without Kerala's exceptionalism); and divergent maternal health indicators

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## Federal Homogeneity from the Bottom Up: Provincial Shaping of National HIV/AIDS Policy in South Africa

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*Federal homogeneity is not always imposed from the center; subnational units can and do influence national policy from the bottom up by developing innovative policies. In South Africa, provincial policies in the area of HIV/AIDS shaped national policies within the context of the overarching normative structure of the national Bill of Rights. The conditions under which this happened were (1) constitutional space for a province to develop an innovative policy and practice, (2) the necessary political will to exploit the constitutional space, and (3) the judicial and political impact of a province's innovative policy on the national policy. While provincial policy informed the court decision, it also furthered the political debate nationally. Finally, intergovernmental competition played an important role in countering the monopolistic tendency that can be produced by cooperative government.*

The focus of uniform policymaking in federal systems is usually on enforcing homogeneity on units within a federation, based often on the implicit premise that the center is “right,” enlightened, or modern and that one or more of the constituent units are “wrong.” Subnational units are perceived as pandering to local interests that may be backward, out of step with the national normative framework, or not sympathetic to national interests. The question is then the extent of the units’ right to be “wrong” or out of line. Questions of democracy, autonomy, and the overall normative framework of a federal system are thus pertinent.

The center has a number of devices that it can use to effect homogeneity from the top down, such as the uniform set of norms enshrined in a bill of rights. A bill of rights with a focus on individual rights holders is not concerned with the functional division of power.<sup>1</sup> Other devices include financial incentives deployed through a variety of conditional grants. There may be also overriding supervisory powers in hybrid-federal countries. For example, in South Africa, national legislation prevails over provincial laws on matters falling even within the provinces’ exclusive jurisdiction if the national legislation is necessary, *inter alia*, to maintain national security, economic unity, and essential national standards.<sup>2</sup> A commitment to the

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<sup>1</sup>Luan-Vu N Tran, *Human Rights and Federalism: A Comparative Study of Freedom, Democracy and Cultural Diversity* (The Hague/Boston/London: Martinus Nijhoff, 2000), p. 183.

<sup>2</sup>See Nico Steytler “Concurrency and Co-operative Government: the Law and Practice in South Africa,” *S A Public Law* 16:2 (2001): 241-254.

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## ART SUPPLEMENT

**The impact of Global Health Initiatives at national and sub-national level – a policy analysis of their role in implementation processes of antiretroviral treatment (ART) roll-out in Zambia and South Africa**

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Global Health Initiatives (GHIs), such as the President's Emergency Plan For AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria (the GFATM), have emerged as new mechanisms for development assistance in health. By 2008, GHIs were providing two-thirds of all external funding for HIV/AIDS globally. In Zambia and South Africa over the past five years, PEPFAR and the GFATM have provided significant funding for the public sector provision of anti-retroviral treatment (ART). GHIs are a feature of a new global health governance. A study of their role in implementation helps to explore some of the challenges of this new system of governance at national and sub-national level.

This paper draws on policy analysis research that involved 150 interviews with policy-makers at national, provincial and district level in both countries, conducted as part of Ph.D. fieldwork between August 2007 and June 2008.

Research findings show that GHIs impacted on policy-implementation processes at national and sub-national level, on aspects of the ART programme and the wider health system. Study results highlight GHIs impact both through funding and the mechanisms, and processes by which their support is provided. Evidence suggests that while GHIs have contributed significantly to enabling the rapid scale-up of ART in both the countries, they may also have had a negative impact on coordination, the long-term sustainability of treatment programmes and equity of treatment access. In addition, their programmes may have contributed to disconnect between HIV prevention and treatment initiatives.

The comparative findings from Zambia and South Africa highlight some of the challenges in implementation of GHI programmes at country and sub-country level that need to be addressed urgently, to mediate against negative consequences for the health systems and policy processes in both countries.

**Keywords:** HIV/AIDS; governance; Global Health Initiatives; Zambia; South Africa

**Background and introduction*****Roll-out of anti-retroviral treatment (ART) in Zambia and South Africa***

Zambia and South Africa have generalised HIV epidemics—adult prevalence in Zambia (Zambia Demographic and Health Survey 2007–2008) is 14.3% and 18.1% in South Africa (UNAIDS/WHO, 2008). Both the countries introduced anti-retroviral treatment (ART) for AIDS in the public sector during the last six years and have currently large public sector treatment programmes (see Table 1). Both the countries received support for HIV, including for their ART programme, from the President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB and Malaria (the GFATM).

Despite these commonalities, significant differences exist between Zambia and South Africa in their respective history of ART roll-out and its implementation. The Zambian Government announced an initial plan to provide ART for 10,000 people in 2002 without donor assistance and despite limited domestic resources. In South Africa, President Mbeki's denial of linkages between HIV and AIDS, and his publicly voiced doubts about the efficacy of anti-retroviral medicines led to delays in the policy decision to provide ART (Nattrass, 2008; Schneider, 2002). It was only following pressure, including legal challenges to the government, by South African civil society organisations such as the Treatment Action Campaign (TAC) that the decision to roll-out ART was taken by the South African Cabinet

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## **China's evolving AIDS policy: the influence of global norms and transnational non-governmental organizations**

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China is moving towards greater rule of law and more accountable governance, including civil society participation. China's AIDS response has moved from denial to pragmatic policy. This change has come both through global influence and domestic pressure and led to adoption of many international norms for prevention, treatment, and care, sometimes in conflict with cultural attitudes and political positions. Connections between China's AIDS non-governmental organizations (NGOs) and transnational civil society organizations have contributed to transfer of new norms and approaches. Policies on sex worker rights, NGOs' role in governance, legal protection from discrimination, compensation for some infected by medical procedures, and intellectual property rights for essential medicines have begun to change. Advocacy and expert input from domestic NGOs connected to global groups have played a role. This paper argues that these soft power processes accompanying globalization are creating inroads even in China regarding universal human rights and protection of citizen's interests.

**Keywords:** China; HIV/AIDS; transnational civil society; global norms

### **Introduction**

The power of transnational social movements to advance human rights and social justice on a variety of issues is a growing reality of our increasingly interconnected world. But country contexts and political realities have a major influence on how far these social movements can progress: the presence and strength of national civil society relative to government limits efforts that may be in conflict with national policies. There has been a sea change in China's response to its AIDS epidemic since the first case of AIDS was identified in 1985. China has moved from denial and inaction to a national policy based on many international best practices and universal principles of justice. This change has come about through a combination of global influence and domestic pressure, resulting in the transfer and adoption of internationally accepted norms and approaches for AIDS prevention, treatment and care, sometimes in conflict with cultural attitudes and political positions. China's emerging civil society actors and their connections with transnational civil society (TNCS) organizations working on key elements of the AIDS response has provided one important mechanism for this transfer of knowledge and approaches. Their efforts working with grassroots organizations and informal alliances, often in tandem with advocacy by global development institutions has instigated movement on a number of policy fronts.

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## To whom do bureaucrats need to respond? Two faces of civil society in health policy

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## ABSTRACT

The South Korean government implemented a law that separates the dispensing and prescribing (SDP) of drugs in July 2000. It was one of the most controversial issues in the Korean healthcare delivery system. Drawing on the conflict-cycle view and stakeholder analysis, which was used to examine how multiple stakeholders influenced this policymaking process, this study examines 1) the role of Korean civil society (i.e., civic and special interest groups) in SDP reform and 2) why SDP reform led to unintended consequences. We argue that bureaucrats in the Ministry of Health and Welfare (MoHW) should have played a central role in accommodating the public interest. Because they failed to do so, civic groups assumed major mediating and moderating roles. Due to the civic groups' lack of technical knowledge and professional experience, however, they played a limited role. In finalizing the proposal, therefore, bureaucrats were captured by strong interest groups, leading to unintended consequences, such as the increased use of non-covered services and higher healthcare expenditures. To ensure that the government serves the authentic public interest rather than special interest groups, bureaucrats should be responsible to the public rather than these interest groups. Moreover, civic groups should be strengthened (in relation to strongly organized interest groups) and included systematically in creating health policy.

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## 1. Introduction

In 1999, the Korean government proposed a model to separate the dispensing and prescribing (SDP) of drugs based on gradual implementation schedules from 1999 to 2005. When this proposal became effective in the beginning of July 2000, Korean pharmacists were no longer allowed to prescribe medications, and physicians were forbidden from dispensing medications to outpatients from their offices or hospitals. This law was one of the most controversial issues in the history of the Korean healthcare delivery system and resulted in substantial changes (Kang et al., 2002).

Prior to this policy, physicians and pharmacists had played the same or similar roles in dispensing and prescribing drugs. Korean physicians and pharmacists were both able to prescribe and dispense drugs to patients, which led to duplication of services and the waste of healthcare resources. Furthermore, this duplication

resulted in the overuse and misuse of medications among Koreans. As drugs are crucial to patient care and most medical treatments involve medication, this behavior had a major impact on the healthcare system (Kwon, 2003).

Although it was implemented in July 2000, physicians and pharmacists protested against the policy for over two years. By 2002, emergency rooms were shut down, five patients died because of medical strikes organized by the medical society. The government arrested physicians, while the public blamed the government for its inaction. The professional associations of physicians and pharmacists refused to negotiate and rejected the policy altogether; civic groups did try to intervene in various manners, but without success. The newly implemented policy, SDP reform, satisfies no one, and due to the absence of a rational system by which to resolve such conflicts, none of the parties were willing to negotiate. The result was social conflict among the stakeholders.

SDP reform was designed to maximize social welfare and public health by abolishing the inappropriate incentives that arose from the traditional system of integrated drug prescribing and dispensing. The changes in the incentive structure from SDP were intended to improve public health and enhance drug safety;

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## The interface between research and policy: Experience from South Africa

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### Abstract

Increasing attention has been paid in recent years to efforts to strengthen the impact of research on policy in low- and middle-income countries. However, the processes by which such research might have policy impact remain a subject of debate. This paper presents an analysis of the research/policy interface, drawing on the experiences of two South African health policy and systems research (HPSR) units and one specific study which traced the development and implementation of three areas of health care financing policy change and debate between 1994 and 1999. The analysis is based primarily on the authors' own experiences and has been developed through a deliberate process of reflection. It suggests, first, that it is important to acknowledge the conceptual and symbolic uses and impacts of research — perhaps, particularly in relation to the system-oriented work of HPSR groups. These uses may not be verifiable by specific changes in policy and practice but are important contributions to the policy environment and do filter into policy-makers' understandings and actions. Second, achieving any form of impact on policy is linked to the attention researchers pay to the context in which the research is undertaken, the nature and credibility of the research; and the importance of nesting any single project in a broader programme of engagement with the policy environment that builds trust in the researchers. © 2008 Elsevier Ltd. All rights reserved.

**Keywords:** Research ethics; Research to policy; Policy analysis; Health financing; South Africa

### Introduction

Over the last 10 years, health researchers and development/research funding agencies working in low- and middle-income countries (LMICs) have become increasingly concerned with whether they are getting research into policy and practice. This issue is, in essence,

an ethical matter linked to the principles of collaborative partnership, respect for communities and the social value of research (Emmanuel, Wendler, Killen, & Grady, 2004).

The international efforts seeking to encourage interaction between researchers and policy-makers range from the Global Development Network ([www.gdnet.org/rapnet/index.html](http://www.gdnet.org/rapnet/index.html)), initially established by the World Bank, to the Overseas Development Institute's RAPID programme ([www.odi.org.uk/rapid](http://www.odi.org.uk/rapid)) as well as the mechanisms established by funding agencies such as the UK's Department for International Development

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## Regular Articles

### The market for ‘evidence’ in policy processes: the case of child health policy in Andhra Pradesh, India and Viet Nam

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Research on policy processes has emerged over the last 30–40 years in Northern contexts. Such research has expanded into Southern contexts. An interest in the use of ‘evidence’ (such as research) in policy processes is a relatively recent phenomenon. There are, to date, relatively few empirical case studies in developing countries. This article seeks to address this gap by providing a comparative case study of two contexts at the opposite ends of the macro-political spectrum: Andhra Pradesh, India – a free participatory democracy with vibrant civil society – and Viet Nam – a society with, historically, more limited political freedom but with some recently introduced participatory processes and a fledgling civil society. We also consider the ‘international’ policy-making context. Senior policy makers and researchers working in child health policy formation were asked about their perceptions of the use of and quality of ‘evidence’ in health policy processes. It has been argued that greater levels of democratic freedoms are associated with greater use of evidence in policy processes. Our research challenges this and explores perceptions of the nature of ‘evidence’ and its use in policy processes.

La manière dont les politiques sociales sont justifiées est un thème de recherche qui est devenu de plus en plus important au cours des 30-40 dernières années dans les sociétés développées. Cette préoccupation commence aussi à s'étendre aux sociétés en voie de développement, où il existe en particulier un intérêt croissant pour les études qui examinent la manière dont différentes « preuves » – telles que la recherche – sont utilisées afin de justifier la mise en œuvre de certaines politiques de développement. En même temps, il existe peu d'études empiriques sur le sujet, et cet article propose donc une étude comparative de deux cas de pays en voie de développement qui se situent aux deux, extrêmes, politiquement parlant, c'est-à-dire l'Etat indien de l'Andhra Pradesh, qui peut être caractérisé de démocratie ouverte et participative ayant une société civile vibrante, et le Vietnam, une société historiquement moins ouverte, mais dont le système politique a néanmoins récemment commencé à évoluer avec l'introduction de mécanismes de participation politique ainsi que l'émergence d'une société civile indépendante. L'étude prend aussi en compte le contexte international, et se focalise sur la perception qu'ont les décideurs politiques ainsi que les chercheurs, dans ces différents contextes, de l'utilisation, ainsi que de la qualité, des « preuves » utilisées tant dans l'élaboration que la justification de politiques de santé infantile particulières. Bien qu'il soit très commun d'associer de plus grandes libertés politiques avec une meilleure utilisation de « preuves » dans l'élaboration et la mise en œuvre de politiques sociales, l'étude présentée suggère que ce n'est pas nécessairement le cas.

**Keywords:** policy processes; child health; India; Viet Nam

## 1. Introduction

Research on policy processes has evolved over the last 30–40 years. An interest in the use of ‘evidence’ (such as research) in policy processes is a newer phenomenon. There are, to date,

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# The effectiveness of NGO campaigning: lessons from practice

*Jennifer Chapman and Thomas Fisher*

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*This article looks at the lessons learned in reviewing two long-running international campaigns, one to promote breastfeeding in Ghana, and the other against the use of child labour in the carpet industry in India. In particular, it focuses on understanding the nature of campaigns and what makes them effective. It asserts that campaigns are not linear or mechanistic, but need to be understood as passing through various stages and requiring different kinds of action at different levels and at different times. The variety of work and skills thus required makes it vital that the various organisations involved collaborate with each other. In particular, grassroots mobilisation has a role that is often forgotten in bringing about sustained policy change.*

## Introduction

Development NGOs are devoting more and more time and energy to policy-influence work, yet there has been no corresponding increase in learning about effectiveness. Until recently, lessons from even the best-known and longest-running campaigns have not been available.

The increasing focus on campaigning and advocacy work applies not only to Northern NGOs, but also to those in the South. There are various reasons for this trend, not least changing South–North dynamics, for example:

- growing recognition that, in many cases, Southern NGOs are better placed to carry out project work on the ground, leading operational Northern organisations to look for new roles;
- growing recognition among all NGOs that project work will have limited effects without changes in the structures that cause poverty;
- increasing links between ideas of development and human rights;
- ongoing desire for public profile; and
- increasing calls by Southern organisations for Northern NGOs to do more campaign and policy work.

Concurrently, the arenas where NGOs are recognised as having an acceptable policy voice are increasing to encompass governments North and South, multilateral organisations, and the private sector. Frequently, issues are debated in all these different arenas at the same time, and by a growing diversity of actors. With both growing engagement in campaign and policy work, and increasingly complex policy arenas, many NGOs are concerned to better under-

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## Understanding change in global health policy: Ideas, discourse and networks

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How is radical change in global health policy possible? Material factors such as economics or human resources are important, but ideational factors such as ideas and discourse play an important role as well. In this paper, I apply a theoretical framework to show how discourse made it possible for public and private actors to fundamentally change their way of working together – to shift from international public and private interactions to global health partnerships (GHPs) – and in the process create a new institutional mechanism for governing global health. Drawing on insights from constructivist analysis, I demonstrate how discourse justified, legitimised, communicated and coordinated ideas about the practice of GHPs through a concentrated network of partnership pioneers. As attention from health policy analysts turns increasingly to ideational explanations for answers to global health problems, this paper contributes to the debate by showing how, precisely, discourse makes change possible.

**Keywords:** Constructivism; ideas; discourse; networks; change; partnerships

### Introduction

In a 2009 speech, Director General of the World Health Organisation (WHO), Margaret Chan stated that to achieve ‘transformational change’ in Africa, ‘the policies must be right, and the money must be used effectively and efficiently’ (Chan 2009). If such radical transformation is possible, *how* is it possible? To answer this question requires a step beyond important, if superficial, statements about getting the policies right: it requires understanding the ideas and discourse, or *ideational factors*, which inform those policies, and the networks through which they travel. As a first step in the application of ideational factors to global public health, I demonstrate how a theoretical framework first developed in the political sciences might usefully be employed to shed light on one particular radical shift in policy – the shift from public and private interaction to public–private global health partnerships (GHPs).

The analysis of discourse that follows is informed by an ideas-based approach to society called Constructivism. Constructivism is beginning to attract interest from global health policy analysts, although it remains on the margins of the discipline (Kickbusch 2003, Harmer 2005, Shiffman 2009). It does, however, have a long pedigree in the political sciences (Adler 1997, Wendt 1999, Hay 2009). I distinguish

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# Praxis Stories: Experiencing Interpretive Policy Research

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## **Abstract**

*This paper is a reflective and experiential piece on practising interpretive policy research – a meaning focussed approach to studying politics. Much effort in recent years has gone into defining and defending interpretive methods against positivist approaches in political science. Yet surprisingly little is known about how researchers actually ‘interpret’ the political world, and what issues they face in practice. This paper follows the journey of an interpretive project and reflects on a series of methodological issues it posed. The discussion reveals that interpretive methods can be demanding on researchers: they need to immerse themselves in policy practice, engage iteratively, embrace uncertainty, and work with multiple interpretations. To encourage learning and improve the practice of interpretive research in political science, this paper calls on scholars to be more reflexive about what they do by sharing their research experiences.*

## **Introduction**

Doing interpretive policy research is intense. It can overwhelm you with material, run you around for weeks on end, and bring you into contact with people whose perspectives you find unsettling. Explorations of the policy world can also be complex. It can inundate you with material and leave you feeling entangled in a web of actors, institutions, ideas, meanings and unknowns. Then there is the struggle of trying to produce research reports that require comments on the ‘scientific rigour’ and ‘objectivity’ of our findings. These are just some of the



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## Confidentiality, anonymity and power relations in elite interviewing: conducting qualitative policy research in a politicised domain

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### ABSTRACT

While the methods used to study 'elites' are of particular relevance in policy research, to date there has been little examination of the particular challenges associated with 'elite' interviewing in this field. More specifically, the issues associated with interviewing 'elites' while conducting qualitative research in a contested policy domain, especially if policy processes are being studied as they play out in real time, remain underexplored. While the extant literature on 'elite' interviewing has begun to grapple with the notions of 'power' and 'vulnerability', the question of how these notions might need to be rethought in the context of a politicised policy domain remains open for examination. This article provides a methodological and reflexive account of the challenges associated with conducting research in one highly contested policy domain, namely, drug policy. Drawing on examples from a study which examined Australian drug policy processes, this article examines issues associated with anonymity and confidentiality produced through power relations between researcher and participant, particularly as these play out in a contested policy domain. In doing so, this article critically reflects on the practical and political implications for data collection, analysis and reporting of policy research.

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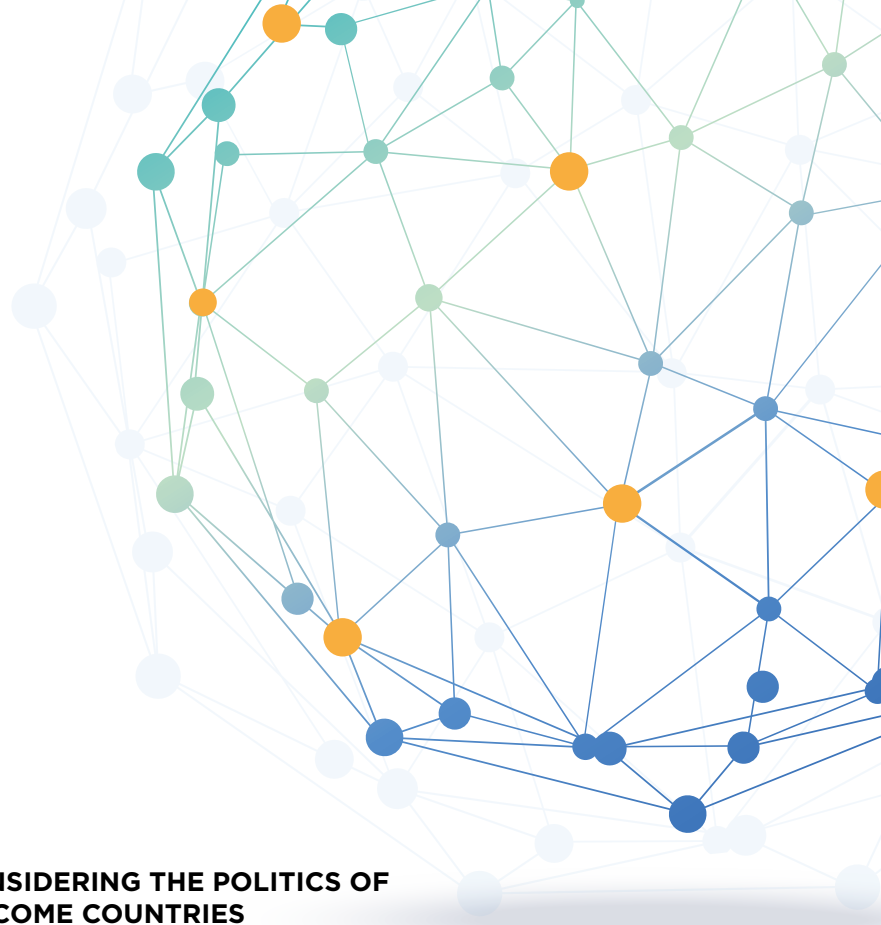
Interview; elites; policy research; anonymity; confidentiality; vulnerability; power

### Introduction

In recent years, a small but growing body of research has documented the issues and dynamics associated with interviewing 'elite' participants in qualitative research (e.g. Duke, 2002; Harvey, 2011; Hertz & Imber, 1995; Mikecz, 2012; Morris, 2009; Neal & McLaughlin, 2009; Smith, 2006; Stephens, 2007; Welch, Marschan-Piekkari, Penttinen, & Tahvanainen, 2002). The term 'elite' is not always defined within this literature, but is generally used to describe individuals or groups who ostensibly have closer proximity to power or particular professional expertise (Morris, 2009). A variety of challenges associated with researching elites have been documented in the literature, ranging from difficulties with gaining access to the suggestion that elite participants may seek to exert too much control over research and manipulate dissemination processes (for discussion see Smith, 2006; Welch et al., 2002). In the context of policy research more specifically, it has been suggested that additional issues must be considered when the 'elite' participants in question also interact and operate within policy networks (Duke, 2002; Farquharson, 2005).

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## **A HEALTH POLICY ANALYSIS READER, CONSIDERING THE POLITICS OF POLICY CHANGE IN LOW- AND MIDDLE-INCOME COUNTRIES**

The primary objective of this Reader is to encourage and deepen health policy analysis work in low- and middle-income countries (LMICs). It illuminates the range of health policy analysis studies that have been conducted in LMICs, highlights relevant theory, and points to new directions for such work. It also includes methodological and analytical pointers, and considers how to use health policy analysis prospectively to support health policy change.

The Reader's primary audience includes all those with an interest in understanding and influencing health policy change, including researchers and educators, as well as policy advocates, managers, and policy-makers. The Reader will also be of interest to those who have specialist policy studies or public administration backgrounds, and also to those with limited prior engagement with relevant social science perspectives.

### **THE VALUE OF HEALTH POLICY ANALYSIS**

In the real world, multiple social, economic and political factors are instrumental in shaping the design and implementation of health policies. The field of health policy analysis helps to shine a light on these complex realities, and is vital to helping us understand how we can influence policy processes to achieve health impacts. Health policy analysis has immense potential in helping to strengthen health systems to achieve health goals. It is an important approach to identify the levers of change that can drive political commitment for universal health coverage, and to understand and advance intersectoral coordination for the achievement of the United Nations Sustainable Development Goals.

*Dr. Naoko Yamamoto, Assistant Director-General, Universal Health Coverage and Health Systems, World Health Organization*