Module 10
Health policy analysis
Addis Ababa University
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Introduction

Policy is what governments choose to do or not to do. It is a complex process with multiple stages and actors, and often spans years, even decades. Policymaking occurs in both public and private spheres. In this module you will be introduced to public policymaking with an emphasis on the Ethiopian health policy context.

Unit 1 of this module explains the importance of health policy and health policy analysis. It also introduces the stages through which health policy is formulated. Unit 2 deals with methodology and describes several of the frameworks used for policy analysis. Unit 3 turns to the practical question of research study design. Unit 4 too has a very practical slant, providing guidance with the application of policy analysis as well as introducing further frameworks used in analysis. Throughout the module, there is a focus on issues in the health policymaking process of Ethiopia, including financing and human resource issues in health care. The final unit of this module involves using Reich and Cooper software for the analysis of a given policy.

In Unit 3, there is an activity based on a World Health Organization article ‘A rapid assessment of utilization, effectiveness and added value of the knowledge centres at Bishoftu and Durame hospitals in Ethiopia’ by Mirkuzie Woldie Kerie, MD, MPH. The executive summary of this article is reproduced in Unit 3, but the full article is available at:

http://www.who.int/workforcealliance/knowledge/resources/eth_knowledgecentre_assessment2011.pdf?ua=1

You will need to read and refer to this article for your study of Unit 3 and it is recommended that you keep it accessible for your easy reference and convenience.

For Unit 4, you will need to familiarise yourself with the following readings. It is recommended that you keep them accessible for your easy reference and convenience. The readings are listed here in the order they appear in the module.


For Unit 5 you will need to download the free PolicyMaker4 software in order to carry out a policy analysis of an Ethiopian Government policy or plan using the software. This can be downloaded from the following url:

http://www.polimap.com/

**Learning outcomes**

After studying this module you will be able to:

**Knowledge and understanding**

• understand the stages of health policy analysis

• compare different frameworks for policy analysis

• understand and evaluate different research designs

• know how health policy is made in Ethiopia.
**Practical and professional skills**

- implement and evaluate health policies mainly using your local context
- apply economic and management skills to design health policies
- use public health and economic data, and choose adequate research designs to carry out policy analysis
- recommend locally feasible and cost effective implementation strategies to translate the plan into action.
Unit 1: Health policy development, implementation and analysis

1 Introduction

Health policy is now becoming a central issue in many developing countries, as national health plans and programmes are key policies for governments. It should be based on the needs of the population and should have the support of all actors.

Health policy is a complex issue as health is by itself unpredictable and uncertain. Government should develop a viable health policy document and devise health plans and programmes to implement it. Health economists, managers, planners or policymakers need to know the importance, concepts and principles of health policy, and the context, content, process and actors to be considered in health policy development, implementation and analysis. They also need to understand the links between health policy and other social policies, such as economic policies and education policies.

Unit 1 introduces the basic concepts and principles of health policy, plans and programmes. It also discusses the framework of health policy, the different processes of health policy, plan and program development, implementation and analysis. The unit also addresses the links between policy, context, actors and process. This unit draws on the book *Making Health Policy* by Kent Buse, Nicholas Mays and Gill Walt, (2012, 2005), and a WHO paper, *Mental Health Policy, plans and programmes* (2004). While this paper focuses on mental health policy, the observations and guidance it provides can usefully be applied to health policy more generally, and it is in this more general way that we have used it.

Learning outcomes

After studying this unit you will be able to:

Knowledge and understanding

- understand the framework of health policy
- define the key concepts: policy, context, actors and process
- describe how health policies are made through the interrelationship of context, process and actors.

Practical and professional skills

- undertake retrospective and prospective policy analysis
- identify policy actors, assess their political resources and current positions on a given policy
- develop successful political strategies to manage policy change
- gather and present data for policy analysis
- implement and evaluate health policy, plan and programme documents in Ethiopia
- recommend locally feasible and cost effective implementation strategies.
2 Health policy

2.1 What is health policy?

*Policy* is often thought of as decisions taken by those with responsibility for a given policy area – it may be in health or the environment, in education or in trade. The people who make policies are referred to as *policymakers*. Policy may be made at many levels – in central or local government, in a multinational company or local business, in a school or hospital. Specific groups of decision makers who hold senior positions in an organisation are sometimes referred to as *policy elites*. These decision makers often have privileged access to other top members of the same organisation and of other organisations. For example, policy elites in government may include the members of the prime minister’s cabinet, all of whom would be able to contact and meet the top executives of a multinational company or of an international agency, such as the World Health Organization (WHO).

Policies are made in the private and in the public sector. In the private sector, multinational conglomerates may establish policies for all their companies around the world, but allow local companies to decide their own policies on conditions of service. However, private sector corporations have to ensure that their policies are made within the confines of public law made by governments.

*Public policy* refers to government policy. For example, Dye (2001) says that public policy is whatever governments choose to do or not to do. He argues that failure to decide or act on a particular issue also constitutes policy. For example, the Ethiopian government has chosen to implement the Health Extension Programme (HEP) to increase public access to primary health care services, national health insurance and community health insurance to reach the poor.

When looking for examples of public policy, you should look for statements or formal positions issued by a government or a government department. These may be couched in terms that suggest the accomplishment of a particular purpose or goal (the introduction of HEP to increase public access to primary health care services) or to resolve a financial burden brought about by illness (introduction of community health insurance).

The term ‘policy’ may refer to a field of activity, such as the government’s health or economic policy, or to a specific proposal, such as ‘from next year, it will be university policy to ensure students are represented on all governing bodies’. Sometimes policy is called a plan or a programme, for example the government’s health sector development plan or the HEP, stating what should be done to increase public access to primary health services and to improve health. The programme is thus the embodiment of policy. Policies may not arise from a single decision but could consist of bundles of decisions that lead to a broad course of action over time. And these decisions or actions may or may not be intended, defined or even recognised as policy.

*Health policy* is assumed to embrace courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system. It includes policy made in the public sector (by government) as well as policies in the private sector. However, as health is influenced by many determinants outside the health system, health policy analysts are also interested in the actions and intended actions of organisations external to the health system that have an impact on health (for example, the food, education, agriculture or pharmaceutical industries).
Just as there are various definitions of what policy is, so there are many ideas about its focus: an economist may say health policy is about the allocation of scarce resources for health; a planner sees it as ways to influence the determinants of health in order to improve public health; and for a doctor it is all about health services (Walt et al., 2008). For Walt, health policy is synonymous with politics and deals explicitly with who influences policymaking, how they exercise that influence, and under what conditions. This variety of views about focus is reflected in a variety of views about the analysis of health policy.

Health policy uses frameworks that incorporate politics. Politics cannot be divorced from health policy. If you are applying epidemiology, economics, biology or any other professional or technical knowledge to everyday life, politics will affect you. No one is unaffected by the influence of politics. For example, scientists may have to focus their research on the issues funders are interested in, rather than questions they want to explore; in prescribing drugs, health professionals may have to take into consideration potentially conflicting demands of hospital managers, government regulations and people’s ability to pay. They may also be visited by drug company representatives who want to persuade them to prescribe their particular drugs, and who may use different sorts of incentives to encourage them to do so. Most activities are subject to the ebb and flow of politics.

Devising a framework for incorporating politics into health policy needs to include consideration of the content of policy. Many of the previous health policies focus on a particular policy, describing what it declares to do, the strategy to achieve set goals and whether or not it has achieved them. These are the ‘what’ questions of health policy. But they cannot be divorced from the ‘who’ and ‘how’ questions: who makes the decisions? Who implements them? Under what conditions will they be introduced and executed, or ignored? In other words, the content is not separate from the politics of policymaking. For example, in Ethiopia, when the government saw evidence that utilisation of health services had not improved as intended after the implementation of Health Sector Development Programme (HSDP) I, it introduced the HEP. To understand how the government made that decision, you need to know something about the political context (an election coming up, and the desire to win votes); the power of the prime minister or the minister of health to introduce change; and the role of evidence in influencing the decision, among other things.

2.2 Why is health policy important?

In many countries, the health sector is an important part of the economy. It absorbs large amounts of national resources to pay for the many health workers employed, and is a driver of the economy, through innovation and investment in the health sector, or through ensuring a healthy population which is economically productive. People come into contact with the health sector as patients or clients, through using hospitals, clinics or pharmacies; or as health professionals – whether as nurses, doctors, medical auxiliaries, pharmacists or managers. Because the nature of decision making in health often involves matters of life and death, health is accorded a special position in comparison to other social issues.

Health is also affected by many decisions that have nothing to do with health care: poverty affects people’s health, as do pollution, contaminated water or poor sanitation. Economic policies, such as taxes on cigarettes or alcohol, may also influence people’s behaviour.
Understanding the relationship between health policy and health is therefore important and makes tackling health problems, such as HIV/AIDS epidemics and drug resistance, as well understanding how economic and other policies impact on health, easier. Health policy guides choices about which health technologies should be developed and used, how to organise and finance health services, or which drugs will be made freely available.

Activity 1
1. Without looking back at the text, define: (i) policy; (ii) public policy.
2. Write down some ways that policy is developed.
3. List some ways policy is implemented.
4. Identify some examples of policies belonging to specific environments, such as the home or the office.

Comment
1. Policy is a way of working, a vision, a programme of action involving duties, responsibilities and accountability, a cultural or ethical code that guides behaviour. It aims to achieve certain objectives and may be enshrined in law.

Public policy is policy made by the state or the government to guide the behaviour of individuals and groups in their civic activities.

2. Policy can be developed in different ways:
   - policies may be negotiated as a way of resolving conflict
   - they may be developed through repetition and habit
   - they may be cultural practices or traditional ways of doing things.

3. Policy can be implemented in different ways:
   - through decree (‘because Dad says so’)
   - through convention (‘because that’s what everyone else in the office does’)
   - through negotiation (‘if you do this you will get …’)
   - through a shared understanding of an ethical code of conduct (for example, the implementation of a patient’s rights charter may be influenced by people’s expectations about how things should happen even though the details may not be written down)

4. Certain policies are appropriate to specific environments, for example:
   - in a supermarket: a dress code; how to deal with customers’ demands
   - in an office: a procedure for booking leave; pay policy
   - in the home: the times children should be in bed; who helps with the household chores.
2.3 Health policy, plans and programmes

**Health policy** is an organised set of **values, principles** and objectives for improving health and reducing the burden of disorders in a population. It defines a vision for the future and helps to establish a model for action. Policy also states the level of priority that a government assigns to health in relation to other social policies. Policy is generally formulated to cover a long period, typically 5 to 10 years. Often the terms ‘plans’ and ‘programmes’ are used interchangeably. They are considered complementary to policies and provide the means for implementing actions.

A **health plan** is a detailed pre-formulated scheme for implementing strategic actions that favour the promotion of health, the prevention of disorders, and treatment and rehabilitation. Such a plan allows the implementation of the vision, values, principles and objectives defined in the policy. A plan usually includes strategies, time frames, resources required, targets to be achieved, indicators and activities. A plan can correspond to the same administrative division and period of time as the health policy. However, this does not always have to be so: a plan can be developed for a smaller administrative division or a shorter period than the policy.

A **health programme** is an intervention or series of interventions with a highly focused objective for the promotion of health, the prevention of disorders, and treatment and rehabilitation. A programme usually focuses on a specific health priority and, like health plans, programmes must be adequately designed, budgeted for, monitored and evaluated. In contrast to the policy and plan, the programme is frequently implemented in a smaller administrative division or for a shorter period.

2.4 How policies are normally formulated

Health policy is commonly established within a complex body of welfare and general social policies. The health field is affected by many policies, standards and ideologies that are not necessarily directly related to health. In order to maximise the positive effects when formulating health policy it is necessary to consider the social and physical environment in which people live. It is also necessary to ensure intersectoral collaboration in order to benefit from: education programmes; welfare policies; employment policies; housing, city planning and municipal services; the maintenance of law and order; and policies specifically addressing the young or the old. There are many options for countries formulating a health policy, depending on cultural factors, political and social organisation, and the importance placed on health by governments. Some of the variables to consider are the institution responsible for the policy, the scope of the policy and the structure of the policy.

2.4.1 Institution responsible for health policy

Every government should have a health policy that is endorsed at the highest level. It is desirable that the policy be the responsibility of the national government for the following reasons:

- Health is closely related to human development and quality of life.
- Disorders are highly prevalent and produce a significant burden of disease worldwide.
The implementation of **health interventions** requires the participation of different sectors of the state.

In most countries there is a ministry or department of health, which is in charge of health policy. This has the advantage that the policy is implemented exclusively through one sector, thus favouring consistency and coherence. However, there are disadvantages in that the health sector cannot provide all the services needed by people with disorders and cannot address all requirements for the promotion of health and the prevention of disorders. These disadvantages can be partially overcome by creating a national commission or council, which, usually, is convened by the ministry of health and represents several stakeholders (welfare, religious, education, housing, labour, criminal justice, police and other social services).

### 2.4.2 Scope of the policy

Whatever the content, the larger the scope of the policy the better it will be in terms of integrating health activities and services with other social services. The scope of the health policy should include preventive, curative, promotional and rehabilitative approaches.

### 2.4.3 Structure of the policy

There is great variability in the structure of health policies, plans and programmes. Some countries have only a policy, while others have formulated policy issues as part of a health law or a reform. If a health plan is not formulated at the same time in any of these cases, some elements of a plan are included in the policy. Other countries have produced a health **strategy**, a health plan or a health programme in which some elements of policy are incorporated. No general recommendation can be made to guide the selection of any of these alternatives in a particular country or administrative division. The ultimate decision is a responsibility of government in accordance with considerations of history, culture, policies, the legal system, social structure, the type of health system and the meaning given to policy, plan and programme. Regardless of the name and format of the policy, the important issue for government is to have a policy that is approved at the highest level.

### 2.4.4 Stages of health policy

The adequate advancement of health policy, plans and programmes in a country or region requires the following key steps.

**Step 1:** The development of health policy, plan and programme.

**Step 2:** The implementation of the policy through the plans and programme.

**Step 3:** The monitoring of implementation.

**Step 4:** Evaluation.

**Step 5:** The reformulation of the policy, plan and/or programme.

The sections that follow consider these steps in turn.
3 Health policy, plan and programme development

3.1 Health policy development

Examining the experiences of various countries it is possible to identify several essential steps for the development of a successful health policy. Developing a health policy, obtaining official approval and implementing the policy through plans and programmes are essential steps. It is important to have a timescale in mind when approaching a health policy. For development one to two years and five to ten years for implementing and achieving changes are probably realistic periods. A shorter timescale is likely to be impossible, while a time horizon that is too long may not satisfy many of the stakeholders and the general population. Different elements of policy, plans and programmes may require different timescales. The persons in charge of the ministry of health and health districts have to be competent, motivated and persistent in order to overcome the multiple obstacles that inevitably arise in this process.

3.1.1 Steps in health policy development

Step 1: Assess the population’s needs

A. Understand the health needs of the population

The development of a health policy begins with the question: What are the population’s health needs? It is essential that health policy is formulated on the basis of some reasonable knowledge of the population’s needs for services. Needs of the population can be determined by the health professionals in the ministry of health in accordance with the available resources. There are several ways in which the needs of a population can be assessed. It is important, for example, to have information around the prevalence and incidence of health problems; to know what communities identify as problems; to understand help-seeking behaviour and so on. Planners also often need to decide which particular problems to address.

B. Gather country information on health services

In addition to having information on the population’s health needs it is necessary to have good data and an understanding of the current situation with regard to the health system and provision of care. This includes information on the human resources available, finances currently spent on health, the structure and emphasis of current services, and the views and attitudes of health workers towards current services and possible changes.

The methods for gathering the information can vary greatly depending on the resources and time available. Methods to collect relevant information include formal research and rapid appraisal. While there is no categorical difference between formal research and rapid appraisal, the latter usually involves active participation of the services and the results become available to decision makers within days or weeks after the end of the survey. Formal research is usually associated with scientific rigour, for example, sample size and use of standardised instruments, and is generally larger in scope and takes place over a longer period of time.
Step 2: Gather evidence for effective strategies

Once an assessment of the population’s needs for health has been formulated it is necessary to gather evidence about effective strategies and interventions. Such evidence can be obtained by visiting local services within the country concerned, visiting other countries and reviewing the national and international literature.

A. Evidence from within the country or region

A large part of the evidence for health development within a country comes from the evaluation of experiences gained in that country. In countries or regions where a policy, plan or programme has been developed or implemented, the first step is to evaluate these processes. Pilot projects on health, especially those that have been evaluated, are an excellent source of information on which to base policy formulation. Successful and unsuccessful experiences can provide invaluable data. Examples of matters that could be dealt with in pilot projects include: the role of primary care in the prevention and early treatment of disease, health promotion through sectors other than health, and community care for persons with chronic conditions. Besides pilot projects, there are several interesting experiences in health which can be described by general health and health teams, people with disorders, their families, NGOs and other sectors. Although most of these activities, particularly in developing countries, have not been formally designed or evaluated, they are certainly helping to improve the health of many people.

B. Evidence from other countries or regions

Other countries or regions, especially those with similar cultural and socio-economic features, can also provide examples of best practices in health. In particular, countries or regions that have formulated and/or implemented health policy and plans can be sources of useful information.

C. Evidence from the literature

Through literature review it is possible to learn lessons from evaluations of national or regional health policies.

Step 3: Consultation and negotiation

The process of developing health policy is largely political. To a lesser degree it involves technical actions and resource-building. Many individuals, organisations and communities participate, each with particular values, interests, power bases, strengths and weaknesses. Many interactions, struggles and negotiations can be expected to occur. From the point of view of the health professionals in a ministry of health, it is not enough to define vision, objectives and areas for action, or to formulate a plan with priorities and resources. Nor is it sufficient that the government provides funding, since this can be wasted or, if insufficient attention is paid to developing local capacities, participation processes and alliances with different stakeholders, can produce powerlessness and dependency.

In order for a health policy to be successful the ministry of health should concern itself with consultation and negotiation at each stage. Policy has the potential to involve people and give them ownership of the health issues that affect them. The development of any policy can begin at the top or from the grass roots. If it originates at the top, without support from stakeholders, it will be difficult to implement later on. The community needs opportunities to
debate the values and principles associated with health and to consider achievable strategies to meet them.

The role of the ministry of health in this process is to listen to the various stakeholders and to make proposals that incorporate their different views with the evidence derived from national and international experience. An active compromise among the majority of the key stakeholders may be necessary in order to develop and implement the health policy.

The health professionals in the ministry of health should have an active role in inviting stakeholders to be involved in the formulation and implementation of the new policy. Everyone can contribute to this process from her or his particular position in society.

The following are examples of stakeholders who may be invited for consultation about health policy, plans and programmes:

- consumer and family groups
- general health providers
- government agencies
- academic institutions
- professional associations
- for-profit and not-for-profit professional non-governmental organisations (NGOs)
- traditional health workers
- religious organisations
- other special interest groups, such as minority organisations, including groups representing indigenous ethnic minorities
- other people and groups, such as national and local leaders, politicians, political parties, trade unions and the business community.

It is very important that the health professionals in the ministry of health obtain political support for the development of health policy. This means making the relevant authorities aware of the magnitude of the burden of disorders in their country, the strength of the needs and demands of the population, and the cost effectiveness of several health interventions.

**Step 4: Exchange with other countries**

Owing to the rapid development of health policies throughout the world it is very useful for ministries of health in different countries to exchange information. The sharing of experiences can lead to countries learning about the latest advances from more developed countries and about creative experiences and lower-cost interventions from less-developed countries.

International experts may be helpful in the first stages of the formulation of health policies. Their knowledge of several countries enables them to recommend a broad range of solutions to the health needs of a population and to validate local pilot experiences. The possibility of adopting new strategies and new interventions may emerge when such experts are consulted. At the stage of policy implementation, international experts can make visits and provide external feedback in order to help the ministry of health to evaluate change.
Professionals in charge of health in the ministry of health need to keep in touch with their counterparts in other countries, particularly those with similar cultural and social backgrounds. They should also maintain close relationships with international agencies, especially the WHO, which can supply them with technical support.

Step 5: Set out the objectives, vision, values and principles of the policy

It is possible to begin determining the main content of health policy once the population’s needs have been identified, evidence for effective policies has been gathered and the consultation process is under way. The WHO (2000) identified three objectives for health policies: improving the health of the population; responding to people’s expectations; and providing financial protection against the cost of ill-health. These can be used as a framework for determining the vision, values and principles of health policy.

A. Determining the vision for health policies

The vision of the health policy represents a general image of the future of health care in a given population. This usually includes the type of services that are required and the way in which they will be financed. The vision usually sets high expectations as to what is desirable for a country or region in the realm of health. At the same time it should be realistic; taking account of what is possible with reference to the available resources and technology. The main elements of a health policy should be blended into a description of the final stage, which will be reached after years of successful implementation. The vision also needs to motivate the different stakeholders of the country or region in question, touching some of their emotional sensibilities and compelling them to make their best efforts in order to achieve a higher level of health for the people.

B. Values and principles in health policies

Values and principles are the base on which governments set objectives and goals and develop strategies and courses of action. Although not always explicitly formulated in policy documents, they nevertheless underlie all policy statements. Countries, regions and cultural and social groups within countries have their own values associated with health and disorders. During the process of formulating health policy it is necessary to discuss which values and guiding principles should be adopted. This has to be done both at the national level and in the administrative divisions of the country concerned. The process should strike a balance between common values and principles on the one hand and the realities imposed by stakeholder’s and countries’ cultural, social and economic circumstances on the other. The professionals in the ministry of health should refer consistently to these values and principles in order to foster greater coherence, integrity, comprehensiveness and continuity in the implementation of health policy.

Step 6: Determine areas for action

The next step is to translate the objectives of the health policy into areas for action. In order to be effective a health policy should consider the simultaneous development of several such areas. The policy should incorporate some actions in most of these areas, although the emphasis given to each one may differ from one country or region to another.
The principal areas for action in health policy include:

- coordinating unit
- financing
- legislation and human rights
- organisation of services
- human resources and training
- promotion, prevention, treatment and rehabilitation
- essential drug procurement and distribution
- advocacy
- quality improvement
- information systems
- research and evaluation of policies and services
- inter-sectorial collaboration.

**Step 7: Identify the major roles and responsibilities of different sectors**

The stakeholders listed earlier are the main sectors to be considered when these roles and responsibilities are being determined:

- **government agencies**: first, it is necessary to determine which government agency is going to be in charge of health policy. It is desirable for the head of government or the minister of health to have this responsibility
- **health**: development of policy, regulation, evaluation, prevention and treatment
- **education**: promotional and preventive activities concerning health in schools
- **employment**: promotional and preventive activities in workplaces
- **social welfare**: rehabilitation, support for special needs and pension plans
- **housing**: supported housing for persons with disabilities
- **justice**: treatment and rehabilitation of persons in prisons, diversion of persons with disorders from the judicial system
- **academic institutions**: in countries with few human resources for health it is necessary for the ministry of health to establish regulations for training institutions (these should focus on training the type of workers required to address the health needs of the population, as identified by the health policy)
- **professional associations**: in many places they play a significant role in regulating the practice of health workers by issuing licences and clinical and ethical guidelines
- **health workers**: policy should determine the nature of the participation of workers in planning and should define workers’ functions in the different services
- **consumer and family groups**: given the increasing level of organisation that people with disorders and family groups are attaining in many countries, policy should cover their incorporation into the different levels of planning and evaluation processes
- **providers**: policy can define the financing and regulatory mechanisms to be used in the public and private sectors.
• *non-governmental organisations*: the role of non-governmental organisations in the provision of health interventions requires definition in most countries or regions

• *traditional health workers*: traditional health workers are an available resource in many developing countries and can be included in policy if their ethical and technical responsibilities are well-defined.

### 3.2 Health plan development

Once the health policy has been written (and, preferably, officially approved) it is necessary to formulate a plan for implementing the identified objectives by building on the process already established for policy development. The information about the population’s needs, gathering evidence, consultation, negotiation and exchange with other countries, which were required for the development of the policy, must be utilised and expanded upon in the formulation of a plan. Additional consultation and negotiation should be undertaken and any new information required should be collected. The next steps are to determine the strategies, activities, time frames, indicators and targets and the resources required for implementing the plan.

**Step 1: Determine the strategies and time frames**

Strategies are the core aspect of a national or regional health plan. In many countries plans are called ‘strategic plans’ or simply ‘strategy’. Strategies represent the lines of action that are thought to have the highest probability of successfully implementing the health policy in a given population. If properly designed in relation to the circumstances prevailing in a country or region, they allow rapid implementation of the health policy. Strategies are often formulated by conducting a SWOT analysis, that is, by identifying the strengths, weaknesses, opportunities and threats associated with current health services and programmes.

On the basis of the SWOT analysis the following steps should be taken by the ministry of health.

- List the main proposals in the health policy for each of the areas for action. The list should also define which sectors would be in charge of each proposal in accordance with the policy’s definition of roles and responsibilities.
- Hold brainstorming sessions with experts in health in order to define the principal strategies for implementing each of the proposals listed in the preceding step. This step requires the analysis of strengths, weaknesses, opportunities and threats, as described above.
- Set priorities for the strategies elaborated in the second step, choosing two or three strategies for every area. Once these are identified an additional priority setting process can be conducted for the whole set of 20 to 30 strategies. A few can be selected as high priorities or all can be placed in order of priority. When carrying out this step it is advisable to consult and negotiate actively with representatives of the main stakeholders.

**Step 2: Set indicators and targets**

Once the strategies have been determined, they must be broken down into specific targets and *indicators* drawn so that later it is possible to assess whether the plan has been
Strategies should have clear targets for what must be achieved and, as already mentioned, a time frame in which to achieve them. It must be clear how the individual activities will contribute to hitting the target.

Strategies must be concrete, feasible and measurable. Planners must thus develop ‘indicators’ to assess whether the strategy has been realised or not. This often requires collection of information or data at the time that the strategy is devised. Only if such information is available at the beginning of the plan is it possible to measure whether the target has been reached at the end of the time period. While numbers or percentages are often good indicators to use, not all outcomes can be measured quantitatively. For example, an indicator for decreased stigmatisation may be measured in terms of changed community attitudes, which may be conducted through a specifically designed, qualitative, attitudinal survey or a focus group discussion. Moreover, there may be more than one indicator for a strategy.

**Step 3: Determine the major activities**

Some planning questions that can be addressed through having a comprehensive plan include the following.

- What ‘activities’ are necessary to implement a particular strategy?
- Who will take responsibility for each activity?
- How long will each activity take?
- Which activities can be done simultaneously and which can only follow the completion of a preceding activity?
- What are the outputs expected from each activity?
- What are the potential obstacles or delays that could inhibit the realisation of each activity, and can steps be taken to obviate these?

**Step 4: Determine the costs, available resources and the budget**

The ministry of health has to undertake the following procedures in order to formulate the resources for the plan. This includes drawing up a budget for each of the strategies of the plan.

- Calculate the cost of each prioritised strategy and the total cost of the plan for every year of implementation. Health costs usually include capital investments and recurrent expenditures, such as human resources and consumables. Physical capital includes buildings, equipment and vehicles, which are typically intermittent expenditures and do not need to be included in every year of a health plan. However, physical capital deteriorates rapidly and it is mandatory to plan for periodic replacement expenditure of this kind.
- Take into account how the resources will be financed. In most countries there is a mixture of state funding (general taxation), social insurance, donors, private insurance and out-of-pocket payments. In addition a number of sectors such as education, labour, justice and housing need to budget for health.
- Adjust the time frame of the strategies and activities to fit the amount of financial resources that government and private institutions can commit to health for every year of the implementation of the plan.
• Replan the time frame and resources annually after monitoring and evaluation of the implementation of the plan. Through experience it becomes possible to know the actual capacity of the health system to implement the plan and the true capital and recurrent expenditures required for the strategies. Sometimes it is also necessary to adjust the time frame and resources because of political circumstances and/or pressure from influential stakeholders.

3.3 Health programme development

Health policy focuses on values, principles and objectives. A plan is a detailed scheme, which allows for the implementation of the policy. Through the policy and plan a country is able not only to put health on to a well-thought through and designed trajectory but to put in place the mechanisms for realising the policy goals. The plan formalises the policy into a set of clear strategic and operational components, which assist countries in reaching their goals. However, in addition to these plans it is often advantageous to introduce targeted programmes into health. It is advisable for teams or individuals making health plans, including people within the ministry of health, to provide ‘spaces’ within their own work (and within the work of the people who implement the services) for programmes to be included and implemented. There are many reasons why, at different points, particular priorities come to the fore and have to be dealt with. These should not be seen as distractions or disruptions to achieving the longer term health goals, or deflections from previous prioritisation processes, but as an integral part of providing health services. Each country will have unique reasons why a programme may need to be implemented at a particular time.

A programme is often a shorter-term initiative than a policy or plan. However, this does not imply that programmes should not undergo thorough planning. Steps outlined in the process of developing policy and plans are also relevant for programmes. As the details of these steps have already been outlined previously, they are not repeated here. However, those involved in developing programmes should go through the following processes:

• determine strategies and time frames based on research and information collected
• set indicators and targets
• determine the major activities and how and by whom these will be implemented
• determine the costs and available resources and orient the programme accordingly
• set up monitoring and evaluation processes.

4 Health policy, plan and programme implementation

A health policy can be implemented through the priority strategies identified by the plan and the priority interventions identified by the plan/programme. The implementation of these strategies and interventions requires several actions.

Step 1: Disseminate the policy

Once the health policy and plan have been formulated, it is important that the ministry of health disseminate and communicate the policy to the health district offices and other partner agencies, targeting key individuals.
Step 2: Generate political support and funding

After a policy has been written, active stakeholder participation and communication activities should be initiated. These activities should last for a few months in order to ensure that enough political support and funding are given for implementation. It is essential to have well-connected facilitators who can advocate the policy at the highest levels of government and in key agencies.

Step 3: Develop supportive organisation

The implementation of health policy requires a competent group of professionals with expertise in health. This group should be responsible for managing plans and programmes, ensuring that the population can access health interventions of high quality which are responsive to expressed needs.

Step 4: Set up pilot projects in demonstration areas

It is recommended that the ministry of health establish pilot projects in demonstration areas where policy, plans and programmes can be implemented more rapidly and evaluated more thoroughly than elsewhere in the country.

Step 5: Empower health providers

It is important to obtain knowledge of how providers function in the country and how they relate to each other within the health system. This knowledge makes it possible to use existing resources more efficiently and to deliver better health interventions.

The characteristics of providers may have a strong influence on the way that health interventions are delivered to the population. The best providers are small multidisciplinary teams, comprising persons from different fields who combine their skills and use their collective wisdom to deal with the complexities of the population’s health.

Step 6: Reinforce inter-sectorial coordination

Most of the health problems need health interventions that are delivered to populations through sectors other than the health sector.

Step 7: Promote interactions among stakeholders

In order to ensure the delivery of health interventions that respond to the needs of a population it is necessary for multiple interactions to occur between the stakeholders. These interactions happen at different levels of the organisation of a country or region.
5 Health policy analysis

5.1 Introduction

Policy change in the health sector is particularly challenging because health systems are technically complex. Experience with health sector reform suggests that the costs of reform often fall on powerful and well-organised groups, while the benefits are often intended for widely dispersed and disadvantaged groups with little political clout. In this section, we will highlight how to analyse a policy, and the policy analysis issues will be further discussed in Unit 5 of this module using PolicyMaker 4 software.

5.2 Retrospective and prospective policy analysis

Policy analysis can be of two types, characterised as analysis of policy and analysis for policy. Analysis of policy tends to be retrospective and descriptive. It looks back at why or how a policy made its way onto the agenda, its content, and whether or not and why it has achieved its goals.

Analysis for policy tends to be prospective. It is usually carried out to inform the formulation of a policy or anticipate how a policy might fare if introduced. Typically, analysis for policy will be undertaken by interested parties to assess the prospects and manage the politics of policy change in a way that meets their goals. Analysis in the early stages of policy making, particularly in problem definition and agenda setting, are particularly important.

5.3 Stakeholder analysis

Stakeholders include those individuals and groups with an interest in an issue or policy, those who might be affected by a policy, and those who may play a role in relation to making or implementing the policy. Policy analysis includes three distinct activities: identifying the policy actors; assessing their political resources (and hence their power); and understanding their position and interests with respect to the issue.

5.3.1 Identifying stakeholders

Stakeholders will be specific to the particular policy and the context within which it is being discussed. Identifying stakeholders who are or might become involved in a particular policy process requires the judgment of the analyst in matters, such as recognising groups within organisations which may hold different interests. Relevant actors will include those who are likely to be affected by the policy either positively or negatively and those who might take action or could be encouraged to do so.
Activity 2
Choose a health policy you are familiar with and then identify some individuals or groups (stakeholders) who have an interest or a role to play in the adoption or implementation of that health policy.

Comment
Health sector policy often involves the following types of groups: consumer organisations (e.g. patient groups); producer groups (nurses, doctors, pharmaceutical companies); economic groups (workers who may be affected, industries, companies with health insurance schemes); and ideological groups (single issue campaign organisations, political parties).

5.3.2 Assessing power
The second step in a stakeholder analysis consists of assessing the power of each actor. Political resources take many forms but can be divided into tangible resources (for example, votes, finance, infrastructure, members) and intangible resources (for example, expertise and legitimacy in the policy issue, access to media and political decision makers). Access to these resources increases stakeholders’ influence in the policy process.

5.3.3 Assessing interests, position and commitment
Interests (as distinct from wants or preferences) benefit an individual or group. Often it is the expected economic effect of a policy on an actor’s interests which plays an overriding role in determining their position on a policy. Identifying these interests can be difficult.

Activity 3
Select one of the stakeholders you have identified in Activity 2 and identify their interests in relation to a specific health policy. Try to suggest what they would stand to gain or lose from the specified policy change.

Comment
This comment provides just one example of the way in which you might have responded to this activity focusing on a particular policy and a single kind of stakeholder. There then follow some more general remarks about stakeholders’ positions relative to policies.

Often the financial or economic impacts of policy change constitute central interests. In the example of a policy to contract out publicly financed services, public sector doctors might perceive their interests at risk if they think that the policy’s aim is to reduce their number (that is, they could lose their job) or if they fear that one outcome of such a policy would be to increase the competition that they face in their private practices (that is, limiting the amount they can earn by practicing illegally). Yet other interests might also be
perceived to be under threat. For example, the potential loss of a public sector position may not be compensated for by improved employment prospects in the private sector due to the credibility, prestige and symbolic value of a public sector post in many countries.

The impact of an issue on stakeholders’ interests will determine their position with respect to the proposed policy – whether they are supportive, neutral or opposed. As with identifying interests, positions may not be easily determined as they may be concealed or because publicly aired positions may be different than privately held ones (the latter often determining what a group may actually do). For example, a minister may publicly support a policy so as to win favour with voters or specific interest groups but may be actively working against the policy from within government. At times, actors may not be certain of their position as they are not sure how a policy might affect their interests. This may happen if the policy content is vague or if there are a number of policy options being discussed, each with different repercussions on the actor.

5.3.4 Developing political strategies for policy change

The feasibility of policy change is determined by position, power, players and perception. The viability of policy change can be improved by developing strategies to manage the position of relevant actors, the power or political resources at the disposal of key stakeholders, the number of players actively involved in the policy arena and the perceptions held by stakeholders of the problem and solution.

5.4 Data for policy analysis

The quality of policy analysis will depend in part on the accuracy, comprehensiveness and relevance of the information that is collected. These, in turn, depend on the time and resources available to the collector, the collector’s official mandate and the collector’s contacts in the relevant policy domain. Evidence for policy analysis usually emanates from documents and people.

5.4.1 Policy documents

Policy-relevant documents might include academic books and journals, reports and evaluations produced by interest groups, think tanks and consultants, government and inter-governmental reports and documents (for example, those of WHO), and the media.

In the age of the internet, there is likely to be a wealth of information about most policies and many policy contexts you can search via search engines. Unpublished reports, email messages, minutes of meetings, memoranda and other ‘internal’ documents can be particularly useful in revealing the true interests of actors. At least some of these are likely to be available online.
5.4.2 Gathering data from people

Talking to actors and undertaking surveys of key stakeholders can provide rich information for policy analysis. These methods may be the only way to gather valid information on the political interests and resources of relevant actors or to gather historical and contextual information. Surveys, which can be administered in person or through the mail or email for self-completion, are occasionally used by policy analysts to generate basic information in relation to stakeholders’ perceptions of a problem or their position in relation to a policy if this information cannot be obtained from documentary sources.

Both documents and people are equally important sources of evidence for policy analysis and both quantitative and qualitative approaches will be required to gather it. Multiple sources and methods increase understanding and the validity of the results.

5.5 Data analysis: applying the policy triangle

Unit 2 explains in detail an approach to modelling the process of policymaking known as the policy triangle. Essentially, this approach conceptualises policymaking as a process in which context, process and content, seen as three ‘corners’, are linked by ‘actors’, which may be individuals, groups or organisations, in the centre of the triangle. Although this approach provides an extremely useful guide to make your exploration of health policy issues more systematic, it is more difficult to apply when you come to writing up your data because the different concepts, such as actors and processes, are so integrally intertwined. A few scholars have presented their policy analysis by talking separately about content, actors, processes and context.

The policy triangle is just one way to organise your material. But on the whole it is usually easier to approach your analysis like a narrative: a story with a beginning, middle and end. In gathering your data, you may well produce a timeline: writing down the dates of a series of events, meetings or conferences, results from research studies, media stories, or a change in government, which will have informed your analysis of how the issue got on to the policy agenda.

Having established how and why the issue reached the policy agenda, you can go on to describe who was involved in formulating the policy: was it largely prepared within a government department, how far did it involve others, such as the finance or social welfare ministries?

At implementation you might refer to what happened once the policy was formulated – how was it executed? Was there good communication between policymakers and those putting it into practice?

5.6 Politics and ethics of policy analysis

Policy change is political, and analysis of policy typically serves political ends. Making policy alternatives and their consequences more explicit and improving the political feasibility of policy are neither value-neutral nor immune to politics. Policy analysis, therefore, will not invariably lead to better policy, or to better policy processes. The substance and process of policy analysis are influenced by who finances, executes and interprets the analysis.
Policy analysis is influenced not just by interests and power but also by interpretation. These issues raise questions about the role of the analyst, or of the organisation for which the analyst works, in the analysis. If the analysis is for policy, it is almost inevitable that the analyst will have a preferred policy outcome.

Policy analysis raises other kinds of ethical issues. For example, is it ethical to allow any group to participate in the policy process so as to develop a more powerful coalition? How far should one compromise on policy preferences so as to accommodate and win over a policy opponent?

6 Summary

Policy development, policy implementation and policy analysis are interrelated steps. And it is clear that policy analysis is important for future policy development. A stakeholder approach to policy analysis identifies policy actors, assesses their power, interests and position with respect to a policy issue and develops a position map on the basis of this analysis. A range of strategies to manage the players and their power and position as well as the perceptions associated with policy change are outcomes of policy analysis. Analysis requires evidence but also encompasses values and ethical questions. While analysis may, more often than not, serve to reinforce the status quo, without the use of policy analysis tools groups without power will remain at a perpetual disadvantage.

6.1 References


Unit 2: Methodology for health policy analysis

1 Introduction

Policy making is a complex phenomenon with multiple actors. To understand it, we need to understand the process by which it operates. Conceptual frameworks, theories and models help us to gain insight into the complex world of policy making.

In this unit you will be introduced to the different conceptual frameworks that are applicable to the health policy making process. These frameworks are developed and applied in western countries. In low income countries they are only rarely applied to policy analysis but this is likely to change as the policy context becomes more complex. The stages heuristic, the multiple-streams framework, the network framework and policy triangle are discussed in this unit. We will raise the challenges and limitations of each framework.

Ultimately, this will help you to design and execute robust health policy analysis studies in Ethiopia so that the new policies and existing ones are made better for the benefit of a strong health system.

Learning outcomes

After studying this unit you will be able to:

Knowledge and understanding

- describe the conceptual frameworks of the policy process
- compare and contrast the different conceptual frameworks of the policy process.

Professional and practical skills

- apply the conceptual frameworks to specific health policy issues.

2 The stages heuristic

The stages heuristic was originally developed by Harold Lasswell (1951). He described a decision-making process in government and termed it ‘decision process’. Lasswell’s decision process includes: intelligence, promotion, prescription, invocation, application, termination and appraisal.

It was popular in the USA until the mid-1980s. Consequently, several authors have researched Lasswell’s decision process and have come up with the approach to policy process described below.

Lasswell’s process approaches the policy from a process point of view, describing stages of the policy process as discrete sets of activities occurring in a short span of time (Leon in early editions of Sabatier, 2007).

It organises the policy process into different stages, such as agenda setting, policy formation, adoption, policy implementation and policy evaluation. Agenda setting is a stage in which problems are identified and an agenda is set. A policy in the making or in the process of change is at formation stage. Once the policy becomes law, when the legislature passes it and it is signed by the head of state, it is adopted. Then it is implemented through
specific mechanisms and activities. Following implementation, there is a need to monitor progress, evaluate outcomes and critically assess the policy. This is the final stage and may be applied to a new or proposed policy.

For example, the Ethiopian Social Health Insurance proclamation was approved by the House of People’s Representatives in August 2010, and four months later the Council of Ministers approved the establishment of a social health insurance agency. In addition, a strategy document and operating manual were produced by the Federal Ministry of Health. And at the time of writing (April 2014) individuals working in the formal sector of the economy will start to enrol in the next few months. Given that it is enacted and the organisational and logistical details of putting it in action are in place, it is in the implementation stage.

Activity 1
Imagine that the Federal Ministry of Health of Ethiopia circulated a discussion paper envisioning how it would like the health sector to be in the year 2035. The paper outlines the current health situation of the country, and projects visions for 2035 together with strategies for achieving these visions. What is the stage of this policy?

Comment
It is at the stage of agenda setting, because it is in the process of identifying national priorities in relation to existing problems and developing strategies to tackle them over the coming 20 years.

2.1 Criticism of the stages heuristic
In the late 1980s the stages heuristic framework received strong criticism from policy scientists. Among the criticisms, four major points stand out. The first is that the stages are ambiguous and inaccurate. Nakamura (1987) noted that policy formation might take place during policy implementation. Parliament may pass an ambiguous policy and pass it to the executive branch of government for implementation. Faced with difficult challenges during implementation, the agencies charged with implementation may modify the provisions or may give them an interpretation that eases its progress.

Second, the stages heuristic framework is intrinsically subject to ‘top-down bias’. It focuses on a policy process initiated in the top echelon of government and hierarchically fed down to the lower branches of government. By doing so it conceives the policy process as consisting of one policy at a given time. However, the government is often working on multiple proposals simultaneously, and the interaction of multiple policy proposals across the different branches of government is ignored by the stages heuristic framework (Sabatier, 1986).

Third, non-governmental organisations and activists deal with multiple policies that are at varying stages in the policy process. For example, the US Agency for International Development (USAID) is engaged concurrently in governance, nutrition and health in Ethiopia. It is helping with the implementation of Ethiopian laws that prohibit early marriage and gender-based violence, it has helped the Ethiopian government to legislate social- and

Fourth, the stages heuristic concept is limited by its inability to put forward a causal hypothesis that works within and between stages of the policy process – a hypothesis that can be applied to predict the outcomes of the policy.

Based on these criticisms, the stages heuristic framework is considered by many to be outdated.

3 The multi-streams framework

The multi-streams framework was first developed by John Kingdon (1984). It explains the policy process in three independent streams. The problem stream is about a set of problems and actors who promote them. The policy stream analyses a number of solutions to specific problems and the actors who promote those solutions. The final stream is related to public offices and elections.

The multi-stream framework seeks to answer a group of questions including how issues are framed and by what means the problems are brought to the attention of the political elite. However, the framing of issues is not clear cut. This is because the same issue might be thought of in many different ways by different actors; resulting in confusion. This is called ambiguity and is part of the intrinsic nature of this framework.

The multi-stream framework has its roots in the ‘garbage can model of choice’. This model comes from a critique of rational models of public administration for example in the work of Herbert Simon (Cohen, March, & Olsen, 1972).

Ridde (2009) suggests ‘… the decision-making processes of organized anarchies, which are characterized by problematic preferences, unclear technology and fluid participation’ as an inspiration for the multi-stream model.

Owing to the ‘bounded rational individual’ who has limited information, time and cognitive ability, the multi-stream framework argues that problems are not fully known, problems are constantly shifting, that it is difficult to determine the relevance of problems and that solutions can be paradoxical. Thus, it recommends focusing on time, over which the individual has greater control than other resources.

This framework largely focuses on the policy formation stage of policy process and on individuals rather than the institutional arrangements. These individuals are policy entrepreneurs. They may come from any one of the three independent streams. When the problem, policy and politics streams converge, policy change occurs. This convergence is the ‘window of opportunity’ and is seized by policy entrepreneurs to effect new policy or policy change. How do they do it? They will couple the problem stream with the political stream. Coupling occurs through ‘temporal sorting’, that is, the way policymakers make choices. They may choose to look for solutions to the problems that need to be solved or may search for problems for which they have a solution at hand.

Ridde (2009) suggests that whether a situation is perceived as a problem by actors depends on nine factors which are listed below.
‘1. it is recognized as important;
2. its causes are recognized;
3. its consequences are specified;
4. the populations concerned are known;
5. it is a new situation;
6. actors are close to it;
7. there are incidents, crises or symbols related to it;
8. there is feedback about it;
9. it is in step with societal values.’

Case study: Window of opportunity and Affordable Care Act (Obamacare)
Successive American presidents tried and failed to reform the American health system. The democrats have long sought reform because it is the source of long-standing criticism. The criticism was the paradox that millions of Americans should be without health insurance in the world’s richest country. The Democrats accepted criticism and wanted to act upon it. Before the Obamacare reform 85% of Americans were covered for health care expenditure. Half of Americans, the majority Republicans, were opposed to major changes in the health care system if it meant an increased role for the government. For this reason, it was difficult to bring about major change in the American health care system.

However, in 2009, a window of opportunity was created. Democrat legislators controlled the House of Representatives and the Senate of the American Congress, and a Democrat was elected to the White House. This is a very rare combination in American politics. Those events led to an opportunity to pass major legislative change. Obamacare was signed into law with its individual mandate requiring Americans without health insurance to obtain it. In this case the problem and solution streams were around for some time. The window of opportunity gave the politics stream an opportunity to join with them.

However, the streams framework has its critics who argue that it is circumstantial, has limited explanatory capacity and focuses too heavily on politics.

Activity 2
Read the following case study from Burkina Faso on the adoption and implementation of the Bamako Initiative to increase the availability of essential drugs and other healthcare services for sub-Saharan African countries. Then answer the questions that follow.
Case study
The empirical findings of this research concern the implementation of the Bamako Initiative (BI) health policy in Burkina Faso (Ridde 2008a). The policy was created to counteract the failure of the 1978 Alma-Ata policy on primary health care (PHC) to foster health equity (Van Lerberghe and de Brouwere 2000). The BI was formulated in 1987 in Bamako, the capital of Mali, at an international meeting of African health ministers, the United Nations Children’s Fund (UNICEF) and the World Health Organisation (WHO). Burkina Faso adopted the BI in 1987, but implementation did not begin until 1993 and, even then, in only a few districts. Its objective is to improve the quality and accessibility of health services. Decentralization takes the organization and financing of health service delivery to the local health district level. Direct payment (user fees) for health care and generic essential drugs is generalized; however, money is not forwarded to the central Public Treasury, but is retained locally and managed by village health committees, which decide on resource allocation. To avoid excluding the indigent, it was decided in 1987 to exempt them from paying user fees. However, as elsewhere in Africa, exemptions have not been applied in Burkina Faso (Gilson et al. 2000; Ridde 2007) and the indigent remain excluded. Although the BI purports to promote equity of access to health care, this has not materialized. (Ridde, 2009)

Note: Burkina Faso has already adopted the Primary Health Care (PHC) declaration of Alma-Ata.

Questions
1. What was the problem which led to the adoption of the BI?
2. What was the policy solution proposed by the BI?
3. Who were the policy entrepreneurs who seized the opportunity so that the Burkina Faso government adopted the BI?
4. Based on the multi-streams framework, propose reasons for the failure of the BI.

Comment
1. Inequity in health status between the rich and the poor lead to the adoption of the BI.
2. Decentralisation of revenue collection and exemption of the indigents from user fees was the policy solution proposed by the BI.
3. The policy entrepreneurs were WHO and UNICEF.
4. The reasons for failure might be:
   a) the exclusion of the indigents is not considered as a problem by the public – a deficiency in the problems stream
   b) there might be a solution. However, there were no policy entrepreneurs who could couple the problem stream with the politics stream
   c) a window of opportunity for coupling might not have been created.
4 The network framework

According to Peterson et al. (1999), policy networks are ‘a cluster of actors, each of which has an interest, or “stake” in a given … policy sector and the capacity to help determine policy success or failure’.

In the USA, policy networks are also called ‘interest groups’.

The network framework is derived from multiple theories in organisational studies and political science. It is highly influenced by inter-organisational theory, which states that organisations depend on each other to advance their common interests. Theory on interest groups also contributed to the network framework. Success of the networks depends on network management, which in turn is a function of the number of actors, communication between them, how conflict is handled and the cost of coordination. The greater the number of actors the greater the cost of coordination in general, and success becomes elusive. This is partly because of the large and diverse number of solutions brought to the table by the different actors. In this case the frequency and scope of communication is important for success or failure. Given that there is more communication, the likelihood of consensus is increased (Kickert and Koppenjan, 1997).

In the networks framework government no longer has a central role. Yet government constantly seeks to steer the networks which more often than not resist the steer.

4.1 Types of policy networks

By combining the distribution of power among actors and the degree of interaction between actors, Adam and Kriesi (2007) argue that there are six types of networks that determine policy change. It is defined in a policy subsystem.

The distribution of power qualifies the interaction modes in each case: the concentration of power introduces a hierarchical element into the pattern of interactions. In the case of conflict, we distinguish between a situation of dominance, where a dominant coalition with a policy monopoly is challenged by a peripheral, minority coalition and a situation which we call competition, where the power differential between the challengers and the (formerly) dominant coalitions is less pronounced. With respect to bargaining, we distinguish between symmetric and asymmetric bargaining, depending on the power distribution. Similarly, we also distinguish between horizontal and hierarchical cooperation. In both instances, we follow the suggestion of Scharpf (1997) that bargaining/negotiation or cooperation in the shadow of hierarchy is conducted under conditions significantly different from those obtaining among actors all of whom are more or less equally powerful (Table 1).

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<th>Distribution of power</th>
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<td>Conflict</td>
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<td></td>
<td>Symmetric bargaining</td>
</tr>
<tr>
<td></td>
<td>Horizontal cooperation</td>
</tr>
</tbody>
</table>

Source: Adam and Kriesi (2007).
In the politics stream, the target population may be constructed by policymakers as positive or negative. This has explanatory power in instances of policy failure or the perpetuation of some policies despite their failure. It also helps to explain why certain policies favour groups that already are privileged sustaining or aggravating social inequalities.

4.2 Criticism of the network framework

Several weaknesses of the network framework have been identified. Three in particular are significant:

- It does not explain why public and private actors interact for common interest (König, 1998: 387).
- It does not provide a causal hypothesis on how the interaction of networks is important to public decision making (Thatcher, 1998).
- It is less applicable to settings where there is rapid change, such as in shifting networks changing politics (Richardson, 2000).

Multiple-streams and the network framework have similarities. Both hold that major policy change requires at least one of three factors: dramatic events or crises, such as the death of a patient in an emergency room; changes in governing coalition, such as when one group dominates branches of a government; or administrative and legislative turnover.

5 Policy triangle

The policy triangle framework was initially developed for health policy analysis by Walt and Gilson (1994). Since then it has been applied to other areas of public policy, such as agriculture and education.

The policy triangle consists of context, process and content with actors at the centre of the framework (Figure 1).

![Figure 1 Walt and Gilson’s (1994) policy triangle](image)
5.1 Actors

An actor can be an individual, a group, an organisation or the government. Individuals have their own values and expectations. Groups are usually interest based. They do not want to assume a political office, and would rather influence decision makers. For example, an association of diabetes patients in Ethiopia may lobby for increased health care expenditure on diabetes care and treatment. Organisations include non-governmental, not-for-profit and private for-profit. For-profit organisations may want to advance policies that maximise their profit. For example, pharmaceutical companies may push for increased expenditure on treatment because ultimately they sell drugs and medical devices. Alternatively, consider MIDROC Ethiopia that employs thousands of individuals and may draft a policy for the provision of free treatment for HIV patients working for the company hoping that productivity will rise. The state is also an important actor in the policy process. Local, state and federal state officials wield power in formulating and legislating policy.

However, the actors are not independent. The power of individuals depends on their position in the organisation, which in turn affects their access to knowledge, resources and authority within or outside their organisation. The power of organisations in turn depends on the values and beliefs of the individuals who operate with that organisation and who shape its culture.

Activity 3
Think about the social health insurance policy in Ethiopia. List the actors that are involved with the policy. Does a way of grouping them suggest itself to you?

Comment
You may have listed the following actors and grouped them as follows:
- government (ministry of health, ministry of labour and social affairs, the parliament, the council of ministers)
- NGOs (USAID)
- interest groups (labour unions)
- individuals (academics working on health systems, health policy, health services management).

5.2 Context

Context refers to political, economic and social systemic factors that affect policy, process and content. Leicher (1979) suggests four types of factor.

Situational factors: these are transient, non-permanent events. They might be short-term, like famine, war or election of a new party to a public office. Or they may occur for a sustained period, as in the recognition of an HIV epidemic. They are strong in making the public focus on a particular issue and may lead to a policy change.

Structural factors: these depend on the political system in which the policymaking takes place. Such factors are more permanent than situational ones. The rule by which power is acquired and the existence of (or lack of) free media affect how policy is framed. Free
media bring issues to the attention of the public and popularise them. Uganda has successfully used mass media campaigns promoting sexual abstinence, monogamy and condom use in order to reduce the incidence of HIV infection (Singh, et al., 2003).

Economic factors are also structural. A country with a small gross domestic product (GDP) may find it difficult ensuring universal health care. A mandatory health insurance policy would not occur when a large proportion of people of working age are unemployed or underemployed. GDP growth may present an opportunity to subsidise costly health policies. For example, Rwanda has harnessed the benefits of fast economic growth to introduce universal health care policy. But there is a challenge here. Other structural factors including demography – for example, age structure of the population – affect the cost of health care. In a country with an aging population, the GDP growth may not match the increasing need for health care of the elderly. Ethiopia has successfully enacted and is implementing policies on child health as well as on sexual and reproductive health because the country’s population is young.

Cultural context: The third factor that builds context is cultural – a domain term for the history, language, customs, norms and religion that make up a society. Cultural norms in most parts of Ethiopia that dictate women as subservient to the wishes of men have hampered the utilisation of modern contraceptives in that country. Husband disapproval is often cited as the major reason for low contraceptive coverage rate in Ethiopia. In the early 21st century, religious beliefs have contributed to the resistance to the increased use of condoms for the prevention of HIV.

International factor: The fourth factor that affects policy process is international or exogenous. Government aid agencies, such as USAID, wield a tremendous influence on how policy is framed and the agenda set. The President’s Emergency Plan for AIDS Relief, largely operating through USAID in Ethiopia, has been instrumental in injecting nearly 1 billion US dollars into the Ethiopian health care system to scale up antiretroviral treatment to about a quarter of a million people living with HIV/AIDS. It has also funded care and support to about 1.1 million HIV-positive individuals (US Government, 2014)

Activity 4
Think about the social health insurance policy in Ethiopia and discuss the contextual factors that influenced its enactment.

Comment
Some of the contextual factors affecting the social health insurance policy that you might have identified are:

- situational – increased awareness of the mixed disease burden with the rise of chronic diseases requiring sustained treatment and care
- political – increased government commitment to the health of the population
- economic – increased GDP growth of Ethiopia
- cultural – increased demand for modern health care partly due to the shift away from traditional medicine
- international – USAID assistance both technical and financial.
5.3 Process

The policy process is about the stages of policymaking described in the stages heuristic including policy formulation, adoption and implementation. There are sub-processes in each stage and they are not all equally important.

For example, in a policy process analysis framework developed for UNICEF to analyse the implementation of the removal of user fees in six sub-Saharan African countries some sub-processes have been found to be more important than others (Hercot et al, 2011).

Out of the 20 hypotheses we developed, some are less supported by the literature, like the sequencing of the implementation in phases. Other hypotheses are supported by most authors, like the involvement of key implementation stakeholders in the formulation stage, the need for broad communication strategies and the importance of monitoring the reform. Still other hypotheses could be reformulated. For example, the distinction between the two hypotheses on international and national evidence could be merged in one more comprehensive hypothesis. Another example is the relevance of separating ‘the process of planning implementation steps’ and ‘the need to sequence the reform’ in two distinct hypotheses. Obviously, the latter could be seen as a part of the former. Although these discussions are valid and should take place each time the framework is used, we suggest that delineating a (sub-) practice helps to draw attention to this practice.

5.4 Content and actors

The content of the policy can be as broad as the Ethiopian Growth and Transformation Plan (GTP) and as narrow as the HIV/AIDS policy. The GTP, for example, outlines targets to be achieved by the plan and its content is very broad in that it contains issues of agriculture, trade, education and health among others, with objective, indicator and implementation agency for each issue. In contrast, HIV/AIDS policy deals with specific issues around the disease, such as prevention, treatment and care. The responsibility for implementing the GTP is shared between different government ministries while for HIV/AIDS the sole responsibility lies with the ministry of health.

A number of policy options can be under discussion for a specific problem, and often the options are vaguely defined during formation. Implementation usually refines the options. Decision on which option to pursue is largely dependent on political discourse and power.

Since the policy triangle framework emphasises the power of the different actors, we will comment on power. Power is the ability to influence others. One may influence others by coercion or by manipulation, but legitimate power avoids both of these. Manipulation is a persuasive method of controlling the thought of others. For example, propaganda can be a tool of manipulation. Monetary incentive, or lack thereof, can also be considered as a manipulative tool. Power is legitimate when the individual is willing and consents to be influenced by other individuals or entities.
Max Weber classifies power in a helpful way. He states the types of power as follows:

- **Traditional power** – when an individual acquires power according to the values of the community in which he or she resides. For example, elderly people in the rural communities of Ethiopia are respected and considered as fit to have arbitration power on issues of marriage, property conflict, etc.

- **Charismatic power** – a person with a strong personality might be revered by the community and may derive his influence as a result.

- **Authority exists when a person has the right to exercise power.** That person may be an elected official or may be just an appointed person. For example, the regional health bureau may appoint someone as an administrator to a regional hospital. The appointed person might have little or no knowledge of health issues. Nevertheless, by the virtue of his or her position, people working in the hospital have no option but to obey.

- **Technical power or expertise** – has been added to Weber’s types of power recently. These are forms of power that result as a function of knowledge. For example, physicians have specialist knowledge on the diagnosis and treatment of health problems. Thus it follows that when an individual has ill health, they will be the first to be consulted.

However, power is also explained differently by other authors as either elitist or pluralistic. Elitist theorists, such as Barker (1996), argue that power is concentrated in the hands of the few – aristocracy, bureaucrats and business people – and that the state serves these select few. Conversely, Matus (1996) contends that power is distributed among individuals, groups and institutions, although it is unevenly shared.

Another alternative explanation of power can be found in institutional economics which explores how institutions devise incentives to influence individual behaviour. This explanation owes a good deal to psychology in its analysis of ways in which institutions can ‘nudge’ individuals into changing their attitudes and behaviour in ways favoured by the institutions.

It is noted that power is determined by content and context. Policies that require a redistribution of budget to address inequity may lend more power to the ministry of finance than to the ministry of health as the redistribution issue affects other sectors beyond health. Moreover, the institutional arrangements of a political system if more democratic may favour pluralistic decision making; whereas in an autocratic system businessmen might wield a tremendous influence on the policies of a state.

The policy triangle framework is lauded for its ability to explain the different factors that affect policymaking.
Activity 4
Discuss the different policy frameworks and write the outcome of your discussion in Table 2.

Table 2 Comparison of the different policy frameworks

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Stages heuristic</th>
<th>Multiple-streams</th>
<th>Policy network</th>
<th>Policy triangle</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit of analysis</td>
<td></td>
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<tr>
<td>Ability to explain</td>
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<td>Advantages</td>
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<td>Factors</td>
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<td>Limitations</td>
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</tr>
<tr>
<td>Context, applicability</td>
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<tr>
<td>Setting</td>
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<tr>
<td>Policy type</td>
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<tr>
<td>Policy subsystem</td>
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</tbody>
</table>

6 Summary
In this unit you have learned about four frameworks for policy analysis: the stages heuristic; the multiple-streams; the network and the policy triangle. You have also been introduced to some strengths and criticisms of each framework. No single framework is clearly superior, and in each policy analysis undertaken a combination of the frameworks can be used depending on the content of the policy, its stage, and context.

6.1 References


Unit 3: A review of research designs

1 Introduction

It is usually difficult to select an appropriate study design for health policy analysis. Policies vary by the stage of implementation, resources available (time, money, information), number and the type of stakeholders involved in the policy, and questions that need to be answered.

In this unit we shall take a practical rather than a theoretical approach to determining the merits of the different study designs in choosing among them.

You will have an opportunity to compare and apply the various study designs for policy analysis for different stages of policy.

Learning outcomes

After studying this unit you will be able to:

Knowledge and understanding

- compare the various study designs.

Professional and practical skills

- apply specific study designs for given policy questions
- evaluate study designs against the stages of policy.

2 Studying how policies are formed and implemented

A case study is an important study design that helps us to answer questions on how policies are formed and implemented.

Gilson (2012) notes that a case study is a study of a phenomenon in a real-life context using multiple sources of data. Yin (2009) argues that the case study approach is mainly valuable in a situation when there is no clear boundary between the phenomenon and the context.

A case can be an event, organisation, community, process (policy formation or policy implementation), relationship between stakeholders, policy intervention or subgroup in a policy.

Gilson (2012) suggests that case studies are important for health policy analysis for three reasons.

Firstly, health policy cannot be separated from the context in which it takes place. For example, suppose the policy intervention is health promotion targeted at women of reproductive age to encourage them to give birth in a health facility. What affects how these women respond to the policy intervention?
Some of the factors that influence whether a woman will avail herself of the health intervention relate to her personal circumstance such as her age and her education. Other factors are more contextual such as the economic status of her household, and the values and beliefs of the community in which the intervention is taking place. These beliefs may dictate that a woman’s role is to stay at home to raise children and to cook food for the family which gives them very little leeway on whether to take the intervention or not. All these contextual factors may operate independently or may interact to influence how the intervention is taken up by the target group.

There are also contextual factors related to the provider of the intervention: consider opening hours, the service package, the availability of services and cost of services. The mothers may be able to access the service only during certain hours of the day which could result in an underutilisation of the intervention. Case studies are an important study design available to policy analysts helping them to unearth both beneficiary- and provider-related contextual factors.

Secondly, the same policy intervention is often perceived differently by different actors. Case studies help to describe the perception of actors towards the intervention activities, thereby contributing to a better implementation.

Thirdly, actors interact in a unique way. Therefore, there is a need to study how the actors relate to each other and how they interact to shape a policy change.

2.1 The goal of case study

Case studies are relevant for policy analysis and they can be used effectively to describe, explore or explain a policy formation or implementation processes. By using a case study the researcher can describe the clients’ experience of the policy intervention. For example, the case may describe the experience of antenatal care users of the counselling they have received from midwives in a health centre. Moreover, the context of policy implementation, with its actors, could be explored using a case study. This might generate concepts that could be tested further.

Finally, it is a difficult task to explain how policies may or may not work. By using a case study a researcher may identify intermediate factors that explain policy success or failure. However, it is a weak method for explanatory policy analysis.

2.2 Types of case study

Three types of case study designs are described by Gilson (2012). Single case study design occurs when a researcher identifies one case and studies it in detail. For example, the study of social health insurance formation process in Ethiopia. A multiple cases study design, in contrast, involves one issue being studied in multiple settings. Its purpose is comparison. The following text is an abstract on the study of HIV/ AIDS policy – condom promotion or lack thereof – in Botswana and Uganda. Note that it uses the multiple cases method. It highlights the differences between the two countries in leadership, engagement of religious groups and ‘procedures of social compliance’.
A comparison of HIV/AIDS policies in Botswana and Uganda is revealing. It helps to highlight the kinds of policies that are necessary to come to terms with the pandemic in Africa, where it is already a public health disaster. It is argued that the promotion of condoms at an early stage proved to be counter-productive in Botswana, whereas the lack of condom promotion during the 1980s and early 1990s contributed to the relative success of behavior change strategies in Uganda. Other important factors included national and local level leadership, the engagement (or alienation) of religious groups and local healers and, most controversially, procedures of social compliance. We end with a call for more draconian measures than are currently envisaged. (Allen, 2004)

The third and most complex type of case study is nested case, a situation when one case is embedded in another or encompasses others. For example, a case study aimed at describing how social health insurance policy is implemented in Jimma Zone can be embedded in a case study on how that policy is being implemented in the Oromiya administrative region.

Activity 1
Think of a phenomenon and develop a case study proposal. In the proposal develop a question, define the purpose and describe the type of case study, data collection and analysis plan you would use.

Comment
We came up with a proposal on how health centres are collecting user fees for the services they are providing and this is how we developed the proposal.

- Study questions:
  - How was the fee determined?
  - What are the mechanisms for user fee collection?
  - Do all patients pay user fees?
- Purpose: to improve the fee collection system.
- Type: a case of a health centre or multiple health centres.
- Data collection method: In-depth interview, observation, record review. You may have planned the data collection by two people – investigator and his assistant.
- Data analysis: Transcription of interviews, organising ideas into findings and thematic analysis – grouping the findings into thematic areas.

2.3 Case study robustness
Whether you can rely on a case study or not depends on the robustness of its design, conduct and analysis. Robustness is a function of the transparent reporting of data collection and analysis.
Table 1 Assessing trustworthiness of case study

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Tactic</th>
<th>Phase</th>
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<tbody>
<tr>
<td>Confirmability</td>
<td>Conduct literature review, identify key concepts</td>
<td>Research design</td>
</tr>
<tr>
<td></td>
<td>Use multiple sources of evidence</td>
<td>Data collection</td>
</tr>
<tr>
<td></td>
<td>Establish chain of evidence</td>
<td>Write up of analysis</td>
</tr>
<tr>
<td></td>
<td>Ask key informants to review draft research report (member checking)</td>
<td></td>
</tr>
<tr>
<td>Dependability</td>
<td>Develop case study protocol (so that others can see the decisions made</td>
<td>Data collection</td>
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<td>in developing the study, and why you made them)</td>
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<tr>
<td></td>
<td>Develop case study database (complete set of data, that others could</td>
<td></td>
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<td></td>
<td>review)</td>
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<tr>
<td>Credibility</td>
<td>Look for patterns in data and across cases (pattern matching)</td>
<td>Data analysis</td>
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<td></td>
<td>Consider explanations for experiences analysed (explanation building)</td>
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<td></td>
<td>Consider rival explanations (alternative explanations for the patterns</td>
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<tr>
<td></td>
<td>identified)</td>
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<tr>
<td></td>
<td>Use logic models to think through causal mechanisms</td>
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<tr>
<td></td>
<td>Triangulation – compare and contrast data across respondents, data</td>
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<td></td>
<td>sources, data types and cases</td>
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<td></td>
<td>Consider negative cases (explicitly seek out experiences that</td>
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<td></td>
<td>contradict your main line of argument, to test that argument and</td>
<td></td>
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<td></td>
<td>refine it)</td>
<td></td>
</tr>
<tr>
<td>Transferability</td>
<td>Use theory in single case studies</td>
<td>Research design</td>
</tr>
<tr>
<td></td>
<td>Use replication logic in multiple case studies (test ideas from</td>
<td></td>
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<td></td>
<td>one case against subsequent cases)</td>
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</table>


Activity 2
This activity is based on ‘A rapid assessment of utilization, effectiveness and added value of the knowledge centres at Bishoftu and Durame hospitals in Ethiopia’, by Mirkuzie Woldie Kerie. The executive summary of this article is reproduced here. You will need to read and refer to this article for this activity which is available at: http://www.who.int/workforcealliance/knowledge/resources/eth_knowledgecentre_assessment2011.pdf?ua=1

After reading the article use Yin’s criteria (Table 1) to help you to judge the robustness of the case study.
Executive Summary

Background: In 2010 the Federal Ministry of Health (FMOH) of Ethiopia in collaboration with the Global Health Workforce Alliance (the Alliance / the GHWA) and the World Health Organization (WHO) agreed to establish three pilot knowledge sharing and exchange centres, or simply knowledge centres (KCs). Funding of the project was mainly handled by the Alliance while WHO provided technical support. Two of these centers have already been functional for about two years and arrangements have been completed for a third one to be established soon. The KCs are meant to ‘contribute to the retention of an effective, responsive and equitably distributed health workforce’ by improving access to up to date information for public health and clinical practice in hospitals of remote areas.

Objective: To explore the benefits and experiences gained since the introduction of the knowledge centres at Bishoftu and Durame hospitals in Ethiopia.

Methods: A case study of the two sites was performed using a mix of rapid assessment techniques which include in-depth interview, record review, observation and mini-survey among users. Participants in the interview included representatives of the hospitals, the FMOH and the WHO. The qualitative data was first transcribed word for word and analyzed using thematic framework approach. Descriptive statistical measures were generated after entering the quantitative data into computer software (SPSS V 14.0).

Key Findings:

- All of the users at the KC in Durame are the employees of the hospital the majority being the health workers. Similarly, users of the KC in Bishoftu are health workers of the hospital although those in the town health office and the health center were also using the services. Health extension workers or other members of the society are not using the services in both of the centers.

- The online services are much more preferred than the offline services by the users of both centers. The preference of the users might relate to the fact that online services provide access to general benefits of having internet connectivity such as e-mail and Facebook communications rather than access to technical materials per se. Consequently, about 60% of the users indicated that they used the online services for e-mail and Facebook communications. It was noted that specific contents used by the users are dependent on the type of the professional.

- More than a quarter of the users interviewed visit the KC at least once per day while another 41.0% visit the centre three or more times per week.

- Specific contents of the offline and online services were highly appreciated by the users and managers interviewed. However, additional technical contents on radiology, anesthesia, medical laboratory, gynecology/obstetrics, pediatrics and internal medicine were recommended to be included in the e-Granary by the users.
• The presence of the KCs in the hospitals has improved access to up to date information, through different literatures and reference materials, by the health professionals.

• All participants of the assessment claimed that the practice, motivation and satisfaction of the health workers in the hospital have improved since the establishment of the KCs. It was also found that the KCs have contributed in improving the ability of the hospitals to retain health workforce.

• The KCs have helped employees of the hospital to develop and maintain a reasonable level of computer and other IT skills.

• The establishment of one additional KC in Asossa is well under way and preparations have been completed.

• The computers available to the users at the KCs were found to be insufficient. This was particularly true since only few of the computers in both centers were functional with all offline and online services working.

• The training provided to the users and others was well appreciated by all of the participants although most felt that there is a need for additional training particularly to users and the IT focal persons. This was suggested since all computers supposed to be available to users are not having all services operating correctly all the time.

• The opening hours of the KCs was judged to be largely inconvenient by the users and representatives interviewed. Location of the KC in Durame was found to be convenient while it was not the case in Bishoftu. Availing the resources at the KCs at the different service areas of the hospital was suggested by respondents of both sites.

• Although registration sheets filled in by the users were witnessed at both sites, there was no any sign of regular reporting of the activities of the KC to the hospital or other authorities. The registration sheets filled in by the users are incomplete in significant portions of the form. This was mainly related to reluctance of the users to consistently and completely register the required information on the registration forms. It was also found that the KC has no any operational plan.

• There were regular supportive supervisions to the KCs initially. Currently, all respondents agreed that it has become irregular and based on reports of failure at the KCs.

• Other challenges reported from both sites include frequent interruption of the online services and power, frequent failure in the offline services particularly the e-Granary and delay in computer maintenance.
Recommendations:
From the main findings listed above it follows that the way forward in the scale up of the KC initiative should take note of the following recommendations:

- The hospital authorities and the supervision team have to be engaged in further awareness creation among hospital staff and others to ensure that the resources at the center are adequately utilized. Emphasis has to be given to the value of using the offline services by the health workers.

- Despite the challenges faced, all the stakeholders in this initiative have to note that the main goal of the initiative is being realized. This has to move the Ministry of health (MOH) at all levels (the hospitals, Regional Health Bureau and FMOH), the WHO and the hospital authorities to ensure availability of enough number of functional computers, functional state of the online and offline services at the centers, and continuous and regular supervision of the KCs.

- To address the issue of regular supervision availing adequately qualified Information Technology (IT) professionals at strategic location to serve a group of KCs is recommended for the scale up phase. Such arrangements as assigning qualified IT professionals in the zonal health departments (ZHDs)/Regional Health Bureaus (RHBs) could minimize the physical barrier between the KCs and the supervisors.

- The hospital and the RHBs should also figure out means of employing adequately qualified IT professionals who can be trained to solve problems of networking and soft/hardware crushes at the KC since this has been a significant problem in both centers.

- The hospitals in collaboration with the RHBs and the local authorities have to create a means to ensure that the opening hours are made convenient to the health workers in the hospitals. This could particularly be realized by keeping the centers open during off duty hours by making the necessary arrangements.

- Users of the KCs need to understand the value of fully completing the registration sheets after using resources at the center. It might also be made a requirement to fill in the registration form at the beginning which means the user will only have to register the contents used and time elapsed before he/she leaves the center after use. More preferably, introduction of an electronic login mechanism which automatically registers all the necessary information every time the user logs in might be designed.

- The FMOH with technical assistance from the WHO should prepare standard operating procedure (SOP) and manual to facilitate operation and maintenance at the KCs.

- Based on the successes of the two centers in meeting the intended objectives to a significant degree, it is recommended that the FMOH and other stakeholders in Ethiopia should plan for the scale up of this initiative to other hospitals located in remote parts of the country.
Similarly, the findings in this assessment imply that other countries with similar context may consider adapting this initiative to their existing circumstances possibly with the support of the Alliance and the WHO.

Comment
Critical evaluation of the article using Yin’s criteria answers three broad questions.

1. What was done by the authors?
   - The researchers used more than one source of evidence. In the study design and participants section the researchers described four sources of evidence namely ‘the users of the KCs (Knowledge Centres) … representatives of the Ethiopian FMOH (Federal Ministry of Health), WHO (World Health Organisation), and the hospitals’. Expanded forms of the acronyms in the parenthesis are mine.
   - The authors looked for patterns in the data. For example, they stated that ‘The main issue raised almost by every respondent concerning the operation of the KC was the concern about convenience of the opening hours.’
   - The researchers looked for experiences that were not in line with the main findings. For example, the majority of the respondents mentioned that they frequently used online sources, such as HINARI and Google. The authors showed that this was not the case with some respondents.
   - The researchers triangulated data sources. It is not clear from the methods section how they did this, but the results section shows that triangulation was carried out. For example, according to the record review the most frequent users of KCs were physicians. The record review showed otherwise – medical laboratory professionals were the frequent users. The authors also tried to triangulate the findings across the KCs.
   - The authors explained the findings. For example, in Durame Hospital, the frequent users – according to the record review – were medical laboratory professionals followed by nurses and health officers. The authors explained that this might be down to the large amount of missing information on the professional category of users in the KC registry. Another explanation was suggested: they said the services are meant to be used by all categories of professionals, but health extension workers are not using the services because of a lack of information and that this may have affected the frequency of use.

2. What was not done by the authors?
   - In the ethical considerations section the authors stated that they developed a study protocol. However, the protocol was not made public so that others could understand what decisions were made during the development of the protocol and reasons behind those decisions.
   - The authors did not place the complete data set in a public repository for review by others.
• In the article, theory was not used to guide the different stages of the study. Furthermore, ‘logic models’ were not applied to identify the causal mechanisms for the findings.

3. What is not clear from the article?
• Whether the researchers did member checking of the draft research report or not.

3 Which policy option to pursue?

Decision makers are often faced with multiple ways of dealing with the same problem or have to decide which problem to address from a host of problems. These problems are compounded by pressure from interest groups, the preferences of the community represented by the decision maker and the advice of experts. However, owing to the scarcity of resources researchers cannot tackle all the problems at once or use all the available resources. They therefore must prioritise and choose which problems to address. These choices can be supported by a decision tool; such tools are based on the need to maximise efficiency.

Pareto efficiency argues that an intervention is efficient if it can benefit at least one person without harming others (Module 8 Health sector economic evaluation, Unit 1). In health policy, a weaker version of the Pareto criterion, known as the Kaldor–Hicks compensation test, is used, whereby the redistribution of resources is said to be efficient if the aggregate number of people benefiting from the policy is more than the number of people harmed as a result of it. To overcome inequity resulting from efficient activities, the beneficiaries share some of the benefits they acquire because of the policy with those harmed by the policy by way of compensation. Thus, policies that are geared towards efficiency have unintended consequence which is inequity (disparity). To mitigate this effect, the policy will have a compensation package for communities affected by inequity. The compensation might take the form of welfare.

If in principle the losers could be fully compensated by the beneficiaries, the Kaldor–Hicks criterion would be satisfied. Below is a discussion of different decision tools taking into account level of intervention, type of information available, validity and purpose of appraisal.

To choose between different policies’ interventions, economists make use of cost–benefit analysis (CBA). CBA expresses both the cost and benefit of an intervention in monetary terms to determine the net gain or loss of an activity. It has been extensively applied to trade and commerce but less so in healthcare. This is partly due to the unwillingness of some parties to quantify the value of human life in terms of money.

To overcome this problem, cost-effectiveness analysis (CEA) was developed as an alternative to CBA. CEA uses health status outcomes as a measure of the value of an intervention. Costs are measured in monetary terms, and health status outcomes may include number of deaths averted and number of life years gained. Costs may be assessed as cost to the provider or cost to society. For example, the cost of treating malaria from the provider’s perspective considers the cost of laboratory tests, drugs given to the patient, personnel costs and capital costs – vehicles, buildings and equipment. Nonetheless, the
cost to the society is far greater capturing indirect cost, opportunity cost and time preference (discounting).

The cost to society of treating a patient with malaria will encompass the cost borne by the patient and care givers, such as transportation, meals and accommodation. These are indirect costs. Moreover, patients and care givers are spending their time seeking treatment, which they can otherwise use for other activity. Depending on the number of minutes or hours they spend looking for treatment the amount of money they could have made varies. This is the opportunity cost. The cost to the society of the intervention will assume different value at different time points – time preference (discounting). Money spent now is more valuable than money in the future because money at hand now can be spent on different options for optimisation of utility.

CEA is limited by its inability to refine benefits. For example, 10 years saved for a cancer patient is different from the same number of years saved for a malaria patient. The former may spend those years in pain while the latter will have less painful remaining years. In addition, CEA may use different variables for different interventions and the purpose is usually to determine whether to implement a certain intervention or not rather than to compare between interventions. Thus, it is sensitive to type of intervention and context leading to a low external validity. Owing to this a sub-set of CEA that lends itself for comparisons across interventions was developed. It is called cost–utility analysis (CUA).

CUA has external validity because it uses a universal variable to measure the benefit of any intervention. Benefits accrued to interventions are measured using concepts such as quality adjusted life years (QALYs) (Module 8, Health Sector Economic Evaluation Unit 2), disability adjusted life years (DALYs) and healthy year equivalents (HYEs). These concepts help to compare the benefits of one intervention against other interventions.

3.1 Validity issues

Internal validity is about the design and conduct of the evaluation and external validity is generalisability/transferability.

Measurement of costs is an important aspect of validity of economic evaluation studies. To ensure internal validity all costs associated with intervention/treatment should be measured. The costs of intervention might be measured on the basis of the local, or of the international market. The two might give different results. Costs measured in the local market may give a higher or lower value than costs in the international market. For comparison it is better to use the international costs. The local costs should be re-expressed in US dollars using the purchasing power parity (PPP) exchange rate between the US dollar and the local currency (Module 5 Economic theory and the health system, Unit 5). This will greatly enhance the external validity of economic evaluations.

The other concern with internal validity is the quality of available data. In healthcare more often than not data on costs of intervention are not available. Thus, the choice of economic evaluation method should be based on available data. But this may reduce the validity of the evaluation as incomplete information compromises the robustness of the exercise leading to a wrong conclusion.
The other issue related to external validity is uncertainty. Results of economic evaluation studies usually present point estimates without standard errors. This has been partly solved recently, but the discussion of uncertainty in economic evaluation is beyond the scope of this module.

4 Measuring the effectiveness of policy intervention

Policy intervention should have been proven effective before its implementation. However, new and innovative policy options that were not tested for effectiveness may come into being. In this case it is important that the policy intervention is tested for effectiveness. This activity will help to show whether the policy intervention works or not, and that will ultimately help to decide whether to continue or drop the intervention. If it is shown to be working, then this is a strong case to appeal to funding bodies so as to get additional funding for its continuation.

At the individual level as is the case in clinical medicine, a randomised controlled trial (RCT) can be undertaken. Randomisation is a process of selecting both participants for intervention and control groups. This random allocation helps to make the comparison groups similar except in the type of intervention. Blinding is a method of preventing psychological effects from influencing the outcome. Both investigators and participants are unaware of the group to which each participant belongs. RCT has a control group for comparison to show the degree of effect due to the intervention by removing effects that are caused by other factors. RCT conducted in a controlled environment is used to assess efficacy. RCT undertaken in a natural environment is used to assess effectiveness. Trials done in ideal/controlled environments are less transferable than effectiveness trials.

In real-life policy situations randomisation might not be possible. The local authority may resist the temptation of researchers for randomisation and may want the community of interest to be in the intervention group. Add to this the near impossibility of blinding. Communities that are receiving the intervention will most certainly know that they are in the intervention group. All factors that are already mentioned make the case for carrying out non-randomised, non-blinded controlled trials.

Consider the example of community-based health insurance in Ethiopia. Certain kebeles were selected for piloting. A researcher who wants to study the effect of community-based health insurance (CBHI) on utilisation of health care will have little opportunity for randomisation and blinding. However, the researcher can still do a controlled trial. The control kebeles might be selected from the same region in which the CBHI is being implemented but need to be geographically separated. Moreover, the investigator needs to make sure that the control communities have similar baseline characteristics to the pilot communities. The researcher could choose a control kebele which has a similar average age, income or education as the pilot kebele. This is very important to control 'statistical noise' that may distort the effect of the intervention. But the opportunity for measuring health status outcomes can be seen as once in a lifetime.

The other important phenomenon that needs to be considered by the researcher is contamination. If the control and pilot kebeles are in close proximity, then, owing to the frequent interaction of people between the two kebeles, the control population may adopt behaviours of the intervention community. This makes it hard for the researcher to determine the net effect of the intervention.
Finally, investigators are faced with policies that are universally implemented. In such a
case control is not available. Nevertheless, evidence of effectiveness might be required at
the implementation stage. What can be done in such a situation is to measure the change
in outcome after the policy intervention. This is called a **before–after study**. In such a study
we need to consider other interventions that may be running in parallel to the policy
intervention and affecting the outcome. Caution is required in interpreting the findings since
it is extremely difficult to determine the net effect of the policy intervention. Nonetheless, the
mere demonstration of change may help to mobilise additional support for the policy.

#### Case study 1

This case study is based on ‘The Oregon experiment – effects of Medicaid on clinical
outcomes’ (Baicker, 2013). Below is an excerpt from the methods section of the article.
After the excerpt you will be presented with comments based on the critical appraisal of
the study.

**Randomization and Intervention**

Oregon Health Plan Standard is a Medicaid program for low-income, uninsured,
able-bodied adults who are not eligible for other public insurance in Oregon (e.g.,
Medicare for persons 65 years of age or older and for disabled persons; the
Children’s Health Insurance Program for poor children; or Medicaid for poor
children, pregnant women, or other specific, categorically eligible populations).
Oregon Health Plan Standard closed to new enrolment in 2004, but the state
opened a new waiting list in early 2008 and then conducted eight random lottery
drawings from the list between March and September of that year to allocate a
limited number of spots. Persons who were selected won the opportunity – for
themselves and any household member – to apply for Oregon Health Plan
Standard. To be eligible, persons had to be 19 to 64 years of age and Oregon
residents who were U.S. citizens or legal immigrants; they had to be ineligible for
other public insurance and uninsured for the previous 6 months, with an income
that was below 100% of the federal poverty level and assets of less than $2,000.
Persons who were randomly selected in the lottery were sent an application.
Those who completed it and met the eligibility criteria were enrolled in the plan.
Oregon Health Plan Standard provides comprehensive medical benefits, including
prescription drugs, with no patient cost-sharing and low monthly premiums ($0 to
$20, based on income), mostly through managed-care organizations.

**Data Collection**

We used an in-person data-collection protocol to assess a wide variety of
outcomes. We limited data collection to the Portland, Oregon, metropolitan area
because of logistical constraints. Our study population included 20,745 people:
10,405 selected in the lottery (the lottery winners) and 10,340 not selected (the
control group). We conducted interviews between September 2009 and December
2010. The interviews took place an average of 25 months after the lottery began.
Our data-collection protocol included detailed questionnaires on health care,
health status, and insurance coverage; an inventory of medications; and
performance of anthropometric and blood pressure measurements. …
Depression was assessed with the use of the eight-question version of the Patient Health Questionnaire (PHQ-8), and self-reported health-related quality of life was assessed with the use of the Medical Outcomes Study 8-Item Short-Form Survey …

This is an experiment because it involves the use of an intervention – Medicaid expansion. It is a randomised controlled trial. The intervention group was selected by a lottery method and received Oregon Health Plan Standard. The control group received no health plan. The groups are similar except in the intervention provided.

Note that the groups have similar age structure, income, possession of assets, 'Oregon residents', 'US citizens/ legal immigrants', 'uninsured in the previous 6 months', and have similar baseline health care and health status. The context is different from the Ethiopian context because baseline data on the participants was available owing to electronic medical recording on the uninsured in Oregon State.

5 Studying why and how a given policy does or does not work

Controlled trials, randomised or otherwise, can measure the effects of policy intervention. But we also want information on why and how a given intervention works or not. To understand this we need another study design which is **process evaluation**.

Process evaluation addresses all aspects of the intervention including: development stages of the implementation; implementation activities and context – the political, social, and economic environment in which the implementation takes place (Platt et al, 2004).

According to Platt, process evaluation is aimed at achieving the following.

- **Describing the intervention** – process evaluation describes the intervention by type, how it was delivered, the reason for its delivery and the target of intervention.
- **Exploring the reasons for success or failure of the intervention** – it helps to identify the element of the intervention that largely contributed to success or lack thereof. It even helps to recognise the element of the intervention that brought about untoward effects. And the subgroup of the intervention community who may have benefited more can be identified with process evaluation.
- **Coming up with best practices during implementation** – what does the communication between stakeholders look like? What were the barriers and facilitators? Should we pursue the intervention? ‘Learning for improved performance’ is a further purpose of process evaluation.

5.1 Elements of process evaluation

Process evaluation should include as a minimum the content, context and actors of implementation. We need to ask what activities are being implemented and in what context they are implemented. The political, economic and social contexts are important. A policy intervention might be taking place in a decentralised health system, for example that of Ethiopia. The perception of the woreda health department and its power to incorporate or modify the elements of the intervention affect the implementation process. The department may or may not have adequate resources. The regional health bureau may need to assign
additional health professionals to a specific woreda. In process evaluation we need to study whether there is an adequate budget to finance the additional personnel. Also, does the setting allow their optimal functioning? Another important element of the context is social factors, which may encompass the ethnic composition of the implementation area. Furthermore, we need to describe the perception of the target population towards the intervention. Actors are inalienable parts of the implementation. The actors may range from the local official to international partners. In between are the health professionals, the community, interest groups and influential leaders in the community. Thus, the values and expectations of the different actors and the interaction among them are crucial in determining the success or failure of any activity.

5.2 Stages of process evaluation

Most of the time, process evaluation starts with a question. What is being evaluated or why it needs to be evaluated. The questions in turn depend on the purpose of evaluation. What do the stakeholders want to do with the result of the evaluation? Then it must be decided who should be included in the evaluation team and carry out the networking. The network should include an evaluation team comprising experts from health economics, health service management, monitoring and evaluation, policy analysts and statistics. Theories and models that will help with the evaluation need to be identified. Multiple sources of data need to be considered, and a decision must be made on the methods that are going to be used. A combination of quantitative and qualitative methods is preferable. Finally, a protocol that encompasses all the stages described above must be developed.

The transition from one stage to the next in process evaluation is not linear. It can be parallel, sequential or circular. A mixture of all those paths is also possible.

5.3 Methods of process evaluation

Both qualitative and quantitative methods can be applied to the process evaluation of policy interventions. Qualitative methods address the organisation of the intervention, whether resources are adequate and the timeliness of resource provision, and the partnerships made during the intervention. Conversely, quantitative methods measure the rate of utilisation of the services, inequities in utilisation, the scope of the intervention and the satisfaction of clients with the services.

Activity 3

Read the section of the Executive Summary of the USAID document, ‘Ethiopia Health Sector Financing Reform Midterm Project Evaluation’ (2011) below. Then answer the following questions:

1. What were the objectives of the midterm evaluation of the Ethiopian health sector financing reform?
2. What was the study design?
3. What were the methods of data collection?
4. Comment on the synchronisation between the objectives and design/methods.
Executive Summary

This report is the midterm evaluation of the Health Sector Financing Reform Project (HSFRP) in Ethiopia, which is a five-year, $15 million U.S. Agency for International Development (USAID) financed bilateral contract to Abt Associates, Inc., to support government at the federal, regional, and woreda levels, as well as to work closely with health facilities to improve financing of health care. The project began August 1, 2008 and is scheduled to end July 31, 2013. The purposes of the midterm evaluation were to: (1) assess the performance of the project in meeting its four main goals, results, and targets; (2) identify areas of success and challenges in the implementation; (3) develop next steps and any modifications for the remainder of the project; and (4) identify opportunities for the future of the health sector financing reform efforts and develop specific recommendations for USAID and Ethiopia for the next five years. The results of the evaluation will be used to inform USAID’s and Ethiopia’s immediate and future program planning and implementation.

This report presents the findings, challenges, and recommendations for each component of the project. The major finding is that the project has had outstanding results and performance in all major components, and no major midterm corrections are required. The depth of ownership, commitment, and passion that are apparent in this project is apparent at all levels. The program’s institutionalization; coordination; communication with national, regional, and local counterparts; and degree of integration with other Ethiopian reforms have been unusually high. As highlighted by counterparts and stakeholders, this project has “revolutionized” the decentralization of health finance at the local level.

The biggest overall success has been the increased availability of drugs, pharmaceuticals, and medical supplies. New medical equipment and facility renovations are also notable accomplishments. These were due mainly to the ability of health facilities to retain revenues at the facility level and use them to purchase drugs, pharmaceuticals, and medical supplies, as well as physical building improvements. Another big success has been the implementation of governance boards at the hospitals and management committees at the health centers. This change has allowed more autonomy and decentralization and led to greater local input and control of resources. While there are some regional variations, the overall findings and challenges are the same in the regions visited.

The project has been highly successful overall. Success was defined as the effective implementation of project plans and methods, and achievement of the targets set. While some components have enjoyed greater success than others, the performance of all components has been high relative to the targets of the project. The greatest accomplishments have been in four major components: (1) development of a legal framework, (2) revenue retention and utilization, (3) facility governance, and (4) development of community-based health insurance (CBHI) schemes. The result of each of these components is clearly outlined in the respective section of this report. The components that have been more difficult to implement or have just started to impact policy and strategy are: (1) revision and updating of user fees, (2) implementation of fee waivers and exempted services, (3)
development of a private wing and outsourcing of non-clinical services, and (4) social health insurance (SHI) development. While these four components have been effective interventions and have been implemented in most health facilities, they have been slower to develop and have experienced more obstacles to implementation. In many cases, the difficulty in implementation was outside the scope of the contractor and was due to national and regional Ethiopian governmental issues. The last component (SHI development) remains at the regulation and strategy level and has yet to be put into action. The performance of the contractor and the project management at all levels has been outstanding. This judgment is based on the team’s experiences with many other health financial reform projects in other countries, as well as a review of the results of project planning and control activities.

Each section of this report clearly outlines the various challenges in each component. At present, one of the larger challenges is continued funding of the project for the remaining project period; this issue is reviewed in a separate memo to USAID. However, funding alone will not solve many of the project problems. There is a need for a strong Ethiopian Government presence and commitment to SHI/CBHI, and there are large cultural, health system readiness, and financial barriers to overcome. Health insurance is a new concept in Ethiopia, and it will take a long time for attitudes and behavior to change. The immediate funding issue is due to the rising number of new health facilities and new personnel coming into full operation within the consolidating regions, as well as countrywide. The project’s demand for continuing technical assistance (TA) is significantly greater than the resources available. As the project management is well aware of the resource problem, they have recommended that some existing health facilities be “graduated” from the project, thus allowing these limited resources to be used in newer facilities. Project management has developed “criteria” for this graduation exercise and is in the process of refining and testing implementation of these criteria. The evaluation team agrees that graduation of the well-developed health facilities is necessary for the next few years of the project and recommends moving forward immediately with this process of shifting some of the resources to the newer emerging health facilities. This report discusses this graduation process in greater depth.

One issue of importance that was discussed in almost every interview with health facility managers and implementing partners was the lack of a “performance-based” reward system for personnel. The evaluation team was informed that efforts to design and implement some system that motivates and provides incentives for staff, increases the quality of care, improves productivity, and retains critical staff have a long history in Ethiopia. With the initiation of the CBHI schemes and the health development army, it is likely that the workload of health professionals will increase significantly. Unless some performance incentive system is permitted, this increase in workload may have an adverse effect on the attitude of staff and the quality of care. If some incentive system cannot be implemented (due to civil service-wide implications), the Federal Ministry of Health (FMOH) and the regions affected could consider revising the negative list on the utilization of the retained revenue to allow, upon approval of their health facility board, a capped percentage of this fund to be
used to compensate for the longer hours. The region could also draw up guidelines on how this can be implemented.

In summary, the reform initiatives are owned and managed by and through the various government management systems and have revolutionized not only the health financing system in the country, but also local ownership and stakeholder involvement in the management of health facilities. Most of the reform program outputs have been realized and a significant number of outcomes and impact targets are likely to be achieved by the end of the program period.

Comment

The goal of the evaluation was to assess the performance of health financing reform in terms of goals, targets, results, successes and challenges. The evaluation team used a mixture of research methods to give rich and reliable data, such as questionnaires with key informants, in-depth interviews with implementing partners, document and literature reviews, focus groups and observation of implementation sites.

The design and objectives were synchronised. For example, the mixed research methods identified clear successes and challenges in implementation.

6 Summary

In this unit you have learned about the different study designs available to evaluate the various stages of the policy process. You may also have noted that case studies are relevant for describing and explaining policy formation. Controlled trials, with and without randomisation, are applicable for studying the net effect of an intervention. In the absence of a controlled trial before—after studies can be used to demonstrate changes after the implementation of a programme. Finally, you used process evaluation to understand why and how a given intervention does or does not work.

6.1 References


Unit 4: Health policy analysis in practice

1 Introduction

This unit is designed to enable you to carry out policy analysis using the models introduced in Unit 2 and to apply them to practical policies and strategies within the context of the Ethiopian health sector.

Using the specific policies and strategies given as case studies, you will engage in the process of policy analysis: the identification of key factors influencing policy and the use of the suggested theoretical frameworks to explain how the interactions between different factors affect the policy formulation and implementation processes.

You will learn about current health policy issues through the review of health sector policies and strategies and will analyse these documents and the issues contained within them from the perspectives of the various policy analysis frameworks.

The documents will be organised across the most important policy issues in the health sector in Ethiopia:

1. organisational structure and governance
2. health care financing
3. human resources for health.

One or more documents from each of the three issues will be made available, and you will divide into groups to work on the documents.

At the end of the sessions for this particular unit, you will present your analyses in groups and consolidate your learning through comments and discussion.

Assessment

Before each class, you are expected to read the required materials for the module as you will be responsible for case analyses, a policy paper, presentations and class participation on your assigned topics at the discretion of your tutor.

In addition to the active participation required during the delivery of the materials for the unit, you will be expected to ask questions, make comments and provide other reflections during individual and group presentations.

Learning outcomes

After studying this unit you will be able to:

Knowledge and understanding

- display knowledge of the principles, concepts, methods and techniques of policy analysis
- understand the inter-linkages between policy development and implementation processes
- review the frameworks available for policy analysis, including their strengths and weaknesses
- understand and process the policy issues within the health sector in a critical manner
- discuss the costs, benefits and unintended consequences of the assigned policies.

**Professional and practical skills**
- conduct policy analysis studies and research in the health sector
- communicate and present analyses of policies and strategies in the health sector orally and in written form
- advise officials within the health sector as well as other levels of the government on issues relevant to the formulation, implementation and evaluation of health care policies, strategies and programmes
- apply new analytical developments, methodologies and research findings to issues of health policy and strategy
- extend and refine existing techniques/models to develop new approaches to health policy analysis.

2 Introduction to policy and policy analysis

2.1 Session objectives and activities

In this session, you are:

1. provided with a brief overview of the unit so that you know what to expect and what activities are required of you
2. introduced to some key concepts relating to policy and policy analysis
3. helped in appreciating the complex nature of policy processes and how the study of policy analysis can guide policymakers and inform stakeholders on policy development and implementations.

Activities for this session are:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time allocated</th>
<th>Learning outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide introduction about the unit</td>
<td>30 minutes</td>
<td>Participants have internalised the unit objectives and expectations</td>
</tr>
<tr>
<td>Brainstorm and discuss on:</td>
<td>135 minutes</td>
<td></td>
</tr>
<tr>
<td>• What does ‘policy’ mean?</td>
<td>15 minutes</td>
<td>Participants: identify the different uses of the term ‘policy’ and clearly understand its meaning in the context of the unit</td>
</tr>
<tr>
<td>• What types of policies are there in the health sector?</td>
<td>30 minutes</td>
<td>Participants outline and appreciate the various policies and strategies within the health sector</td>
</tr>
</tbody>
</table>
What do you understand by the term 'policy analysis'?

What are the steps involved in policy analysis?

Introducing the cases and documents assigned for the various groups for analysis

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>What do you understand by the term 'policy analysis'?</td>
<td>30 minutes</td>
<td>Participants have understood the meaning and relevance of policy analysis to various stakeholders in the process</td>
</tr>
<tr>
<td>What are the steps involved in policy analysis?</td>
<td>30 minutes</td>
<td>Participants understand the key steps involved in policy analysis</td>
</tr>
<tr>
<td>Introducing the cases and documents assigned for the various groups for analysis</td>
<td>30 minutes</td>
<td>Participants are presented with the cases and the documents assigned to them for the analysis</td>
</tr>
</tbody>
</table>

### 2.2 Background on policy and policy analysis

Policy is defined in various ways, including:

1. a set of principles guiding decision making
2. what governments intend or do not intend to do
3. a proposed course of action of a person, group or government within a given environment providing opportunities and overcoming obstacles to reach a goal or realise an objective or purpose.

Individuals or groups can have their own policies on various issues. However, the focus of the module is on public or government policies. Public policies are those that affect a large number of people (having broad effects) or those that involve consequences for those not directly involved. More specifically, public policies can be defined as those that:

- are developed by some form of government body
- are directed toward some goal
- involve some action over time
- may be positive (involve action) or negative (decisions to do nothing)
- have an authoritative, legally coercive quality.

There are various typologies for classifying policies. Among these typologies are:

1. the source of the policy:
   i. administrative: made by individuals working in public agencies responsible for implementing public policy
   ii. legislative: development of statute law
   iii. executive: policy made by elected officials who carry out legislative policy
   iv. judicial: interpretation of existing law in the courts

2. substantive versus procedural policies:
   i. substantive: policies involving actions (e.g. building highways, distributing welfare)
   ii. procedural: regulations how things are to be done (e.g. preventative, regulatory policies)
3. distributive, redistributive and regulatory:
   i. distributive: using public funds to assist particular groups, communities or industries
   ii. redistributive: Involves reallocation of money, rights or power
   iii. regulatory: imposing restrictions and limitations on behaviour of individuals or groups.

Policy analysis is the process of evaluating past policies and predicting the impact of possible future policies through systematic evaluation of the technical and economic feasibility and political viability of alternative policies, strategies for implementation, and consequences for policy adoption. Analysis aims to:

- generate feasible courses of action in order to help policymakers choose the most advantageous ones
- reduce uncertainty and provide information and evidence on the benefits and other consequences of courses of action.

There are steps in conducting policy analysis. Usually, these steps include:

1. defining the problem and establishing the context: one must find out the underlying problem that must be dealt with and the goals to be pursued in confronting the problem
2. choosing relevant policy goals and identifying the alternatives: one should be knowledgeable about the particular policy and programme
3. assessing and predicting outcomes and consequences (estimating the likelihood of the alternatives): one should rely heavily on the analytic techniques of management sciences (economics, operational research, forecasting and simulation, cost–benefit analysis, etc.)
4. valuing and evaluating the outcomes of policies and those of the alternatives: one should try to choose objective (often quantitative) standards or criteria against which policy choices can be evaluated
5. reaching a conclusion.

2.3 Introducing the various groups and the cases assigned

Three groups of policy and strategy documents are assigned for use in the analysis exercise.

1. Organisational structure and decentralisation:
   - Ethiopian health policy
   - organisational structure for the health sector

2. Health care financing:
   - health care financing strategy
   - social health insurance strategy

3. Human resources for health:
   - health sector human resources development framework
   - human resources for health strategy
2.4 Readings for the session

The readings are primarily FMOH documents which are readily available on the internet. The two other readings are also available online and the URL is provided.


3 Outline and reviewing different models of policy analysis

3.1 Session objectives and activities

In this session, you will be:

1. introduced to the various models used for policy analysis
2. enabled to identify the key factors influencing policy and how they are factored within the various theoretical frameworks
3. enabled to apply the introduced models and explain how the interactions between different variables within the different models affect policy outcomes
Activities for this session are:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time allocated</th>
<th>Learning outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participants list and briefly outline models of policy analysis that were introduced in Unit Two (the stages heuristic model, the multi-streams framework, the network framework and the policy triangle framework)</td>
<td>45 minutes</td>
<td>Participants already have working knowledge of the models and are able to describe their organising concepts and the variables applied during policy analysis</td>
</tr>
<tr>
<td>Introduce additional models for policy analysis:</td>
<td>45 minutes</td>
<td></td>
</tr>
<tr>
<td>The rational actor model</td>
<td>15 minutes</td>
<td>Participants get working knowledge on the organising concepts and the application of the rational actor model in policy analysis</td>
</tr>
<tr>
<td>The organisational process model</td>
<td>15 minutes</td>
<td>Participants get working knowledge on the organising concepts and the application of the organisation process model in policy analysis</td>
</tr>
<tr>
<td>The bureaucratic politics model</td>
<td>15 minutes</td>
<td>Participants get working knowledge on the organising concepts and the application of the bureaucratic politics model in policy analysis</td>
</tr>
<tr>
<td>Demonstrate the application of the newly introduced models to a case (policy scenario)</td>
<td>60 minutes</td>
<td>Participants will be able to exercise the application of the models to different cases (policy scenarios)</td>
</tr>
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</table>

3.2 Background on the models for policy analysis

You have been introduced to various models of policy analysis (the stages heuristic model, the multi-streams framework, the network framework, policy triangle framework) in Unit 2 of this module. In this unit, three other additional models are introduced: the rational actor model, the organisational process model and the bureaucratic process model.

3.2.1 Rational actor model

The basic unit of analysis in this model is the national government making policy decisions. The government is conceived as a unitary, rational decision maker that sets national security goals and goes about seeking them by calculating costs and benefits of different actions. Analysts who use this model seek to show that decisions are rational, calculated responses to problems.

The model is closest to the traditional economic view of rationality, which sees behaviour as a value-maximising choice (Module 5 Economic theory and the health system Unit 1). Nations/leaders act in a consistent manner such that their acts are all internally consistent, so an analysis seeks to show how the actors could have rationally chosen that action.
The organising concepts in this model are:

- **basic unit of analysis**: key actors. Action is chosen by nation/national government
- **national action**: the nation or government is the rational actor
- **problem framing**: action is chosen in response to the strategic problem faced
- **static selection**: action is single, large, steady-state choice (rather than many smaller decisions in a stream)
- **nation or government evaluates alternatives and makes the best choice.**

### 3.2.2 Organisational process model

This model maintains that governments are not monolithic but contain loosely allied large organisational actors who respond to problems with certain standard operating procedures. These procedures are often effectively the only options available to governments trying to deal with a problem. Each organisation ‘perceives problems, processes information, and performs a range of actions in quasi-independence (within broad guidelines of national policy)’ (Allison, 1971). The basic assumptions here are that organisations are not homogeneous and that actions are not the deliberate choices of leaders but rather the outputs of large organisations functioning according to standard patterns of behaviour. In addition, even though organisations are capable of learning, the learning process occurs slowly.

The organising concepts in this model are:

- **basic unit of analysis**: policy as organisational output
- **organisational actors**: constellation of loosely allied organisations above which government leaders sit
- **factored problems and fractionalised power**: problems are divided and parcelled out to the various organisations
- **parochial priorities, perceptions and issues**: organisational structure encourages parochialism
- **action as outputs of organisations and**:
  a) problems/goals are handled sequentially
  b) organisations rely on standard operating procedures to handle problems
  c) organisations seek to avoid uncertainty by negotiating with their environments or establishing set of standard scenarios that constitute contingencies for which they prepare
  d) organisations learn, but slowly and incrementally.

### 3.2.3 Bureaucratic politics model

According to this model, national action is the result of political compromise between various organisations and actors. Thus, the roots of action are extremely complex. The model looks at policy as an explicitly political outcome. The key actors are the individuals who hold various positions in the national security apparatus. The general proposition of this model is ‘where you stand depends on where you sit’, that is, policy positions can be derived with a high likelihood by looking at a person’s political position.
The organising concepts in the bureaucratic politics model are:

- the basic unit of analysis is political ‘deals’
- actors are individual actors in positions of power
- interests take the form of stakes and power – actors use their power wisely and strategically as it is not possible to attend to all interests all the time
- individual actions result in an aggregation of outcomes of minor and major games and foul-ups. Understanding of the overall outcome requires that it be disaggregated.

3.3 Discussing application of the models to different situations

You will discuss the appropriateness of application of the various models to different policy situations. Each of the models has its own advantages for being well suited to the analysis of a particular policy situation.

3.4 Application of the models

Cases (policy scenarios) will be presented to demonstrate the application of the various models and to show the outcomes through the use of different models to analyse a given policy scenario. For this particular session:

1. you will be assigned to groups
2. each group will be given a case (policy scenario)
3. each group will report back within the allocated time on overall policy issues identified and what policy analysis framework they applied to the case with prediction of the policy outcomes based on the analysis.

3.5 Reading for the session


4. Identifying key actors and stakeholders as well as their roles in the policy process

4.1 Session objectives and activities

In this session, you will be:

1. introduced to the concept and bases of power for different actors within organisations
2. enabled to identify key actors and stakeholders as well as their roles in policy process
3. enabled to conduct stakeholder analysis.
Activities for this session are:

<table>
<thead>
<tr>
<th>Activities</th>
<th>Time allocated</th>
<th>Learning outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and discuss the concepts of actors, stakeholders and their influences on policy process</td>
<td>45 minutes</td>
<td>Participants identify key categories of actors and their roles and their actions in influencing power relationships and policy processes. Identify the sources of power of actors and the factors influencing the behaviour of actors in policy process</td>
</tr>
<tr>
<td>Introduction to the concept of stakeholders analysis</td>
<td>45 minutes</td>
<td>Participants understand the concept and approaches to stakeholder analysis</td>
</tr>
<tr>
<td>Provide case scenarios for stakeholders analysis</td>
<td>60 minutes</td>
<td>Participants will be able to apply stakeholders analysis to given cases</td>
</tr>
</tbody>
</table>

4.2 Readings for key actors, stakeholders and their roles in the policy process

Readings:


4.2.1 Power, influence and politics

Power is defined as the ability (or potential) to perform actions that either directly or indirectly cause a change in the behaviour and/or attitudes of another individual or other groups. It can also be defined as the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance, regardless of the basis on which this probability rests. The concept of power can also be said to refer to the capacity to change the behaviour or attitudes of others in a desired manner. Authority is the right to exercise power.

The term ‘influence’ most often indicates actions that, either directly or indirectly, cause a change in the behaviour and/or attitudes of another individual or group. It can also be thought of as power translated into action. When someone attempts to affect another in a desired fashion, that person is said to be using social influence. If this influence attempt is
successful, that individual will have exercised control over the other. People generally prefer to use open, consultative forms of influence rather than coercive methods.

Behaving in a manner that is not officially approved by an organisation to meet one’s own goals by influencing others is known as organisational politics. Such activities typically occur under ambiguous conditions (such as in areas of organisational functioning in which clear rules are lacking). Political tactics may include: blaming and attacking others; controlling access to information; cultivating a favourable impression; developing an internal base of support; and aligning oneself with more powerful others. This may involve the playing of political games, such as: asserting one’s authority; enhancing one’s power base; attacking one’s rivals and trying to foster organisational change.

Politics is a domain of activity in which participants attempt to influence organisational decisions and activities in ways that are not sanctioned by either the formal authority system of the organisation, its accepted ideology or its certified expertise. The use of power and politics in organisations occurs most frequently in situations in which goals are in conflict, where power is decentralised or diffused throughout the organisation, where information is ambiguous, and where cause and effect relationships between actions and outcomes are uncertain or unknown (high task or strategic uncertainty).

The power and political model of organisation assumes that the goals of an organisation are not specific or agreed upon (in contrast to the rational model which assumes that organisations have specific goals and that problems can be logically solved). Organisational departments have different values and interests, so managers come into conflict. Decisions are made on the basis of power and political influence. Bargaining, negotiation, persuasion and coalition building decide outcomes.

4.2.2 Bases of power

Power may reside within individuals, and five bases of individual social power have been identified:

1. position power: the power vested in individual or group by virtue of their role or position in an organisation and sometimes called legitimate power
2. resource power: the key to resource power are dependency and scarcity
3. social power: having many potentially valuable connections is an important power base
4. expert power (expertise) including control of vital information: knowledge or expertise must be relevant to the particular task or issue at hand
5. personal power: this derives from an individual’s personal qualities and personality. Intelligence, confidence, self esteem, charm, drive and friendliness are all qualities which may enhance credibility and influence in the eyes of others. People with these qualities are often said to have charisma.

However, having a basis of power is not enough. The individual must act in order to become the influencer, they must expend energy, use the basis of power. When the basis is formal, little effort would seem to be required to use it. Conversely, when the basis of power is informal, much effort would seem to be required to use it. Finally, the influencer must not only have some basis of power and expend some energy, but often they must also do it in a clever manner, with political skill.
4.2.3 Stakeholder analysis

Stakeholder analysis is an approach or set of tools for generating knowledge about actors. It helps to analyse past experiences in order to understand how policies have developed and to assess the actors’ concerns about an issue, their level of interest and power, how much they know about the issue, whether or not they are likely to support or oppose the policy. It also allows for consideration of the feasibility of future policy directions and strategies.

There are various approaches to stakeholder analysis. Whatever approach is used, there are three essential steps in stakeholder analysis:

1. identifying the key stakeholders and their interests (positive or negative) in the project
2. assessing the influence of, importance of, and level of impact upon each stakeholder
3. identifying how best to engage stakeholders.

4.3 Introducing key actors and stakeholder analysis in health policy process

1. Participants will be assigned to groups.
2. Each group will be given a case (policy scenario).
3. Each group will report back within the allocated time on the application of stakeholders analysis to the given case with the identification of which actors had most influence in the case and explaining how and on what bases of power the actors influenced the outcome of interest.

5 Participant presentations of assignments

5.1 Session objectives and activities

During these presentation and discussion sessions:

1. each group now has an opportunity to show how they have applied what they have learned during the module to their analysis of a particular policy scenario
2. each group will get feedback on their presentations
3. all participants will interact and discuss the cases and the analyses among themselves and with all audience.

6 Summary

This unit has introduced you to the practice of policy analysis. It built on familiar concepts, as well as introduced new additional models used in policy analysis. A focus has been on the central role of actors and their bases of power for influencing policy processes. Stakeholder analysis was discussed as a tool for assessment of the roles of various stakeholders and the political feasibility of policy implementation. The unit finished with the opportunity to consolidate and extend your learning through group assignments analysing a particular policy scenario.
6.1 References

Unit 5: Policy analysis report writing

1 Introduction

In Unit 1 of this module, we defined what policy, public policy and health policy are. We also discussed issues in policy, plan and programme development, implementation and policy analysis. Most of the issues raised in Unit 1, but especially policy analysis, are helpful for this unit.

This unit introduces the basic steps of health policy analysis using PolicyMaker4 software by Reich and Cooper. This is a free software which you can download and use. It is available at the following url:

http://www.polimap.com/download.html

It has been widely used to assist politicians and policy makers to achieve their policy goals. For example, it has facilitated ‘the setting of local health priorities in Tanzania, to assess national pharmaceutical policies in nine African nations, and to impose major health sector reform in Zambia, Mexico, and the Dominican Republic.’ (Seeman, 2000) In this unit, we take you through the stages of using the software. PolicyMaker4 approaches policy analysis through a five stage process. These are (i) policy content, (ii) identifying the key players involved in the policy analysis, (iii) developing political strategies to improve the feasibility of the policy, (iv) the impacts of those strategies on the future position and power of players, and finally (v) generating a report capturing the results of the analysis. The example policy used in this unit is the Clinton Health Reforms in the US in the early 1990s. Through the use of screenshots looking at the analysis of this policy, we provide the necessary orientation for you to carry out your own analysis of an Ethiopian Government policy or plan. The latter is done by signposting activities through the unit.

Learning outcomes

After studying this unit you will be able to:

**Knowledge and understanding**

- appreciate the utility of the PolicyMaker4 software.
- Apply the PolicyMaker4 software to an Ethiopian Government policy or plan.

**Professional and practical skills**

- Analyse a policy content
- Effectively identify and analyse key players for a policy
- Develop strategies to improve the feasibility of a policy
- Assess the impacts of strategies on the future position and power of players of the health policy
- Report on the health policy analysis.
2 Framework for health policy analysis

A policy analysis paper requires students to research in depth an issue of public concern. It can be an issue of on-going political debate or an issue that has not yet gained the attention of policymakers. A policy analysis defines the problem or issue at hand, describes its background and provides a balanced assessment of the options that policymakers could pursue to resolve the problem and finally recommends a course of action for policymakers. This is demonstrated in Figure 1 below.

Figure 1 Stages in policy analysis using the PolicyMaker4 software, Main menu

As you can see from Figure 1, PolicyMaker4 software allows you to do the following:

1. define a policy to analyse
2. analyse the key players (groups, organisations and individuals) by considering their position and power
3. develop political strategies to improve the feasibility of your policy
4. assess the likely impacts of your strategies and envision possible future scenarios.
5. Generate a report on the policy analysis.

We will now look at each stage in turn, and you will have an opportunity to apply your learning to an Ethiopian government policy or plan.
3 Stage 1: Policy content

For this to be successful, you need to select a policy that has clear boundaries and multiple stakeholders who have different positions and interests. Figure 2 shows how to capture the details relating to the policy. By navigating between the buttons at the top of the screen – add, edit, delete – you can record the policy goals, assign an importance level for example high priority to low priority, identify the mechanism to achieve the goal, and an indicator to evaluate whether the goal has been achieved.

Activity 1
Select a policy or plan from the following list from the Ethiopian Government. Your tutor may provide a more extensive list.

- Strategic Plan for Intensifying Multisectoral HIV and AIDS Response in Ethiopia II (SPM II) 2009–2014 (FMOH, 2009)
- Health Sector Development Plan III (HSDP III) 2005/6 – 2009/10 (FMOH, 2005)
Analyse the policy content of your selected policy following the policy content Stage 1: goal, priority, mechanism and indicator.

Comment
The policy or plan you have used for this activity should be used for the remaining stages of your health policy analysis for continuity. This stage enables you to begin to deconstruct the policy or plan in order to help you dive deeper into understanding the players.

4 Stage 2: Players
This is a more detailed stage necessitating a number of steps; player table, current position map, current feasibility, consequences, interests and coalition map. This is demonstrated in Figure 3. In identifying and analysing the key players or stakeholders, the following steps (2A–2F), are used.

Figure 3 Stage 2: Players
2A. **Player table**

Here key players (named) are identified, the level (national or regional) at which they operate for the policy focus, and their position (for and against) and power (low, medium or high) over the policy is determined. The example for the Clinton Health Reforms is shown in the screenshot in Figure 4. This analysis provides the basic data for your stakeholder analysis which is carried out later.

![Player Table](image)

**Figure 4 2A. Player table**
2B. Current position map

This involves visually representing the players according to their current position of support, non-mobilised and opposition. The example for the Clinton Health Reforms is shown in Figure 5.

![Current position map](image)

Figure 5 2B. Current position map

2C. Current feasibility

This provides a graphical representation of the extent of the current support for and opposition to the policy as shown in Figure 6. Note that by placing the cursor on one of the columns and clicking, a further breakdown is provided as in Figure 7.
Figure 6 2C. Current feasibility

Figure 7 Drilling down into content from Figure 6
2D. Consequences

This stage assesses the consequences of the policy for the key players. It includes the type (financial, beneficial, harmful, symbolic, etc.) of consequences, the size of the player and the timing of the consequence for each of the players. It also evaluates the importance of the consequence as demonstrated in Figure 8.

![Figure 8 2D. Consequences](image-url)
2E. Interests

This step analyses the interests of the key players involved in the policy. The interest is described in terms of the type of interest (political, financial, self-interest, etc.), and whether the interest is of high, medium or low importance for each of the players. This is demonstrated for Clinton’s health reforms in Figure 9.

Figure 9 2E. Interests

2F. Coalition map

This is a graphical representation of the key players. By clicking and dragging players you can build a more meaningful representation of players, showing clusters, those more pivotal and marginal to the policy system etc. There is scope to customise the coalition map to enable it to represent the alliances you wish. This is demonstrated for Clinton’s health reforms in Figure 10.
Activity 2
Using the health policy or plan you used for Activity 1, identify and analyse the major players involved in your health policy by going through steps A-F described above using the PolicyMaker4 software tool.

Comment
Key players are groups, organisations and individuals influencing your health policy or health plan. You may not have identified as many as in Figure 4 considering the Clinton Health Reforms, but as competence with policy analysis increases this is an area that you are likely to see improvement in your skills.

The creation of the player table will be useful later to generate the current position map and a feasibility graph.
5 Stage 3: Strategies

Having carried out your analysis of your players, you are now in a position to consider player-specific strategy development. This is demonstrated for the Clinton Health Reforms in Figure 11.

Figure 11 Stage 3: Strategies
3A. Opportunities and obstacles

Here you can identify potential opportunities and obstacles pertaining to players, and add your own notes to develop your points. This is demonstrated for the Clinton Health Reforms in Figure 12.

![Figure 12 3A. Opportunities and obstacles](image-url)
3B. Suggested strategies

In developing suggested strategies, the approaches are power strategies, position strategies, player strategies and perception strategies. This is demonstrated for the Clinton Health Reforms in Figure 13.

Figure 13 3B. Suggested strategies
By double clicking on a strategy that you have identified, you can drill down to the detail of the strategy, identifying actions that support the strategy, the human, financial and other challenges of implementing the strategy, and a suggested timeline for implementation. This is demonstrated for the Clinton Health Reforms in Figure 14.

Figure 14 Drilling down into Figure 13
3C. Strategy table

Here you can design strategies to influence players to strengthen support and minimise opposition to the policy. The strategy table includes the player’s name, strategy and actions, challenges, timeline and probability of success. This is demonstrated for the Clinton Health Reforms in Figure 15.

![Strategy Table Image]

Figure 15 3C. Strategy table

Activity 3

Using the health policy or plan you worked with in Activities 1 and 2, develop political strategies to improve the feasibility of the policy.

Comment

You have now identified a set of policy options that government might take to move forward with the policy. Be sure the options involve substantive policy measures aimed at the issue in question.
6 Stage 4: Impacts

Having identified your strategies, you are now in a position to consider their potential impacts. This involves four steps as shown in Figure 16, and brings together work done in previous steps, demonstrating the cumulative and iterative nature of policy analysis.

Figure 16 Stage 4: Impacts
4A. Strategy impacts

Here you can estimate the future position and power of players for a given strategy, but you have to select one of the strategies you developed in the last step to go forward with this. You should be presented with a table of your proposed strategies to select from. The example we chose for the Clinton Health Reforms was to ‘win support from key opponents’ (American Medical Association) the output of which is demonstrated in Figure 17.

![4A. Strategy Impacts: Win Support from Key Opponents](image)

Figure 17 4A. Strategy impacts
4B. Future position map

Here you can view the players according to their future positions of support, non-mobilised and opposition to the policy as shown in Figure 18. Again, you will be prompted to select which strategies you want the position map to display for.

Figure 18 4B. Future position map
4C. Future feasibility

Here you can view a graphical representation of the extent of the future support and opposition to the policy for a particular strategy or selection of them as shown in Figure 19 for the Clinton Health Reforms.

Figure 19 4C. Future feasibility
4D. Strategy implementation

Finally, in this step, you can track the implementation of strategies to evaluate whether the actual impacts match the expected impacts. This is demonstrated in Figure 20 for the Clinton Health Reforms.

Figure 20 4D. Strategy implementation

Activity 4

Using the health policy or plan you worked with in Activities 1, 2 and 3, assess the impacts of strategies on the future position and power of players using the steps (4A–4D) from the PolicyMaker4 software.

Comment

This forms the main body of your policy analysis research paper. You would need to discuss how each alternative would meet the criteria for issue resolution identified in your introduction. Quantitative methods are especially effective in comparing the anticipated costs and benefits of a policy proposal. Consider political factors as well. Understanding how the stakeholders would be affected by the various policy alternatives is a major consideration.
7 Stage 5: Report

The final stage is to generate a policy analysis report as shown in Figure 21.

Figure 21 Report

Activity 5
Prepare a report of the policy analysis results using PolicyMaker4 software for the policy or plan used in Activities 1, 2, 3 and 4.

Comment
We hope that you have found the PolicyMaker4 software easy to navigate and useful for helping your analysis of your chosen Ethiopian Government policy of plan. Undoubtedly it will have been challenging at times, perhaps most especially because you did not have all the evidence and information you needed. But this in itself is a useful benefit of the software, alerting you to what you do not know but need to know to strategise more effectively.
8 Summary

This unit has introduced you to the PolicyMaker 4 software and has given you the opportunity to use the software to carry out some practical policy analysis. It has demonstrated first hand that policy analysis is an iterative process, shaped by policy actors from many different sectors and organisations, with often quite narrow opportunities to bring about change.

But before we end this unit, we would like you to reflect on the ethical issues that the software does not address. It is software to achieve a policy goal. But it is less sensitive to the harms and benefits that the policy goal may produce. Thus, the software can be used by both popularly elected politicians, but also by tyrants. We leave you with this sobering thought.

8.1 References


Summary

In this module you have learned that policymaking in government is a complex process. You may have also noticed that policymaking has multiple stages that are not mutually exclusive with non-linear relationships. By this time you have practical skills in analysing policy formulation, adoption, implementation and evaluation with emphasis on the Ethiopian healthcare system. In developing these skills you have developed another important skill which is the ability to judge and select between the different conceptual frameworks and research designs that are used to analyse health policies. Finally, you have experimented by feeding a set of variables and assumptions about a health policy into the Reich and Cooper software to produce a policy analysis report.
Glossary

Areas for action  Complementary aspects of a policy that are separated for the purpose of planning.

Before–after study  A design without randomisation and control group that seeks to measure change in outputs/outcomes/impact over the period of an intervention within the same group.

Case study  A research design for studying a phenomenon in a particular context.

Conceptual framework  A general list of variables for describing a broad phenomenon. Example: conceptual framework on public policy.

Economic evaluation  A method of determining the efficiency of a policy by comparing the costs of the intervention against its benefits.

Health district  A geographical or political division of a country, established with a view to decentralising the functions of the ministry of health.

Health intervention  An activity whose purpose is to promote health, prevent disorders, provide treatment or favour rehabilitation.

Health plan  A detailed pre-formulated scheme for implementing strategies for the promotion of health, the prevention of disorders and treatment and rehabilitation.

Health policy  An organised set of values, principles, objectives and areas for action to improve the health of a population.

Health programme  A targeted intervention, usually short-term, with a highly focused objective for the promotion of health, the prevention of disorders, and treatment and rehabilitation.

Health stakeholders  Persons and organisations with some interest in the improvement of the health of a population. They include people with disorders, family members, professionals, policymakers, funders and other interested parties.

Model  A representation of precise relationships among a small set of variables

Principle  A fundamental truth or doctrine on which rules of conduct are based.

Process evaluation  A method of explaining how and why a given intervention works.

Provider  An organisation, health team or institution that delivers health interventions to a population.

Randomised controlled trial  An experimental study design used to measure the net effects of an intervention.

Strategy  An orderly organisation of activities for achieving an objective or goal.

Value  A cultural belief concerning a desirable mode of behaviour or end-state which guides attitudes, judgments and comparisons.
Acknowledgements

Unit 1: Health policy development, implementation and analysis


Unit 3: A review of research designs


Unit 5: Policy analysis report writing