

Part II.B

The Policy Environment

- Existence of policies, plans, guidelines that promote access to and/or quality of RH services
- Removal of barriers to RH policy development and/or service delivery
- Number of policy incentives to increase private sector participation in RH service delivery
- Resources available for RH
- Number of new financing mechanisms identified and tested
- Political and popular support for RH
- Participation in RH policymaking
- Number of NGO networks or coalitions working for RH
- Adequacy of the policy planning process

THE POLICY ENVIRONMENT

Promoting policy reforms is an important tool in ... overall development assistance... Experience in every sector has shown that gains realized from providing training, institutional capacity building, and direct resources are either enhanced or hindered by the policies, regulations, and administrative practices in that sector. When policies and regulations foster equitable opportunities and sustainable economic growth, they play an important part in creating an environment where development can flourish (USAID, 2000).

Policy and *policy environment* are often used interchangeably. The *policy environment* is both extrinsic and intrinsic to RH program operations: it forms part of the socio-political context in which programs must operate, and it influences the scope of program actions, the resources allocated, and the organizational structure of the program itself. We define a *supportive (or enabling) policy environment* as one in which (a) laws and executive orders mandate provision of products and services without imposing undue restrictions on providers or eligibility requirements on clients; (b) public and private resources are adequate to ensure full population coverage; (c) government and civil society leaders openly speak in favor of RH services and healthy practices; and (d) the policy formulation process is characterized by good planning principles and broad participation.

The indicators chosen for this chapter explicitly recognize both the broader socio-political context and the policy issues more narrowly focused on RH.

The policy environment is not static, but constantly changes in response to changes in the political and economic arenas, to changes in availability and costs of RH technologies, and to emerging public health issues. Thus, any policy evaluation must address the *processes* by which policies are formulated and revised as well as the policies themselves. Giving voice to groups previously under-represented in the policy process, such as women or rural citizens, may produce pressure for a different array of public services; an adequate policy environment for family planning could be rendered obsolete in the face of a burgeoning HIV/AIDS epidemic; lower prices of medications may

provoke debate about offering anti-retroviral therapies, once out of reach because of cost. The chapter also includes an indicator of the policy planning process (also referred to as *policy formulation, policy reform, or policy change*).

Defining the boundaries or limits of policy is a challenge. Policy includes formal governmental declarations, laws, and statutes. Policy also covers operational regulations, guidelines, norms, and standards (Cross, Jewell, and Hardee, 2001). It is arguable whether *practice*, such as spending resources or following established norms, should fall within the boundary of policy. Practice may be considered an outcome of the policy environment rather than a component of the environment itself. This “boundary” issue is not unique to policy, but is manifest in almost every program process. For example, training programs seek to improve program performance; yet this *Compendium* considers training indicators separately from performance improvement indicators.

In addition to these definitional issues, program evaluators may want to consider other issues when they adapt the indicators to a specific application. Such issues are briefly summarized below.

Methodological Challenges of Evaluating Policy

- **Policy is difficult to quantify.**

With few exceptions (such as size of health budgets), policy indicators are inherently qualitative. That is not to say they are not objectively verifiable. Most

indicators use a nominal scale (e.g., presence/absence of a policy), and some indicators may be ordinal (e.g., higher or lower checklist ratings). Even when interval or ratio measures are theoretically possible (e.g., percentage of parliamentarians or of the general public in favor of a particular policy), policy program evaluation budgets are seldom large enough to include them on an on-going basis.¹

- **Policies operate at different levels.**

Within the same country, policies can be enacted at different levels of the program and by different processes. The legislative branch of government and/or the executive branch enact most health policies, the legislative branch through acts of parliament or other laws, and the executive branch through presidential and ministerial decrees, departmental guidelines or norms. Similarly, this *Compendium* does not pre-judge the relative worth of executive vs. legislative policies – a national population law is considered the same regardless of whether it was passed by parliament or issued by the president’s cabinet. Decentralization adds a further layer of complexity, when sub-national regions are granted policy and budgetary authority. As a rule of thumb, this *Compendium* defines a “policy” as any guideline or ruling that affects more than one service delivery post. For example, instituting user fees at a single clinic is not considered a policy, whereas using the results of a pilot test to set user fees throughout the entire system (be it a Ministry of Health or a family planning association) is considered a policy.

- **Policy change is usually incremental.**

A given policy is complete when it receives official approval at the highest level at which it was intended (e.g., a legislative action signed into law by the president, program protocols published by program director). This is often a multi-year process; adopting an all-or-none criterion (approved vs. not yet approved) may mask significant improvement in the policy environment. Those involved in field applications may find it useful to include progress toward approval (e.g., drafted, discussed in committee, submitted for approval, approved, revised, and updated) as part of the indicator’s definition. In addition to whether a particular policy exists or has been recently adopted, evaluation of the policy environment should consider factors that improve the probability of its implementation, such as political and popular support, and sufficient resource allocations.

- **Several factors affect implementation of policy.**

Supportive policies improve programs and change reproductive health only to the extent that the policies are implemented. Most policy assessments include at least the *content* of the policy or policies (whether it guarantees access to a service, permits a variety of providers). A host of other factors within the policy environment influence policy implementation. These factors include the *actors* involved in the policy reform, the processes used to carry out the reform, and the *context* within which the policy was developed (Walt and Gilson, 1994). Political and popular support, participation, and the planning process itself should be included as policy indicators, because they affect both the likelihood of implementation and the process of policy formulation. Evaluating implementation would be a chapter in itself, because the indicators depend on the specific policy in question. For this reason, the *Compendium* does not specify indicators of implementation or compliance with the content of the policy. However, several indicators include a brief section on “implementation issues,” which discusses how implementation evaluation might be addressed.

- **In some circumstances, policy may include unwritten rules of conduct.**

In many cases, unwritten practices govern provider behavior more than published policies or norms do. Do these unwritten rules qualify as “policy?” The answer to this question lies in part in the intervention chosen to remedy a situation. If the remedy chosen is to develop or modify a formal policy, then the unwritten rule of conduct should be considered a policy issue. If the remedy chosen is a different, non-policy programmatic action, then the unwritten rule should not be considered a policy issue. For example, if physicians refuse to offer hormonal contraceptives because they lack experience with modern low-dose formulations and the chosen remedy is contraceptive update training, then the unwritten rule of not refusing hormonals would *not* be a policy issue. However, if the remedy is to draft new norms stipulating that all clients, regardless of age or parity, should be offered hormonals, then the unwritten rule *would* qualify as a policy issue. Stigma and discrimination surrounding HIV/AIDS are another good

¹ See “Monitoring the Policy Reform Process,” (USAID, 2000) for a discussion of quantitative, composite, and descriptive approaches to measuring policy.

case in point. By definition, discrimination appears in written legal documents, and as such, is a policy issue. Stigma, on the other hand, is an extra-legal concept dealing with attitudes and behaviors of individuals. If the response to stigma is to conduct public education campaigns on the rights of HIV-positive individuals, it is probably not a policy issue. If, however, the response to stigma is to pass new legislation stating that HIV status does not affect the rights of individuals to public goods and services, it would be a policy issue. In other words, whether or not unwritten rules of conduct qualify as “policy” depends on the nature of the *response* to those rules and not the rules in and of themselves.

In this section on policy indicators, we consider four broad aspects of the policy environment: (a) **formal**

policies, (b) resources and finance, (c) support for reproductive health and participation in the policy process, and (d) policy formulation. Taken together, they span the dimensions of a *supportive policy environment*.

The indicators in this section are ordered according to the following four categories:

- Formal policies;
- Resource and finance;
- Support for RH and participation in the policy process; and
- The planning process.

Indicator

EXISTENCE OF POLICIES, PLANS, GUIDELINES THAT PROMOTE ACCESS TO AND/OR QUALITY OF RH SERVICES

Definition

“Policies, plans and guidelines” includes broad health and population policies and laws. They also include programmatic and organizational documents whose objective is to regulate the kinds of services to be delivered, to whom, and under what conditions. They appear in constitutional provisions; legislation; implementing rules and regulations; executive orders; ministerial level decrees, and other measures of a regulatory nature (including related regulations and enforcement mechanisms); official goals and plan programs; statements and other formally documented government directives; standards; guidelines; and decrees (The EVALUATION Project, 1998).

Most developing countries now have some national RH policies or laws in place (although few have a stand-alone RH policy). Experience has shown, however, that macro-level policies, laws, councils, and programs do not guarantee RH service availability and quality. Therefore, we strongly recommend that any policy review include operational policies.

“Promote access” refers to mechanisms that encourage provision of RH services, and increase the number of service delivery points (SDPs) offering services and/or types of services and methods available.

“Promote quality” refers to mechanisms that encourage quality RH services such as technical competence of providers and responsiveness to client needs.

When evaluators measure both access and quality, they should construct separate indicators for each to maintain uni-dimensionality of each.

Not all individual policies will be complete. For example, a national development statement may cite reproductive health as a development issue, without detailing the steps necessary to improve RH. In such cases of incomplete policies, evaluators should consider the aggregate of all policies relating to RH, rather than examining individual documents. To measure changes

over time, the indicator should consider only those policies developed or modified during a specific reference period, such as the last calendar year.

Data Requirements

Evidence of policies, plans and/or guidelines Supporting documentation should include the policy/plan/guideline itself, where or by whom it was issued or published, and an explanation of how the policy/plan/guideline promotes access to or quality of RH services. For example: Is support given to a full range of RH dimensions, or for only a single program element? Are all populations – women, men, youth – covered? Is accountability discussed?

At times, evaluators may wish to measure progress towards supportive policies. In this case, they can construct separate indicators for each stage of development (e.g., in draft, submitted for approval, approved), or can devise an ordinal rating scale to track progress from draft to final approval.

Data Source(s)

Actual policy/plan/guideline document with evidence of approval (or submission for approval). A content analysis of the documents should include level (e.g., national, provincial), topic area addressed (e.g., access, quality, FP, HIV/AIDS), and, where applicable, crosscutting issues (e.g., gender, human rights, youth).

Purpose and Issues

The purpose of this indicator is to measure the degree of explicit support for access to and/or quality of RH services on the part of government and other bodies, including service delivery institutions. However, presence or absence of policies alone is of limited usefulness. We encourage evaluators also to include the indicator, **Adequacy of the Policy Planning Process** (the last indicator in this section on the Policy Environment).

An important limitation of this indicator is related to the collection and analysis of all the relevant policy

documents. Evaluators may face difficulty defining “RH policy” within each country for a number of reasons:

- Following ICPD, the scope of RH significantly broadened to include safe motherhood and breastfeeding, aspects of sexual health such as female genital cutting, adolescents, HIV/AIDS, as well as family planning and population growth;
- Because of the extensive scope of policy they must explore, evaluators should carefully identify all RH-related policies. National development plans, poverty reduction plans, and other economic policies may include RH;
- Policy may be enacted by different processes in different countries and thus make cross-country comparisons difficult;
- Determining whether the policy/plan/guideline “promotes access and/or quality” is a qualitative assessment. Refer to Parts II.H.1 and II.H.2 of this *Compendium* for indicators of program access and quality; and
- Implementation of or adherence to policy directives is a separate issue.

In assessing implementation, evaluators must determine whether the health and population policies and laws include an implementation plan that designates institutional roles and responsibilities, time frames and activity plans, budgets, and monitoring and evaluation plans. When assessing implementation of broad policies and laws, evaluators should first consider whether or not an approved implementation plan exists (which will be an indicator in its own right), and then whether the activities have been conducted according to plan. Operational policies, on the other hand, are more specific; evaluation of their implementation should focus on whether their provisions are being carried out in practice.

Gender Implications of this Indicator

A gender perspective on plans and policies examines their content and their implementation strategies.

1. The Contents of the Plans

- Are the contents and language in line with major international agreements, such as ICPD, that focus on sexual and reproductive rights, not on demographic targets?
- Is the language gender sensitive (e.g., using “women” and “men” rather than “couple,” which is gender insensitive; couples may or may not have common reproductive health goals or the barriers a “couple” faces may depend on whether the male member or the female member of the couple is seeking care)?

2. Implementation Strategies

- Do the strategies explicitly account for gender specific ways for women and men to access the care they need?
- Do the strategies exclude all elements of coercion or any such elements that act to disempower individual men or women (e.g., policies that give husbands control over the reproductive health of women)?

REMOVAL OF BARRIERS TO RH POLICY DEVELOPMENT AND/OR SERVICE DELIVERY

Definition

This indicator constitutes a subset of the indicator, **Existence of Policies, Plans, Guidelines that Promote Access to and/or Quality of RH Services**. Whereas the previous indicator includes the broad rubric of policies, laws, and program documents that encourage provision and quality of RH services, this indicator focuses on modifying existing policies to eliminate obstacles to service access and quality.

This indicator is especially pertinent to legal and regulatory reform in RH. Policy barriers may affect participants in the policy process, service providers, and/or potential clients. They may affect both the public and private sectors (such as restrictions on particular contraceptive methods or eligibility requirements for RH services) or may affect primarily the private sector. Kenney (1993) distinguishes five categories of regulatory barriers:

- Regulations that constrain contraceptive options;
- Tax and import policies;
- Advertising and promotion regulations;
- Other regulations affecting the commercial sector; and
- Regulations affecting non-profit organizations.

Added to these are restrictions on access to training and exclusions from policy formulation meetings and other arenas in which policies are made.

Data Requirements

Old and new policy documents, showing evidence of restrictions in the old policy that do not appear in the new policy.

Data Source(s)

Legal and regulatory reviews; actual policy documents with evidence of government approval, submissions for approval

Purpose and Issues

The purpose of this indicator is to measure the extent to which national governments expand participation in developing policy and in providing RH services and facilitate increased access to RH services for all sectors of the population. Removing client eligibility requirements – such as marital status, minimum age, or parity for receiving FP methods or RH care – empowers women and youth to demand the services and products they want. Private sector participation in policy development may ensure that RH programs address the needs of all different groups in a population (e.g., women, men, commercial sex workers, men who have sex with men). The private sector can also be an important provider of RH services, especially in countries where government programs are either overburdened by demand or are unable to reach certain population groups.

This indicator can be quantified in several ways. As a baseline measure, it may be expressed as the number and type of policy barriers that significantly hinder private sector participation. To measure change over time in a country application, the evaluator should count and qualify the policy barriers identified at baseline, which were subsequently removed. Evaluators can measure change through naming and counting those identified policy barriers that do not appear in the new policy. Evaluators should link clearly the barriers identified at baseline, the policy interventions carried out, and the barriers identified at follow-up.

Because policy barriers by their nature tend to be very specific, evaluators can readily assess whether the new policy removes them. For example, if the barrier removed is import duties on contraceptives, evaluators can interview commercial distributors to determine if they no longer pay duties. Similarly, if the barrier is one that constrains contraceptive options – such as requiring parental consent to provide services to unmarried youth under age 18 – evaluators can interview providers to assess their awareness of the barrier removal and can interview youth to assess their ability to obtain services.

Gender Implications of this Indicator

A gender perspective on policy barriers examines the question:

- Do the plans recognize the common and different barriers women and men face in access to health care?

Indicator

NUMBER OF POLICY INCENTIVES TO INCREASE PRIVATE SECTOR PARTICIPATION IN RH SERVICE DELIVERY

Definition

This indicator constitutes a subset of the indicator, **Existence of Policies, Plans, Guidelines that Promote Access to and/or Quality of RH Services**. It focuses attention on the private sector.

Policy incentives refer to any course of action that facilitates private sector participation in providing RH services. Such incentives may include tax breaks for private sector organizations that provide RH services or for individuals who contribute to NGOs or mission hospitals providing RH, tariff relief, and public vouchers.

Data Requirements

Evidence of policies enacted that provide incentives

Data Source(s)

Actual policy documents with evidence of government approval, or submission for approval

Purpose and Issues

Governments can *hinder* private sector participation through the policy barriers described in the preceding indicator. The reverse does not hold – governments cannot *mandate* private providers to offer RH services.

The purpose of this indicator is to measure the extent to which governments facilitate the private sector's involvement in providing RH services. It may also indicate the relative importance governments place on the role the private sector can play in providing RH services.

Evaluators have limited experience in applying this indicator in developing countries. Tariff relief that exempts contraceptives from import duties is the most widely-practiced policy incentive to private sector service delivery. In South Korea, the family planning program at one time provided vouchers to reimburse private sector physicians for performing voluntary sterilizations and IUD insertions. Indonesia is testing a similar voucher system with private midwives, and Nicaragua has tested special vouchers for sex workers. Tax codes may offer deductions for charitable contributions to NGOs.

Policy incentives attempt to increase private sector participation. Evaluators must assess not only the presence of incentives (e.g., are vouchers available), but also their effectiveness (e.g., whether private practitioners are serving more clients than they did before receiving incentives).

Indicator

RESOURCES AVAILABLE FOR RH

Definition

“Resources available for RH” programs includes money, human resources, physical infrastructure, and material support. Resources may be expressed in monetary forms, such as local currency budgets or dollar conversions; other units, such as number of staff or staff time assigned to RH, are also possible. If used within a single country, the indicator can be expressed in terms of total resources. If cross-country comparisons are intended, the indicator should be expressed over a common denominator, such as resources per capita or RH resources as a percentage of the total budget.

Program administrators mobilize resources through four main sources: direct government (central or local) financing, donor financing (including bilateral, multilateral, and private foundations), user fees, and third-party payment mechanisms such as health insurance. In the face of declining government and donor funding for RH, new (alternative) financing mechanisms such as user fees and health insurance take on added importance. See **Number of New Financing Mechanisms Identified and Tested during a Reference Period**, (the next indicator in this section).

Data Requirements

Evidence of allocations to or expenditures on RH, by source of funding

Data Source(s)

National expenditure budget documents with evidence of approval; national accounts; invoices, and other evidence of expenditures; personnel or staff assignment rosters; time and motion studies

Other sources of information on national funding include the surveys commissioned by UNFPA and the Netherlands Interdisciplinary Demographic Institute (NIDI: www.nidi.nl/resflows/index.html), the UNAIDS/Harvard University study on national expenditures on HIV/AIDS, and individual country studies of national expenditures and efforts to develop national health accounts.

Purpose and Issues

This indicator measures the commitment of resources by either a government, an NGO, or the private sector to the RH program. Evaluators must carefully define this indicator before they apply it to a country. First, they must define the realm of expenditures – does the evaluator refer to only public sector resources, or also to private expenditures on RH? Money paid out of pocket by individuals for their own care should not be included in this policy indicator, but expenditures made on their behalf by employers or insurers may be considered.

Second, evaluators must decide how to treat the source of public funds. For example, they may exclude donor grants but may include loan funds.

Third, evaluators may track separately capital expenditures (for new or renovated facilities, equipment) and recurrent expenditures for program operations (salaries, supplies, maintenance). Capital budgets may fluctuate widely from year to year, rising to cover construction of new facilities and falling when construction is complete. Thus, a decreased capital budget may not demonstrate or indicate a worsened policy environment. On the other hand, recurrent budgets should show at least maintenance or preferably steady increases over time, to cover growing populations and expanded and/or higher quality services.

Particularly in countries that provide FP/RH services along with other maternal child health (MCH) or primary health care services, evaluators may have trouble identifying and linking the line item in the budget of the appropriate ministry/organization to FP/RH. Moreover, when personnel provide other health services in addition to FP/RH, evaluators may have difficulty determining the proportion of time devoted to FP/RH.

In such cases, evaluators have the following options. First, the most commonly used, though least reliable approach, is to interview supervisors and health workers, asking them to estimate the percentage of their time

spent providing FP/RH services. This percentage can then serve as a basis for allocating labor and other joint costs.

Second, evaluators can conduct a time-use survey of a sample of facilities, using either the technique of patient-flow analysis or direct observation of health workers at specified intervals (i.e., work sampling). Bratt et al. (1999) showed that, compared to direct observation, neither self-reports nor patient-flow analysis reliably estimates allocation of staff time.

Third, another commonly used indicator of government resource commitment to RH is the share of the national budget allocated to family planning and reproductive health. The main problem with this alternative is that RH programs are often financed by several levels of government (e.g., national, state, local). Another problem is that such an indicator is sensitive to variations in the size of the national budget due to political, ideological, or national security considerations.

Fourth, some evaluators convert total expenditures to a per capita measure. This conversion permits cross-country comparisons and at the country level may complement, rather than replace, the total resources indicator.

Fifth, as a precursor to **Resources Available for RH**, evaluators may track, on an interim basis, newly enacted plans or policies (either at the government, organizational, or programmatic level) that attempt to increase resources for RH services. Examples include new, separate budget line items for RH services in national and local MOH budgets, or a directive that insurance plans must cover RH services. Planning to increase resources for RH services may signal an increased recognition of the importance of such services.

Finally, government can enhance resource adequacy by spending existing resources more efficiently.

An important question regarding implementation is whether funds or other resources allocated are actually expended to provide RH services. Many governments fall short of implementing their published budgets. When assessing implementation, evaluators must confirm that the resources allocated to RH programs actually flow to the operational units in the field providing the services. In practice, most evaluations will not be able to follow the money trail down to the operational level.

Indicator

NUMBER OF NEW FINANCING MECHANISMS IDENTIFIED AND TESTED

Definition

This indicator complements the indicator **Resources Available for RH**.

This indicator measures the “financing mechanism” – any process that raises funds for RH service provision. Examples of these mechanisms may include: fee for services, sliding fee scales, subsidized services through donor financing, and third-party payment mechanisms such as health insurance.

“Identified and tested” refers to actions that assess the feasibility and appropriateness of certain funding mechanisms for providing RH services. To meet this indicator, a country or program must both identify and test a new financing mechanism.

Data Requirements

Information on type of financing mechanisms identified and/or tested

Data Source

Documents and meeting minutes; pilot tests; study results

Purpose and Issues

Funds for reproductive health services can be mobilized through four main sources: direct government (central

or local) financing, donor financing, user fees, and third-party payment mechanisms such as health insurance. This indicator highlights the importance of financial resource mobilization as an essential component of a national plan or policy. Its purpose is to measure the extent to which governments and local NGOs initiate and experiment with different strategies aimed at increasing access to RH services.

Not all new financing mechanisms are necessarily good. Adding a new mechanism like fee for service can be good if it increases available resources for RH, or bad if it suppresses demand. Often economic barriers, such as high fees for services or high transportation costs, restrict access to health services. On the other hand, charging nominal fees for certain reproductive health services may increase demand for such services, because people may associate better quality of services or a greater need for those services with having to pay for them.

In terms of implementation, evaluators will need to distinguish between the testing of a new mechanism and the mechanism’s success at increasing revenues without unduly depressing demand. Organizational willingness to test a variety of financing mechanisms signals a positive policy environment, even if the organization ultimately adopts only one or two of the mechanisms.

POLITICAL AND POPULAR SUPPORT FOR RH**Definition**

“Political support” refers to the positions taken by government leaders on RH, both in public meetings and in closed policy deliberations. Support may be manifest in public speeches, voting records, or behind-the-scenes lobbying. Popular support refers to the positions taken by members of the civil society and is measured by civic involvement (e.g., NGOs, media, religious and community organization leaders).

Data Requirements

To distinguish this indicator from the previous indicator, **Existence of Policies, Plans, Guidelines**, evaluators should not gauge political support for RH from official documents such as national development plans. To construct this indicator, an evaluator requires prior definition of the reference group (e.g., which government or civic leaders, stratum of the public at large) and the means to assess the group’s opinions. Evidence of oral or written statements or public forums should include dates, position/responsibilities of the person(s) involved, intended audience, and media employed.

Data Sources(s)

To construct this indicator, evaluators may draw upon a variety of data sources, ranging from voting records, quantitative opinion polls of defined leadership groups (e.g., parliamentarians) or of the general public, to key informant interviews. Media scans that archive texts (or audio or video tapes) of official speeches, newspaper articles, government communiqués, official documents, or other public expressions may be available but are difficult to implement and interpret. Evaluators should avoid anecdotal evidence or non-systematic clipping services, especially if they intend to measure change over time.

Purpose and Issues

The purpose of this indicator is to measure the degree of explicit political and popular support for RH services on the part of government, civic leaders, and society at large.

This indicator is basically qualitative, and as such, many consider it fairly “soft,” both difficult to quantify and to interpret. Even if one assiduously follows all official speeches and documents of numerous high level decision-makers, assessing such statements is difficult. For example, should reading a prepared speech on World Population Day or at the opening session of a donor-sponsored event be taken as support for RH? Moreover, a single statement by the president of the country may carry more weight than 100 statements by lower level officials.

The impact of political and civil society support is greater if statements continue over a long period of time and if successive leaders make much the same commitment to RH. If, on the other hand, successive leaders vacillate between strong support and weak or no support, the policy impact of such statements may be minimal.

Opinion polls or key informant interviews are the preferred data sources, providing that leaders are willing to be interviewed. These may include parliamentarians or public or opinion leaders previously singled out for an advocacy campaign. Evaluators can measure popular support with opinion polls, readily conducted in countries with “omnibus” marketing surveys.

Experience has shown that media scans of public statements are difficult to maintain and to interpret.

Despite the inherent difficulties in data collection and interpretation, this indicator is one of the few available markers of progress in advocacy for policy change. Opinions of public officials may constitute the earliest signals of impending change in the government’s position on RH, whereas civil society support may become increasingly important as governments open the policy process to wider participation. Once governments enact favorable policies or budget resources to RH, continued political and popular support is vital to ensure program implementation.

Evaluators should use this indicator in conjunction with **Existence of Policies, Plans, Guidelines that Promote Access to and/or Quality of RH Services and Resources Available for RH**. Support manifest in such concrete actions as constituting a new organizational unit or program to oversee HIV/AIDS or funding a leadership position can be legitimately considered a new policy (such as the one creating the HIV/AIDS body) and increased resources to RH (such as the budget allocated to the HIV/AIDS unit and the official's salary).

Evaluators have used this indicator as a component of several global program assessment measures, such as the Family Planning Effort measure, the POLICY I Project Policy Environment Score (PES), and the

UNAIDS AIDS Program Effort Index (API) [Stover, Schwartlander, and Roehnstrom, 2000; Ross and Stover, 2001]. For example, the Lapham/Mauldin/Ross Family Planning Effort measure includes *favorable statements by leaders*: "Whether the head of government speaks publicly and favorably about family planning at least once or twice a year, and whether other high officials also do so." Similarly, the API (presented in Part III.C) includes eight items, rated from 0 to 5, under the dimension of "Political Support." Critics have cited some analysis and interpretation issues, such as treatment of inter-rater differences and measurement of change over time (e.g., comparison of ratings made at different points in time vs. retrospective ratings).

PARTICIPATION IN RH POLICYMAKING

Definition

This qualitative indicator measures the *number and breadth* of different governmental, nongovernmental, commercial sector, religious and/or community organizations that participate in the policymaking process, and the *nature of their participation*. Mechanisms may include public hearings, multisectoral boards or consultative committees, and appointment of civil society representatives to official decision-making bodies (USAID, 1998).

Data Requirements

Evidence of individuals and agencies involved in the policy process with information on the nature of their involvement

Data Source(s)

Meeting agendas and attendance lists; focus group discussions; and/or key informant interviews

Purpose and Issues

This new indicator for RH reflects experience over the last decade – from ICPD to decentralization to mobilizing national responses to HIV/AIDS – which amply demonstrates that RH policy transcends central decision makers and even the health sector itself. Responding to these broader needs requires that governments “open up” the policy development process to stakeholders traditionally excluded from decision-making, including them as active participants rather than as passive recipients of decisions made on their behalf.

This indicator explicitly recognizes the links between RH policy and larger issues of democratic governance. From the perspective of governance, widespread participation in the policymaking process is seen as a good in and of itself. However, participation *per se* does not guarantee that resulting policies are better than those enacted through a closed process, although this is a testable hypothesis.

For participation to occur, public institutions must be open to wide involvement in all phases of the policy process, including formulation, implementation, and oversight. For this involvement to occur, mechanisms must exist for the exchange of information and views on the key issues (USAID, 1998).

The purpose of this indicator is to measure the degree to which different organizations (public, private, community, religious, among others) are involved in the RH policymaking process. This indicator relies on the assumption that the greater the number and the more varied the type of organizations involved, and the greater the opportunity for their substantive input, the more that policy will reflect the population’s needs.

A limitation of this indicator is its multidimensional quality – including numbers of different actors, breadth of organizational representation, and degree of involvement. Evaluators may have particular difficulty ascertaining the level of “involvement” by different actors. Data collection should solicit information on degree of participation in the process of formulating this policy, involvement in work or discussions leading up to drafting the document, and input before the draft document was prepared.

Given the breadth of this indicator, most applications will concentrate on a single factor, such as the number of institutional participants or number of different sectors participating. Evaluators can ask participants to rate their involvement (e.g., on a scale from actively engaged in problem definition and policy formulation, to simply being invited to a policy dissemination seminar), or the degree to which they felt that their opinions were requested and taken into account. Evaluators can design a composite descriptive measure combining all three dimensions (number of actors, breadth of representation, degree of involvement), and can then track both the component profile and the composite score.

Gender Implications of this Indicator

A gender perspective on participation examines the process for developing the plans:

- What was the percentage of women and men who helped to write the initial draft? What organizations or strata of society did they represent?
- Did the intended beneficiaries, including women's organizations, review the plans?

NUMBER OF NGO NETWORKS OR COALITIONS WORKING FOR RH

Definition

This indicator is based on the premise that there is greater power in numbers. In other words, the more organizations that come together and speak with a joint voice for RH, the more effectively they can present their message. The greater their institutional stability, the more likely that they will be heard and will be effective advocates for RH issues. Evaluators may use this indicator in conjunction with **Political and Popular Support for RH**.

In this section, “network” and “coalition” are used interchangeably to refer to groups of organizations and individuals working together to achieve changes in a policy, law, or programs for a particular issue (POLICY, 1999).

The indicator assesses the status of NGO networks or coalitions that work in support of RH. Three parameters are included – formation, expansion, and strengthening. Depending on baseline conditions, any or all of these may constitute separate indicators.

- Number of NGO networks or coalitions that meet regularly and work in support of RH;
- Number of member organizations and/or individuals belonging to NGO networks or coalitions; and
- Sustainability of NGO networks or coalitions working in support of RH.

Data Requirements

Evidence of network status and functioning, based on pre-determined criteria (number of members, activities, degree of sustainability)

Data Source(s)

Membership lists of networks or coalitions; management and/or financial information systems; meeting minutes; external assessments of sustainability

Purpose and Issues

Democratic governance implies popular participation, including participation by disadvantaged social groups, in both public policymaking and its implementation. By promoting and protecting civil rights, civil society organizations (CSOs) ensure that citizens have the means to express their preferences, engage in dialogue with policy makers, and affect public policy decisions. After governments establish policies, CSOs perform as watchdogs of state performance by demanding accountability in the allocation and management of public resources.

For CSOs to intervene effectively in the policy process, they must gain or strengthen their own advocacy skills. Such skills run the gamut from simply collecting information on the subject at hand to such other tasks as obtaining or allocating human and fiscal resources to advocacy functions, building coalitions and networks, acting to influence policy, and monitoring implementation once a policy decision has been made.

ADEQUACY OF THE POLICY PLANNING PROCESS**Definition**

This indicator measures the process through which policies, plans, guidelines or programs were formulated, developed, or reformed, independent of the documents themselves. It uses a rating scale that brings together a number of parameters into a checklist and is adaptable to individual country situations (POLICY, 2001).

Evaluators assess the adequacy of the policy planning process based on three criteria:

1. Who participates in the planning process; does it
 - Materially involve representative(s) from multiple sectors – public, commercial, and NGO sectors; donors; community or grassroots leaders; special interest groups (e.g., youth, women, and human rights organizations).
2. Do policy makers use empirical information in the planning process; specifically, do they
 - Include information-based needs assessment;
 - Identify and prioritize problems;
 - Consider alternative strategies for addressing identified problems; and
 - Formulate strategies for implementation.
3. Evaluators can readily assess whether the new policy removes the barriers. Does the policy document specify the operational aspects of the program, in that it
 - Includes development of a detailed action plan (inclusive of roles and responsibilities);
 - Includes assessment of resource needs and availability (financial, human, materials);
 - Is medium to long-term (at least one year); and
 - Establishes monitoring and evaluation procedures.

Data Requirements

Results of the Planning Checklist questionnaire or similar qualitative assessment

Data Source(s)

Rating forms or planning checklists (such as the one shown in Table II.B.1). Evaluators collect information from key informant interviews; if the organization involved kept written records, evaluators may review minutes or proceedings.

Purpose and Issues

Planning includes coordinating all aspects of RH policy or program development. This indicator encompasses policy processes and decision-making in both public and private sectors. Broad buy-in and ownership may be as important for program success as the technical bases upon which decisions are made. Therefore, the first set of criteria to ensure adequate planning involves participation in the planning process. The second set of criteria judges the extent to which policy makers use empirical information to understand the RH needs of the population and trade-offs among potential interventions. The third set of criteria addresses operational aspects of the program, from staffing and activity plans to monitoring and evaluation.

The illustrative checklist identifies basic tenets of good planning as presented in the literature on strategic planning. Evaluators can use the checklist to establish a priori criteria to fit the particular aspects of planning that the project is trying to improve.

This indicator is still “experimental” in that evaluators have not routinely used it in policy work. However, to the extent that assistance includes improvement of the planning process as well as the content of the actual policies and plans, it provides an interim measure of progress prior to adoption of the final plan.

Gender Implications of this Indicator:

A gender perspective on the planning process examines the process for developing the plans.

- What was the percentage of women and men who helped to write the initial draft? What organizations and/or strata of society did they represent?
- Did the intended beneficiaries, including women's organizations, review it?

Table II.B.1 Planning Checklist

Persons involved in the planning process – relevant staff, external advisors (consultants), and other relevant stakeholders – use this type of checklist as a baseline assessment to identify current deficiencies with the planning process. In the process of the assessment, this group may identify and may add additional areas that will “improve planning.” At the conclusion of the planning process, or in conjunction with the completion of a plan document, this same group of staff, advisors, and other relevant stakeholders will again complete the checklist. A comparison of the checklist results with the baseline assessment will identify specific areas of improvement. To claim “improved planning” results, the country manager/director will write up a description of how planning had improved and submit it along with the baseline assessment, the completed checklist, and a copy of the plan document produced.

Country Name:

Date:

Describe nature of plan being developed:

The planning process:

- Materially involved representative(s) from [number] of the following: public, commercial, and NGO sectors; donors; community/grassroots leaders; special interest groups (youth, women, and human rights organizations)
- Included an information-based needs assessment
- Identified and prioritized problems
- Considered alternative strategies for addressing identified problems
- Formulated strategies for implementation
- Included development of a detailed action plan (inclusive of roles and responsibilities)
- Included assessment of resource needs and availability

Financial: (specify) _____

Human: (specify) _____

Materials: (specify) _____

- Included medium- to long-term objectives
- Established monitoring and evaluation procedures

Name of person: