Assessment of capacity of the Ministry of Health to conduct health policy processes in the Republic of Tajikistan

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Relevant Chapters of the thesis	Jointly-authored publication, authors	Work directly attributable to the candidate	Contributions of other authors to the work
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Abstract

The widely-recognised importance of robust health policy processes suggests the need for capacity to ensure these. Whilst research exists on capacity or policy processes, little is known about how these two are related. This study starts to fill this gap by developing a conceptual framework and testing it in the Republic of Tajikistan, where independence reinforced the need for Ministry of Health's (MOH) capacity to conduct country-level policy processes.

The following overarching research question guided this qualitative study: *What are the key elements of, and main effects on, MOH capacity to conduct health policy processes in RT and how has this capacity changed since independence?* Data was collected using semi-structured interviews, document reviews and observations of policy events. A framework approach was used for analysis, drawing on the conceptual framework.

An understanding of what constitutes robust health policy processes is important and six characteristics were identified: holistic, evidence-informed, efficient, effective, feasible and sustainable. The conceptual framework distinguishes five components: MOH capacity to conduct policy processes (comprising elements of policy cycle, use of evidence, leadership and governance, and resources), actors, context, policy contents and policy results. This study explored the MOH capacity related to its management or response to the first three components.

Though positive changes since independence were identified, the study found that MOH capacity is lacking in all following areas: recognising and managing stages of policy cycle, considering wider context, managing involvement of policy actors, ensuring evidence-informed policy processes, applying good governance and effective leadership, and establishing and effectively using resources.

Each area is dynamic, interrelated with others and involves intra-relationships, with implications for overall MOH capacity. Two underlying issues are important: the need for both *ability* and *willingness* and the inter-relationships and interdependence between different capacity levels. As a result of the study a revised framework was developed.

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Abbreviations

ACU	Aid Coordination Unit
ADB	Asian Development Bank
AMWs	Association of Medical Workers
BBP	Basic Benefits Package
CBHP	Community and Basic Health Project
CSOs	Civil Society Organisations
DCC	Donor Coordination Council
DFID	Department for International Development
EBP	Evidence-based policy
EA	Executive Administration of the President of the RT
ECHO	European Commission for Humanitarian Assistance
FPMD	Family Planning Management Development Project
FSU	Former Soviet Union
GBP	Guaranteed Benefits Package
GFATM	Global Fund Against Aids, TB and Malaria
GOT	Government of Tajikistan
HF	Health Financing
HFTF	Health Financing Task Force
HMIS	Health Management Information System
IDRC	International Development Resource Centre
INGO	International Non-Governmental Organisation
M&E	Monitoring and Evaluation
MOE	Ministry of Education
MOF	Ministry of Finance
MOH	Ministry of Health
MOJ	Ministry of Justice
MRC	Medical Research Council
NGO	Non-Governmental Organisation
PHC	Primary Health Care
PSRP	Poverty Reduction Strategy Paper
QDA	Qualitative data analysis
RT	Republic of Tajikistan
SDC	Swiss Development and Cooperation Agency
SWAp	Sector Wide Approach
UNDP	United Nations Development Programme
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
USAID	US Agency for International Development
USSR	Union of Soviet Socialist Republics
WB	World Bank
WHO	World Health Organisation

1 BACKGROUND AND RATIONALE

1.1 Introduction

This study explores the capacity of the Ministry of Health (MOH) in the Republic of Tajikistan (RT) to conduct health policy processes. This Chapter provides introduction to the study and identifies its main objectives and outputs. It is structured as follows. First the gap in the literature is identified as a background to the study. This is then followed by a brief introduction of the context of RT. The main focus of the study is then summarised including specific research questions addressed in this study and Chapter concludes by identification of the main study outputs.

1.2 Analysis of health policy processes and MOH capacity

The word 'policy' is used widely but its meaning may be obscure, with different interpretations (Exworthy, 2008). Health policy, "*… a word that trips easily… off the tongues of political actors and academic theorists alike*" (Jenkins, 1978 p.294), can be defined as a statement of government's intent concerning the development of an aspect of a country's health system. Barker defined health policy as *"… the networks of interrelated decisions which together form an approach or strategy in relation to practical issues concerning health care delivery"* (Barker, 1996 p.27). Although similar to John's definition policy as the ongoing interaction of institutions, interests and ideas (John, 1998), one disadvantage of this definition is that it limits the application of health policy to health care services thus undermining the importance of wider health system. A more holistic view of health policy is "*…actions of governments and other actors in society that are aimed at improving the health of populations.*" (Niessen et al., 2000).

As shown above, definitions of health policy found in the literature differ in their scope. Furthermore, authors focus on different aspects of health policies, as a reflection that:

> "*…health policy means different things to different people. For most people, health policy is concerned with content… For me health policy is about process and power…"* (Walt, 1994 p.1)

Analysis of health policy *processes*, one of the key elements of health policy-making (Bird et al., 2007; Walt and Gilson, 1994), provides an opportunity to develop a deeper understanding of the mechanisms and approaches in developing and implementing health policies. Health policy-making is normally seen as a prerogative of the national government (Saltman and Ferroussier-Davis, 2000) with national ministries of health (MOH) usually

spearheading this process. Therefore, their capacity to develop and implement health policies effectively is important. Typically, this capacity includes the ability to use evidence effectively in policy decisions, and to establish health policy processes in a logical and transparent way through ensuring the participation of key policy actors. It may also include further elements such as integration of health policies with wider non-health policies (LaFond et al., 2002).

Donor-funded health reforms, if not appropriately coordinated, can fragment health systems development (Peters and Chao, 1998) . Many former Soviet Republics, in contrast with many low-income countries in Africa and Asia, are relatively new to the government-donor relationships and are facing the need to develop ability to build effective dialogue with the international community (Mirzoev et al., 2010). This reinforces the need for an adequate MOH capacity to manage health policy processes effectively as means of ensuring trust from the international community.

Whilst some work has been done at the international level in the areas of *capacity* and *health policy analysis* (Buse et al., 2005; Gonzalez Block and Mills, 2003; LaFond et al., 2002; McKee et al., 2000; Schouwstra and Ellman, 2006; Sutcliffe and Court, 2006), no literature was found that brings these two concepts in a single framework. This study attempts to bridge this gap by developing a conceptual framework for assessing MOH capacity to conduct health policy processes (either directly or indirectly, for example through managing involvement of other policy actors) and testing it in the context of Tajikistan which is introduced next.

1.3 The policy context of Republic of Tajikistan

The Republic of Tajikistan (RT) is a former soviet republic, geographically located in Central Asia. Its total population is estimated at 6.7 million (WHO, 2010) with about 80% living in rural areas (World Bank, 2000). Formerly one of the most neglected republics within USSR, the country became independent in 1991.

Tajikistan experienced a sharp reversal in its Human Development Index between 1985 and 2003. The country is currently ranked 122nd, the lowest of the former soviet republics (see Table 1), and its health indicators are currently amongst the worst for this group.

Table 1: Human development indicators for selected countries

Data from: (UNDP, 2005)

HDI rank	Country	Life expectancy at birth (years)		Maternal mortality (per 100,000 live births)	Total per capita health expenditure (US$)
		Female	Male		
1	Norway	81.9	76.8	16	3,409
…					
62	Russia	72.1	59.0	67	535
…					
109	Kyrgyzstan	71.1	62.7	110	117
…					
111	Uzbekistan	69.8	63.4	24	143
…					
121	Equatorial Guinea	43.9	42.6	880	139
122	**Tajikistan**	**66.3**	**61.0**	**100**	**47**
123	Gabon	55.2	53.7	420	248

Many problems were inherited from the soviet era. Many documents emphasise the post-soviet reliance on excessive numbers of health professionals, particularly doctors (Hemming, 1999; McKee et al., 2002) and an oversized network of health facilities (Gedik et al., 2002; McKee et al., 2002; Mira, 2002). The economic constraints and the resultant emigration and unequal distribution of staff and other resources during 1990s (Mirzoev et al., 2007) contributed to the many non-functioning facilities and had devastating effects on policies addressing the needs of vulnerable groups (Falkingham, 2003; Hemming, 1999; Keshavjee and Becerra, 2000). Up to 2008 the Tajik health system continued to be highly dependent on external aid with government's health expenditure being extremely low (Cashin, 2004; Mirzoev, 2004; Vargas and Clary, 2002). Furthermore, RT's lack of economic and institutional capacity has been further worsened by civil war (1991-1996) and the country's location in a politically volatile region.

Having experienced deep political and economic crises during the first few years of independence, RT is gradually shifting from a relief to development stage (McKee et al., 2002; Mirzoev et al., 2007). This transition poses challenges to health systems development with examples including the need for careful planning of pace and scale of health reforms. Health policy-making plays a crucial role in this process.

Health policies do not usually provide a short-term solution and countries, such as RT, are faced with a dilemma as to how to find the right balance between short-term priorities and long-term sustainable development (Falkingham, 2005; McKee et al., 1998; Mirzoev et al., 2007). Health policy-making is a cornerstone of successful development of a national health system through ensuring the sustainability of changes such as health reforms (Berman, 1995; Frenk, 1995; Walt and Gilson, 1994). Tajikistan is planning to implement a health SWAp and improvements to health policy-making in the country are seen as a high priority (World Bank, 2006).

Health policy-making in the former Soviet Union (FSU) was carried out primarily at the central level [Moscow] with peripheral republics such as Tajikistan having a limited role in health policy development (McKee et al., 2002). This meant that the capacity of the republican ministries of health (MOH) in policy development was limited and they were involved primarily in implementing nationally-set policies. The country's independence in 1991 meant a sudden and dramatic shift in the functions of the Tajik MOH from a regional to the national-level (McKee et al., 1998). With the flexibility to identify local priorities and align resources more effectively towards health sector development came the responsibility for developing national-level health policies. Due to the limited capacity of Tajik health policy-makers to develop country-level health policies, the above shift has proved to be one of the biggest challenges for the Tajik health system (McKee et al., 1998; McKee et al., 2002; Mirzoev, 2004; Mirzoev et al., 2007).

After a spell of economic and political turbulence, the Tajik MOH in 2000, with support from WHO, developed a comprehensive health policy document, Health Reform Conception for 2000-2010 (MOH, 2000). However, the MOH did not follow this up with a feasible implementation plan. This weakness was criticised by various commentators (McKee et al., 2002; Mira, 2002) and seems to have resulted in numerous fragmented small-scale pilot health reform initiatives.

Little is known within RT and other similar countries about how the concept of MOH capacity to conduct health policy processes is interpreted. This is possibly due to the recent history of independence in FSU and to attention to health policy-making being overshadowed by the relief needs of the transition (Duffy, 1997; McKee et al., 1998; Mirzoev et al., 2007). As the country gradually progresses towards the development stage, the issue of MOH capacity to ensure robust health policy processes are becoming important and this study beginning to bridge this knowledge gap.

1.4 Focus of the study

This study **aims** to understand the MOH capacity to conduct health policy processes in RT in an attempt to contribute towards strengthening MOH capacity in ensuring robust health policy processes in the RT and other similar contexts.

The **overarching research question**, corresponding to the study aim is:

What are the key elements of, and main effects on, MOH capacity to conduct health policy processes in the RT and how has this capacity changed since independence?

Four assumptions were made in formulating the above:

- The changes in *MOH capacity* are the primary focus of the study and health policy processes are examined from the perspective of their relationship to MOH capacity.
- The MOH capacity is assessed in relation to health policy *processes* and assessment of the effectiveness of resultant policies (policy contents) is outside the scope of this study.
- The analysis of different elements of, and effects on, MOH capacity is required to form a comprehensive understanding of MOH capacity.
- The changes in MOH capacity will relate to the period since independence i.e. the period from 1991 until the timing of the data collection (August 2008).

The study aim is achieved through addressing the following **specific objectives** and answering the corresponding **specific research questions**, which are structured around the key components of the study Conceptual Framework (see section 2.4) and are shown in Table 2.

Table 2: Specific objectives and research questions for the study

SPECIFIC OBJECTIVES	SPECIFIC RESEARCH QUESTIONS
1. To identify and assess the understanding among the key policy actors in the RT of the concept of MOH capacity to conduct health policy processes	• How is the concept of MOH capacity to conduct health policy processes interpreted in the RT? • Are there differences in interpretations between key policy actors?
2. To identify and assess the health policy processes in the RT and explore their interrelationships with MOH capacity	• What stages exist in health policy processes in the RT and how are these perceived by the MOH and other policy actors? • What are the main characteristics of these key stages of health policy processes? • What are the interrelationships between health policy processes and MOH capacity?
3. To identify the key elements of the wider context of health policy processes and analyse its	• What are the key elements, and characteristics, of the context of health policy processes in RT? • What are the effects of the wider context on MOH

SPECIFIC OBJECTIVES	SPECIFIC RESEARCH QUESTIONS
effects on MOH capacity to conduct health policy processes	capacity?
4. To identify and discuss the composition, and practices of, health policy actors and analyse their interrelationships with MOH capacity to conduct health policy processes	• Who are the key actors and what are their main roles in health policy processes in RT? • What is the MOH ability to ensure involvement of different actors in health policy processes? • What are the implications of the composition of, and interrelationships between, health policy actors, on MOH capacity to conduct health policy processes?
5. To identify the extent to which health policy processes are evidence-informed and assess implications on the MOH capacity to conduct health policy processes	• What different types of evidence exist, and how are these informing health policy processes in RT? • Who is involved in the production, dissemination and use of evidence in RT? • What is the MOH ability to ensure the evidence-informed nature of health policy processes in RT?
6. To identify and assess the current governance and leadership arrangements in RT and analyse their interrelationships with MOH capacity to conduct health policy processes	• How does the MOH make health policy decisions and in what way does this affect health policy processes? • What health policy decision structures have been established by the MOH and in what way do these affect health policy processes? • What is the MOH capacity in relation to the governance and leadership in order to ensure the good health policy processes in Tajikistan?
7. To identify and assess the MOH capacity to establish and use resources effectively in support of health policy processes.	• What resources exist in support of health policy processes and who established these and how? • What is the MOH capacity to establish and use resources in support of health policy processes in the RT effectively?
8. To develop a set of recommendations for strengthening the MOH capacity to conduct health policy processes	• In what way can the MOH capacity to conduct health policy processes be improved?

The above questions provide a broad framework for study outputs, which are set out next.

1.5 Study outputs

The primary academic output from the study is the PhD thesis, this document. It is structured in twelve Chapters. After the introductory Chapter the conceptual framework for the study is developed, drawing on available literature. This is followed by the description of the study methodology in Chapter three, including reflections on the strengths and limitations. Chapter four reports the study findings in relation to the understanding of the concept of MOH capacity to conduct health policy processes in the RT. The next six Chapters (5-10) report and discuss the study findings in relation to the implications of the following individual areas on the MOH capacity (health policy cycle, policy context, policy actors, use of

evidence, leadership and governance and resources in support of health policy processes. Chapter 11 integrates the findings from the individual Chapters and revises the conceptual framework drawing on the improved understanding of the concept of MOH capacity. Lastly, Chapter 12 concludes the thesis with the key conclusions in relation to the MOH capacity, recommendations for the strengthening the MOH capacity and the study implications on future research in this area.

In addition to the formal thesis, writing of academic papers on various aspects of the study is planned. Examples of the potential publications include:

- Conceptual framework for assessing the government/MOH capacity to conduct health policy processes;
- MOH capacity to conduct health policy processes in each of the six main areas/components of conceptual framework (see section 2.4);
- Set of practical recommendations for strengthening the MOH capacity to conduct health policy processes in the RT.

It is believed that various parts of this study represent useful resources for health policy actors, such as policy-makers, academic community and international policy actors, in RT and wider. The appropriate communication of results constitutes an integral part of any research (Court et al., 2005; Hanney et al., 2003; Lavis et al., 2009). Various dissemination strategies will be explored after the defence of the thesis, in order to achieve the best possible effect from the study. Possible examples of these, in addition to publications, include (subject to the availability of resources): translation of parts or the whole thesis into Russian and/or Tajik, conducting workshop(s) with the MOH and others to discuss recommendations for further strengthening of MOH capacity.

1.6 Conclusion

This Chapter has provided a broad overview of the main context of RT and identified a lack of published knowledge on MOH capacity to conduct health policy processes in RT. The latter forms the primary focus of the study and different specific research questions were developed for the research. The specific research questions correspond to the different elements of the study conceptual framework, which is discussed in the next Chapter along with the underlying literature.

2 CONCEPTUAL FRAMEWORK FOR ASSESSING CAPACITY TO CONDUCT HEALTH POLICY PROCESSES

2.1 Introduction

As mentioned in Chapter 1, the bulk of research related to health policy has focused on the *content* of health policies and it is relatively recently that research has turned its attention to health policy *processes* (Court et al., 2005; Gilson and Raphaely, 2008). These processes, about which there is limited research in low- and middle-income countries and where the body of knowledge remains "…*small, diverse, fragmented and quite descriptive in nature*…" (Gilson and Raphaely, 2008 p.294), are the focus of this study.

An underlying assumption in studies on health policy processes is that robust health policy processes will lead to better policies[1]. The process of making health policy is complex (Barker, 1996). This complexity is due partly to the existence of technical and political dimensions in developing and implementing health policies but also to the large number of actors, who may or may not be involved in the policy processes (Buse et al., 2005; Erasmus and Gilson, 2008; Walt and Gilson, 1994; Walt et al., 2008). The sensitivity of its nature and the resultant challenging methodology means that health policy analysis at both the national and international levels has often been avoided among researchers (Barker, 1996; Court et al., 2005; Gilson and Raphaely, 2008; Walt and Gilson, 1994).

The following sets out the conceptual framework for the study which guides the approach to and findings of the study. It is worth noting that there is a difference between analysis of effectiveness of the contents of health policies and analysis of health policy *processes* which focus on mechanisms and interactions in policy development and implementation. This study focuses on the latter, as shown in the study aim, though it recognises that there are various ways for interpreting health policy and inevitable overlaps between the processes and contents of health policies.

This Chapter is structured as follows. It starts by providing a detailed overview of the main issues related to analysis of health policy processes, including the main theories and frameworks and characteristics for understanding and assessing robust health policy processes. This is then followed by a discussion of understanding of the concept of capacity,

[1] An analogy can be made with health service delivery where better approaches to service delivery will lead to better health outcomes

its main elements and levels.. The Chapter concludes by setting out the conceptual framework that guides the study.

2.2 Understanding health policy processes

Health policies are complex and, due to the sensitivity of their nature and the resultant methodological challenges, health policy analysis at both the national and international levels has been neglected (Barker, 1996; Court et al., 2005; Gilson and Raphaely, 2008).

Gilson and Raphaely (2008) distinguished three categories of policy process-related studies: *policy transfer* papers describing the process through which international policy guides and ideas are translated into national health policy agendas, *advocacy–related* publications which examine processes for advocating and lobbying practices and *research-policy* papers which assess the use of research evidence into policy decisions (Gilson and Raphaely, 2008).

The study of the processes of setting and implementing policies in the health sector is, as shown above, relatively new. Despite this, different approaches to empirical research and theoretical developments can be distinguished. Approaches to study health policy processes range from those focusing on the specific processes themselves (Bird et al., 2007; Walt, 1994) to particular aspects of the process such as the *use of evidence* (Almeida and Bascolo, 2006; Bowen and Zwi, 2005; Hanney et al., 2003) and to models incorporating policy *actors* and their interrelationships (Gaventa, 2005; Parsons, 1995), and *contextual influences* (Schouwstra and Ellman, 2006; Sutcliffe and Court, 2006; Walt and Gilson, 1994). Some authors focus on a particular aspect of health policy-making such as a stage of the policy process such as agenda-setting (Kingdon, 1995), referred to by some commentators as meso-analysis (Tarin, 2003). Others cover different determinants of health policy-making such as actors, processes, content and context (Walt and Gilson, 1994) comprehensively. Attempts have also been made explicitly to link determinants of health policy-making (actors, institutions, policy arena) with characteristics of the above determinants such as interests and ideas (CMPS, 2006).

In the next three sub-sections, the key features of the main theories and approaches to study health policy processes are highlighted. This is followed by an overview of possible criteria for assessment of health policy processes, as a background to the development of the study conceptual framework.

2.2.1 Main theories and frameworks for analysis of health policy processes

Conceptual models, frameworks and theories can provide tools to describe, understand and explain health policy processes (Exworthy, 2008). However, the terms [conceptual] *frameworks*, *models* and *theories* have often been used interchangeably in relation to analysis of health policy processes. For example, consideration of different streams has been referred to as models (Exworthy, 2008) as well as theories (Walt et al., 2008). Frameworks provide a way to organise enquiry into policy processes through the identification of elements and their interrelationships that need to be considered for developing a theory or series of hypotheses (Ostrom, 2007). Frameworks include those that describe the policy stages, the widely used policy triangle and policy networks. Theories are more specific than models and frameworks, and '…identify precise relationships among variables that can be tested or evaluated empirically'(Walt et al., 2008 p.311).

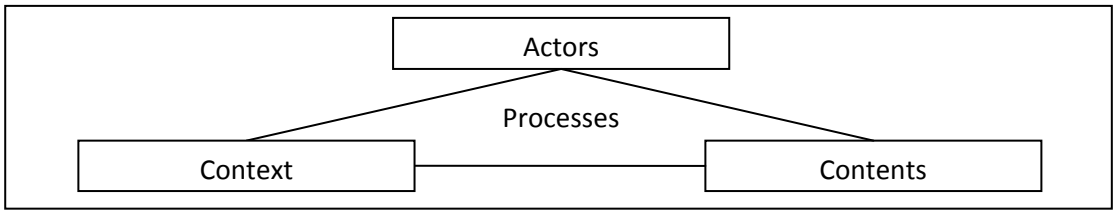
Three broad frameworks are widely used in the literature, including the *policy triangle*, *networks* and *advocacy coalition* frameworks, as set out below.

The health *policy triangle* (see Figure 1)*,* which stems from a political economy perspective (Walt et al., 2008), is the most commonly used framework for health policy analysis over the last decade (Gilson and Raphaely, 2008). This framework comprises four determinants of health policy-making:

1. How policies are made i.e.. *processes*
2. By whom policies are made i.e.. *actors*
3. What are wider issues affecting health policies i.e.. *context* and
4. What are the outputs i.e. *contents* (Walt and Gilson, 1994).

Figure 1: Health Policy triangle

Adapted from[2]: (Walt and Gilson, 1994)



[2] The authors placed policy actors (as individuals and as members of groups) in the centre of the framework. The emphasis in this study on health policy *processes* is reflected in Figure 2.

Networks models are based on an assumption that policy processes are the result of interrelationships within, and between, different health policy actors, each with their own values, agendas, interests and motivations (Exworthy, 2008). The concept of policy network

> "*…has been fuelled in part by recognition of the complex array of actors involved in policy choices as well as inability of contemporary government to move unilaterally without incorporating the constraints, preferences and resources of other social actors"* (Bressers and O'Toole, 1998 p.215)

Network models focus on one aspect of the policy triangle, actors, and their interrelationships. The literature distinguishes between *policy networks* and *issue networks*. A policy network or *policy community* (Tantivess and Walt, 2008) is often referred to as comprising a small number of actors with shared responsibility and close interaction, such as working groups (Exworthy, 2008). Some authors use the term *policy communities* to describe policy networks which are "*…tight-knit networks with few participants who share basic values and share resources…"* (Walt et al., 2008 p.310). By contrast, *issue networks* are seen as having larger number of members, which operate around a specific policy 'issue' and tend to involve a looser interaction of actors, often in a dynamic, shifting group of stakeholders (Exworthy, 2008).

Some authors also use the term *advocacy coalition frameworks (ACF)* (Hudson and Lowe, 2004), a concept similar to 'issue networks'. ACFs consist of a group of advocacy organisations or individuals united by a set of core values, ideologies and beliefs which are resistant to changing ideas and introducing new policies (Exworthy, 2008). Advocacy coalitions - the foundations of the concept of ACFs - are defined by Buse as

> "*…potent forces within the policy rubric which can serve to limit participation, decide which issues will feature on agendas, shape the behaviour of participants, privilege the interests of certain groups, or manipulate the evidence reaching decision-makers"* (Buse, 2008 p.353)

Commonly used *theories* in health policy analysis literature include *multiple streams* and *punctuated equilibrium theories* (Walt et al., 2008).

Kingdon (1995) developed the *multiple streams theory* to understand the processes involved in the first stage of health policy-making - agenda-setting. He identifies a combination of three issues, problems, policies and politics, flowing in independent streams. The *problems stream* arises from the broad problems and conditions facing societies, some of which

become identified as issues that require public attention. The *policy stream* refers to the set of policy alternatives that researchers and others propose in order to address national problems. This stream contains ideas and technical proposals on how problems may be solved. The political environment, including political transformation of the country and social pressures, are among the elements of the *politics stream*. At a particular point, the three streams merge and a 'window of opportunity' emerges for the government to act.

The multiple streams approach involving the merging or conjoining the streams is also deployed in other policy models. For example, Webb and Wistow (1986) and Challis et al (1988) suggest that three different streams (the policy, process and resource streams) need to merge to complete the policy process. The policy stream is, as in Kingdon's theory, concerned with policy aims and objectives; the process stream is concerned with policy means (instruments or mechanisms to achieve policy aims) and the resource stream is related to the human, technical, financial and other resources required by the process stream (Exworthy, 2008).

One view of the dynamics of the public policy processes – also applicable to health policy processes (Leeds HEPVIC team, 2009) - is described by Baumgartner and Jones (1993) in their *punctuated equilibrium theory*. They argue that issue changes may occur through two processes which are distinctly different yet not mutually exclusive. The first set of processes comprises incremental changes which appear to be at the margins of policy-making and which take place within a context referred to as equilibrium. The second set of processes refers to the changes which occur, at times, quite dramatically and are described as punctuations. The two processes are raised together in the punctuated equilibrium theory. This theory seeks to explain both the general stability and the occasional upheavals of the agenda-setting stage of the policy process. According to the punctuated equilibrium theory, both stability and radical change, which characterise the policy process, are the result of interactions between subsystem politics (i.e. issue networks).

Merely describing a pattern is only a first step. Baumgartner and Jones explain the change in the agenda-setting process as the interaction between the two important concepts: *policy image* and *policy venue* (1993). *Policy image* is the way in which a given problem and set of solutions is perceived. Policy images play a critical role in taking issues beyond the control of specialists and special interests that occupy what the authors label as "*policy monopolies*". A *policy venue* is referred to as the set of actors or institutions that make decisions concerning a set of issues. These actors may hold monopoly power but eventually face competition as

new actors, with alternative policy images, gain prominence. When a particular policy venue and image dominate over an extended period of time, the policy process is stable and incremental. When new venues and images emerge, rapid bursts of change are possible.

The idea of several factors forming an enabling environment where the rapid bursts of policy processes are feasible is similar to the combination of different streams at the agenda-setting stage (Kingdon, 1995) as well as the four groups of factors (power of actors, ideas, political context and characteristics of the policy issue) which were suggested as determining priorities at the global level (Shiffman and Smith, 2007). Shiffman and Smith (2007) argue that the political priority (closely related to Kingdon's politics stream) plays an important role in shaping the prioritisation of the issues for consideration in health policies. More specifically, they suggest a framework of factors which shape the global political priority for global health initiatives. This framework could also apply to the national/country context. According to this framework four broad groups of factors are distinguished: strength of the actors involved in the initiative, the power of the ideas they use to portray the issue, the nature of the political contexts in which they operate, and the characteristics of the issue itself. As illustrated in Table 3 each of these factors, in turn, comprises different sub-factors.

Table 3: Factors determining the shape of global political priority for health initiatives

Source: (Shiffman and Smith, 2007 p.1371)

	Description	Factors shaping political priority
Actor Power	The strength of the individuals and organisations concerned with the issue	1. *Policy community cohesion*: the degree of coalescence among the network of individuals and organisations that are centrally involved with the issue at the global level
		2 *Leadership*: the presence of individuals capable of uniting the policy community and acknowledged as particularly strong champions for the cause
		3 *Guiding institutions*: the effectiveness of organisations or coordinating mechanisms with a mandate to lead the initiative
		4 *Civil society mobilisation:* the extent to which grassroots organisations have mobilised to press international and national political authorities to address the issue at the global level
Ideas	The ways in which those involved with the issue understand and portray it	5 *Internal frame*: the degree to which the policy community agrees on the definition of, causes of, and solutions to the problem
		6 *External frame*: public portrayals of the issue in ways that resonate with external audiences, especially the political leaders who control resources
Political contexts	The environments in which actors operate	7 *Policy windows*: political moments when global conditions align favourably for an issue, presenting opportunities for advocates to influence decision-makers
		8 *Global governance structure*: degree to which norms and institutions operating in a sector provide a platform for

	Description	Factors shaping political priority
		effective collective action
Issue characteristics	Features of the problem	9 *Credible indicators*: clear measures that show the severity of the problem and that can be used to monitor progress
		10 *Severity*: the size of the burden relative to other problems, as indicated by objective measures such as mortality levels
		11 *Effective interventions*: the extent to which proposed means of addressing the problem are clearly explained, cost effective, backed by scientific evidence, simple to implement, and inexpensive

Existing approaches to health policy analysis reveal a predominant focus in developing countries on disease-specific priorities with less consideration of wider fundamental issues and values such as equity and the social determinants of health (Exworthy, 2008; Gilson and Raphaely, 2008). This may reflect the organisational structure of health systems in many developing countries where vertical initiatives often operate in relative isolation and where there are few attempts to integrate different priorities into a comprehensive and holistic view (Exworthy, 2008).

Each of above frameworks and theories represents it own logic and needs adapting to a particular context where analysis of health policy processes is performed. Despite the existence of numerous theories and frameworks guiding the understanding and interpretation of policies and their elements, there is still little methodological guidance on how to perform policy analysis within the context of developing countries (Walt et al., 2008). The latter may be affected by the lack of explicit characteristics for assessing health policy processes, which are explored next.

2.2.2 Characteristics for assessment of health policy processes

Although several theories and frameworks exist for *describing* health policies and health policy processes, there are no explicit frameworks for *assessing* the degree of robustness of health policy *processes* in developing countries. The literature-based characteristics normally refer to health policies as a whole rather than health policy *processes* and most policy analyses tend to focus on high-income countries (Gilson and Raphaely, 2008; Hailey, 2008). This sub-section develops a set of characteristics of robust health policy processes in order to guide assessment of MOH capacity required to achieve those.

What constitutes robust health policy processes? Due to the complex nature of health policies there is no simple answer to this question, other than the obvious critical first characteristic of good health policy - whether it achieves (or works towards) better health.

However, various other characteristics of health policies can be found in the literature. In particular, an economic perspective was suggested which includes the ability of government to mitigate the adverse economic effects of markets on population groups (Filmer et al., 2000); a political perspective which includes the political dimension of health policies (Buse et al., 2005); a perspective which balances the power relationships between different actors in the process (Walt, 1994); and, more recently, a growing number of attempts to apply a more technical perspective which focuses on the use of evidence in health policy processes (Bowen and Zwi, 2005; Marmot, 2004; Sauerborn et al., 1999).

Despite the different degree of detail in defining the different stages, Exworthy proposes common characteristics of health policy processes generally. Firstly, health policy processes have a continuous nature resulting in policy decisions often being protracted over a period of up to several years. Secondly, despite various calls for transparency of policy processes, they predominantly occur behind closed doors. Finally, much of the evidence on health policy processes originates from outside developing countries (Exworthy, 2008), which suggests that researchers rarely have access to study health policy processes in such country contexts.

The starting point for understanding the characteristics for assessment of health policy *processes* is the broader health policies. A comprehensive policy analysis should focus on more than one determinant of health policy-making (Barker, 1996; Buse et al., 2005; Walt and Gilson, 1994). For example, McKee *et al* (2000) suggest prerequisites for effective policies on challenges to health (see Table 4)

Table 4: Prerequisites for effective policies on challenges to health

Source: (McKee et al., 2000)

Prerequisite	Justification
Visibility	For a health problem to be addressed, its scale and nature must be made visible. This requires both effective analysis and interpretation of data and appropriate presentation to policy-makers
Capacity	Public health professionals have a key role in making health problems visible. However, they must have appropriate skills in both analysis and implementation.
Ownership	Health problems are most likely to be addressed if one or more groups have a sense of ownership over them. Where ownership is diffuse they are more likely to be overlooked.
Intersectoral action	Many health problems require intersectoral responses. Where there is no tradition of intersectoral working, an effective response will be less likely.
Effective government	Governments have an important role to play in health policy. This encompasses both the development of legislation and its implementation. Where either are weak, policy is less likely to succeed.

In the UK a more detailed set comprising eight self-explanatory characteristics has been suggested as one potential framework for evaluating health policy recommendations (Macintyre et al., 2001):

1. Evidence-informed nature
2. Supported by cogent argument
3. Scale of likely health benefit
4. Likelihood that the policy would bring benefits other than health benefits
5. Compliance with other government policies
6. Possibility that the policy might do harm
7. Feasibility of implementation
8. Cost of implementation

References can be found in the literature to rational and the status quo approaches to health policy processes (Peabody, 1996). *Rational* approaches to health policy processes imply clear and transparent stages of policy processes with an adequate use of evidence, widest possible participation of actors and integrated nature of health policies (direct or indirect links between different health policies and with wider public sector policies) (Walt, 1994). It is assumed that rational approaches to policy-making normally include an assessment of the feasibility of their development/implementation (political, technical) and thus result in sustainable health policies. The *status quo* approaches to policy processes contrasts with the rational model. These often follow a historical pattern, with blurred stages of policy processes, limited participation of actors, no integration with other health and non-health policies and virtually no use of evidence in policy processes (Buse et al., 2005; Lindblom, 1959). The status quo models do not seem appropriate to the rapidly changing contexts of countries in transition.

Two issues emerge from the above classification. Firstly, neither rational nor status quo models exist in isolation and in the majority of health policy processes the different elements can be rather mixed (Buse et al., 2005; Walt, 1994). For example, wide participation of actors can co-exist with a rather limited integration of health policies; or the dominance of one group of actors can potentially guide the types of evidence to be used in policy processes. Secondly, the conventional interpretation of the term 'rational' is heavily dominated by two aspects, use of evidence and participation of different actors in health policy processes, with other aspects such as feasibility or sustainability often being presented as part of the wider context (Walt and Gilson, 1994). To avoid losing potentially important elements in this study

the term 'good' or 'robust' policy processes is used to replace the term 'rational'. The interpretation of robust policy processes in this study comprises the characteristics of an 'ideal' health policy *process* which then serves as a framework for assessing MOH capacity to achieve these characteristics.

The term 'characteristics' instead of 'criteria' is intentionally used, recognising that measurability of each characteristic may be problematic. The reasons for the difficulty in measuring policy processes could include the dynamic nature of health policy processes, different understanding and interpretations of the above characteristics in the formal and informal health policy processes including different perspectives of actors who are or are not involved in the health policy processes. For example, wide participation of actors in health policy processes may be interpreted as an inherently good characteristic but it is difficult to define an optimal number of actors to be involved for different health policies even within a single context.

The above discussion identified various potential aspects of robust policy processes. Table 5 brings these together in a set of characteristics in three broad groups, corresponding to the classic input-process-output continuum:

- *Resource availability and utilisation* which is an important set of inputs into the process;
- *Health policy process stages* which refers to the different stages of policy processes (agenda-setting, development, implementation);
- *Health policy* or an output from the health policy processes. This element, the result of the policy process, illustrates the notion of the policy process not being an end in itself but rather a means to achieve desired change through health policy processes.

Table 5: Proposed characteristics of robust health policy processes

Characteristic	Description/Notes
Resource availability and utilisation	
Clarity of resource framework	Clear and known resources, both generic (within the health system and wider) and specific, in support of health policy processes
Consideration of generic resources	Generic resources are drawn upon and used in support of health policy processes
Availability of specific resources	Specific resources are established and are available when required to support the policy process including: • Range of skills • Adequate number of personnel • Decision-making structures

Characteristic	Description/Notes
	• Supporting resources (e.g. budget support)
Efficiency of resource use	Resources are efficiently utilised at all stages of health policy process
Health policy process stages	
Transparency, clarity	Clear and publicly accessible statement/description of the policy processes including: • Underpinning principles and values of decision-makers (and other policy actors where appropriate) • Information preferences of policy actors • Clear and known criteria, conditions and mechanism(s) for stakeholder involvement in different aspects and stages of the policy process • Clear and known target dates/milestones for health policy processes including interim and end-of-stage outputs of the process and feedback/consultation mechanisms
Effectiveness	Output-oriented nature of health policy processes with consideration of feasibility of policy options
Efficiency	Optimal balance between resources used in the processes and policy outputs
Integrated nature	Consistency and clarity of approaches across the different stages (e.g. development, implementation) of health policy processes as well as between the different policies (including wider public policies)
Responsiveness	Accountability of actors, including decision-makers, in the policy process, to wider stakeholders, including the general public, is recognised and upheld
Flexibility	Flexibility of the formal policy processes to accommodate emerging needs
Evidence-informed nature	Utilisation of robust evidence at each stage of health policy processes in order to: • Inform decisions by all actors of health policy process • Ensure transparency of, and provide justification for, health policy decisions
Clarity of evidence processes [to all policy actors]	Clear and known evidence processes (to decision-makers) in order to ensure the adequate planning of evidence-informed health policy processes
Outputs from health policy processes (policy)	
Evidence-informed nature	Processes result in policies informed by robust (methodologically rigorous, timely, and relevant) evidence including policy's effectiveness, efficiency and feasibility
Integrated nature	Policies include clear statements of, and links to, underpinning principles and values as well as the other policies
Feasibility of outputs	Resultant policies are politically, technically, socially and financially feasible and respond to identified need and consider wide determinants of health

One important cross-cutting issue within Table 7 is related to values and ideologies of policy actors. Although not included as a separate characteristic, values and ideologies can be perceived as a 'platform' on which health policy processes are built. For example, values affect actors' perceptions of the transparency of the process as well as the clarity of the resource framework. At the same time, there are interrelationships between the different actors which can affect their values and hence agendas and involvement in health policy processes. Furthermore, different characteristics are also engaged in a complex interplay – for example responsiveness is informed by the transparency and clarity of the policy process or the evidence-informed characteristic may be counter-balanced by the notion of efficiency of the process.

The second group of characteristics from Table 7, health policy process stages, is particularly relevant to this study. Based on the above review, the following six characteristics are suggested as a framework for understanding robust health policy processes: holistic, evidence-informed, efficient, effective, feasible and sustainable. Each of these characteristics is complex and comprises more than one element, as set out below.

Holistic nature of health policy processes.

Within this study this characteristic comprises the following two elements:

- *Integrated nature of health policy processes.* This is normally referred to as the degree of integration of health policies with other non-health sector policies (Mustard, 1996) such as Poverty Reduction Strategy Paper (PRSP) or Millennium Development Goal (MDG) project. However in our study this characteristic is interpreted as integration of the different health policy processes (such as health financing and PHC where for example, variation of actors may affect the composition and nature of the stages of health policy processes).
- *Transparency of policy processes*, i.e. a clear understanding of the different stages and mechanisms used by the key actors. This element is increasingly seen as one of the important characteristics of health policy processes (Niessen et al., 2000) and incorporates MOH ability, as the main actor, to interpret and understand the policy processes as well as its ability to effectively communicate its vision to other actors.

Evidence-informed nature of health policy processes.

This characteristic attracts an increasing amount of academic literature (Bowen and Zwi, 2005; Court et al., 2005; Dobrow et al., 2004; Shaxson, 2005) and in practical terms includes

how different types of evidence/information are generated, disseminated and used in different stages of health policy processes. It comprises three elements:

- *Different types and forms of evidence.* This includes formal and informal; published and unpublished evidence.
- *Processes involved in generation, dissemination and use of evidence.* This also includes application of these processes at different stages of health policy processes (discussed later in the conceptual framework).
- *Different actors involved in evidence processes.* This element includes the MOH ability to recognise the balance between values, ideologies and agendas of individual actors (including MOH itself) versus the 'objective'[3] evidence (relatively unbiased and based on facts) in health policy processes.

Effectiveness of health policy processes.

Effectiveness normally refers to the analysis of the content of health policies and/or policy outputs/impact (Buse et al., 2005; Walt, 1994). However, the primary focus of this study is on *policy processes* rather than outputs. Effectiveness of health policy processes in this study is interpreted as comprising the following:

- One aspect is *responsiveness to perceived needs*, which is reflected in the representation of actors and is briefly discussed in the efficiency section earlier.
- Another aspect is the *consideration of the wider context*. This is interpreted as the ability of policy-makers to take into account and/or influence the wider context in order to ensure the development/implementation of health policy processes. This element may be regarded as being close to the integration described earlier as part of the holistic nature of policy processes and represents another area for consideration further in the study.
- Another aspect refers to its contribution to the next round of processes and/or decisions as opposed to resulting in a 'dead end'. Effective health policy processes may serve as examples of good practice for other health and non-health policy processes.

[3] It is recognised that there is no fully objective evidence for such a complex issue as health policy processes and it is inevitably affected by actors' values, beliefs and ideologies. Therefore, the term 'objective' in this study is interpreted flexibly.

Efficiency of health policy processes.

This characteristic stems from the economic definition of efficiency, attainment of the best possible result using the least resources and in the least time (Färe et al., 1983). In relation to this study it is interpreted as:

- *Involvement of key actors* in the health policy processes. From an efficiency perspective this refers to the involvement of a limited but adequate number of actors to ensure robust health policy processes. Different factors affect the degree of actors' involvement in health policy processes. Firstly, this can be seen as a reflection of responsiveness of health policies to the needs of some [vulnerable] groups of population. Secondly, involvement of actors can be seen as a reflection of their (actors') power and ability to engage in policy processes. Thirdly, this can be a reflection of actors' agendas, values and ideologies and their relevance to particular policies. The first dimension overlaps with effectiveness of health policies; the second could be regarded as directly relevant to efficiency whereas the third dimension can be described from the perspectives of efficiency and evidence-informed nature of policy processes. The above dimensions are considered in the study in order to form a comprehensive picture of the complexity of policy processes.
- *Timing of different stages of policy processes.* This refers to the least time in which a particular policy could be effectively developed or implemented. In practical terms this incorporates the number and duration of events such as working group meetings at different stages of policy processes.

Feasibility of health policy processes.

This is one of the 'standard' criteria for assessing any intervention. The following three dimensions of feasibility are considered as being directly relevant to the health policy processes (Geva-May, 1997; Jenkins, 1978; Meltsner, 1972):

- *Technical feasibility*, which refers to the available resources (such as financial, human) and structures to develop and implement health policies.
- *Political feasibility*, which refers to the values and agendas of different actors who are involved or will be involved in the development and/or implementation of health policy processes. This includes different actors at different levels and in practical terms this may, for example, include the possibility of agreement from the Ministry of Finance as part of the health financing strategy or of narrow specialists as part of PHC strengthening strategy.
- *Cultural feasibility,* which refers to the acceptability of the change by the groups who are covered by particular health policies. This may be regarded as overlapping with the next

characteristic, sustainability of health policies, and examples of this include acceptability of certain types of services (for example family planning) by some groups of population (for example women).

Sustainability of health policy processes.

This refers to the sustainability of change induced by health policies such as health reforms (Berman, 1995; Roberts et al., 2004) and is understood as stemming from the feasibility of health policy processes. Two broad elements are distinguished: *acceptability of change* which is described earlier as cultural feasibility and *technical sustainability* which is also introduced in the feasibility criterion.

One question arising from the above is whether there is a minimum number of essential characteristics which can be regarded as comprising a robust health policy process? Related to this, is whether all the criteria bear the same relative importance or whether some may be perceived as carrying 'more weight' ?

It is acknowledged it may be difficult to assess the relative importance of each characteristic as there are many overlaps between the characteristics; and some characteristics (for example "holistic nature") may be perceived as values and ideologies of the key stakeholders. Furthermore, definition of robust health policy processes is dependent on who provides this interpretation. For example, the understanding of "adequate" participation of actors may vary across the policy actors. This is particularly important in policy research because of the multiplicity of actors involved and hence the different views/perspectives. None of above criteria operates in isolation and each inevitably affects others. For example, the use of evidence in policy processes is closely linked with the representation of actors in health policy processes and the latter can be seen as a reflection of the transparency of policy processes.

Having explored the understanding of health policy processes, the literature on the concept of capacity is discussed next.

2.3 The concept of capacity

The United Nations Development Programme defined capacity as: *'…the ability of individuals, institutions and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner'* (UNDP, 2006 p.3). A simpler, though similar, definition of capacity to that of the UNDP is suggested by the Development Assistance Committee as: *"…the ability*

of people, organisations and society as a whole to manage their affairs successfully" (Development Assistance Committee, 2006 p.12). Perhaps the simplest definition was proposed by Goodman et al, who defined capacity as "*the ability to carry out stated objectives*" (Goodman et al., 1998).

The concept of capacity is described as a process as well as an outcome; it has a dynamic nature and is clearly multidimensional (LaFond et al., 2002). The starting point for defining capacity is its synonym *ability to....*[perform, produce, hold, generate, learn, interact or to carry out stated objectives] (Goodman et al., 1998; LaFond et al., 2002).

However, the *'ability to..'* itself needs exploring and may contain within it, not only functioning skills, mechanisms and resources but also motivation and power. It is important to recognise the importance of wider contextual factors such as the social-structural environment, although this recognition can sometimes lead to a sense of powerlessness (Green and Gadsby, 2007). Morgan describes the phenomenon of *potential state* in the interpretation of the concept of capacity referring to its 'elusive' and 'latent' nature (Morgan, 2006) which helps to understand the importance of the existence of a favourable environment to apply potentially existing knowledge and skills. An example of this from the health policy processes field is that the MOH's ability to engage other actors in policy processes may be constrained by political and ideological factors in the wider public sector and the engagement practices of other actors.

Closely linked to this is the distinction between *ability* and *willingness* with the latter playing an important role in the application of existing capacity for certain tasks. The distinction between ability and willingness is evident in the formal definition of capacity development, which includes the element of 'unleashing' existing capacity which may be constrained by different factors including lack of willingness:

> *"the process whereby people, organisations and society as a whole unleash, strengthen, create, adapt and maintain capacity over time"* (Development Assistance Committee, 2006 p.12)

The DAC definition of capacity development, which includes the term 'unleashing' existing capacity, is helpful in understanding the balance between 'current' and 'projected' capacity and whether establishing an enabling environment is an explicit part of capacity strengthening. For example, Morgan's characteristics of the concept of capacity such as collective ability and systems phenomenon (Morgan, 2006) suggest that capacity may exist at

an individual level but a comprehensive approach is required to at an a organisation and system levels. This raises the importance of effective interaction within networks, establishment of appropriate organisational and regulatory procedures and the enabling environment as an integral part of capacity development (Green and Gadsby, 2007).

The wider contextual environment or enabling environment (Potter and Brough, 2004) plays an important role in understanding capacity at all levels. For example, at an individual level, Grindle and Hildebrand found that performance of individuals is often affected by '*opportunities for meaningful work, shared professional norms, teamwork, and promotion based on performance*' rather than targeted training and development of specific skills and knowledge on the subject (Grindle and Hilderbrand, 1995 p.441).

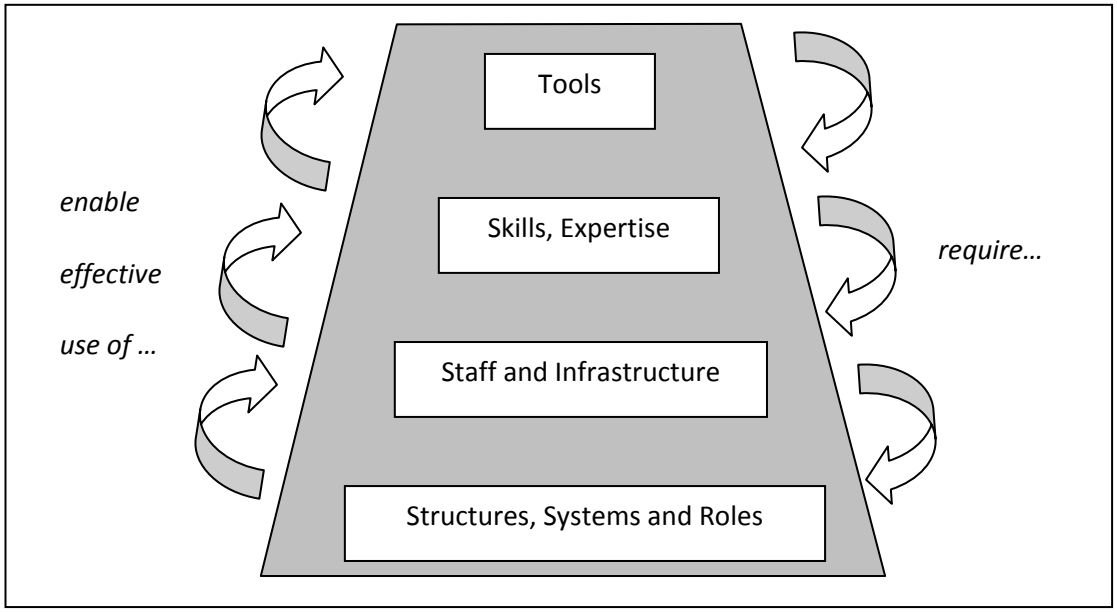
In this study capacity is defined as *the ability and willingness of an individual, an organisation or a system (including partnerships and consortia between different individuals, organisations and systems) to perform a defined task, in a sustained way, either individually or as part of the wider team/network.* Two aspects of this definition are worth emphasising. Firstly, the distinction between *ability* and *willingness* – both being required. Secondly, the recognition that *individual* ability can be affected by the abilities of other members within a larger team or partnership – a phenomenon understood as being part of organisational capacity (LaFond et al., 2002; Potter and Brough, 2004).

Different authors focus on different aspects of capacity such as capacity for health systems as reflected in their performance (Murray and Frenk, 2000), capacity for health systems and policy research (Gonzalez Block and Mills, 2003; Green and Gadsby, 2007), capacity for utilisation of research (Hanney et al., 2003) and, most commonly, capacity for improving the performance of health programmes. A very recent attempt to understand capacity of the French MOH identified the three aspects of capacity: a) *technical capacity* or ability to identify priority issues and develop feasible plans to address those, b) *institutional capacity* or ability '*…to support its diagnoses and prescriptions with the appropriate instruments and resources to achieve its policy goals*' and c) *political capacity* as a reflection of department's power and will (Briatte, 2010 p.159). Potter and Brough's capacity pyramid (see Figure 2) distinguishes four levels of capacity: a) structures, systems and roles; b) staff and infrastructure; c) skills and d) tools with each subsequent element enabling the effective use of the subsequent one and requiring the previous one (Potter and Brough, 2004). In fact, many terms used by international organisations to define capacity development efforts since

the 1950s (such as institutional development, human resource development, or institutional strengthening) (Lusthaus et al., 1999) focus on different parts of the capacity pyramid.

Figure 2: Elements of the Capacity Pyramid

Adapted from: (Potter and Brough, 2004 p.340)



Green and Gadsby describe the interrelationships between the different aspects of the above capacity pyramid as 'links in a chain' where one weak link can undermine the whole chain (Green and Gadsby, 2007). An example of these interrelationships of capacity in policy processes includes the leadership and governance element of the national government where a) the regulatory framework and normative documentation provide structures and systems which are dependent on b) the existence of competent staff and a formal infrastructure with clear and adequate distribution of roles across the levels, with the former largely linked to c) relevant skills and expertise in health policy analysis and d) appropriate tools to perform health policy analysis and ensure effective means of communication with different actors.

A similar approach has been suggested by Morgan who distinguished between the *foundation elements* of capacity (such as financial resources, structures, information, culture), *competencies* (such as energy, skills, behaviours) and *capabilities* that can be distinguished between *"… 'harder' (e.g. policy analysis) and … 'softer' (e.g. the ability to earn legitimacy, … to create meaning and identity)"* (Morgan, 2006 p.8).

2.3.1 Key considerations in understanding capacity

Three considerations are important in understanding the concept of capacity: a) clear focus on whose capacity is addressed and in relation to what tasks, b) what levels of capacity are distinguished and c) what elements of capacity exist at each level, particularly if more than one level is included. These are set out in this section, followed by identification of interrelationships between levels and elements of capacity.

Focus and tasks in understanding of capacity

When defining capacity it is important to be explicit on two aspects of capacity: capacity of *whom* and capacity to do *what* (Green and Gadsby, 2007). Thus the capacity for example of national government to ensure wide participation of policy actors involves government (who) and ability to ensure participation (what). Some authors have also emphasised the need to distinguish between functional and performance capacity within the health system. The former refers to the ability to undertake specific tasks effectively and the latter comprises abilities needed to be able to perform effectively at a more general level (Green and Gadsby, 2007). The interpretation of the above two aspects may differ significantly even within a single context. In other words, different stakeholders, even when in agreement that there is a 'lack of capacity within a national health system', may have different views as to which particular aspects are lacking and need strengthening at different levels of the national health system. Therefore, the creation of a shared understanding or a 'public value' is important to agree the needs for capacity development (Morgan, 2006; UNDP, 2006).

Five measurement stages of the process of application of capacity can be distinguished, including inputs, processes, outputs, intermediate outcomes and ultimate outcomes or impact (Brown et al., 2001). The last two are long-term effects. Each of the first three elements comprise specific elements of capacity, as shown in Table 6.

Table 6: Examples of elements of organisational capacity.

Adapted from: (Brown et al., 2001; LaFond and Brown, 2003)

Capacity stage	Elements of organisational capacity
Inputs	• Leadership • Resources (finances, infrastructure, human resources) • Context (financial policy, Organisational culture)
Process	• Strategic and operational planning • Resource mobilization, allocation and management • Research and monitoring & evaluation, including quality assurance • Working with other policy actors (for example, coordination, advocacy, community mobilisation)

Capacity stage	Elements of organisational capacity
Outputs	• Staff trained • Financial management system established • External linkages established (to donors, partners, • individuals, community) • Strategic & operational plans developed

The above examples of elements of organisational capacity broadly correspond to six general areas of an organisation's capacity: Strategic management practices: organisational learning, use and management of technical knowledge and skills, financial resource management, human resource management and administrative infrastructure and procedures (Sarriot, 2002).

Levels of capacity

It is important to identify explicitly the *level* to which the capacity is referring. For example, some definitions of capacity refer to a set of resources available to an organisation or a system combined with the actors transforming those resources into performance (LaFond and Brown, 2003), suggesting three levels of capacity, individual, organisational and systems. As referred to earlier, Potter and Brough suggest three levels of capacity comprising individual, organisational and wider contextual environment (Potter and Brough, 2004). The United Nations Development Programme distinguished *enabling environment* or wider context as one of the three levels of capacity, along with individual and organisational (UNDP, 2006). The wider context could be described as a combination of external factors affecting the balance between willingness and ability, rather than as a composite element of capacity per se. Some authors propose a more detailed, four-level classifications, including health systems level, organisational level, health programme personnel level and individual or community level (Brown et al., 2001; LaFond et al., 2002).

In this study capacity is understood as comprising three levels: individual (i.e. staff members), organisational (i.e. MOH) and systems (i.e. health sector), as set out next. At the *individual level,* three main elements of capacity can be distinguished: motivation, knowledge and skills, leading to performance. Both can be addressed through targeted training (Green and Gadsby, 2007; LaFond et al., 2002) and some authors also propose performance evaluations and professional networking as additional capacity development measures (Brown et al., 2001). Implicit in these is expertise of individuals to perform or assist in carrying out specific tasks.

At the *organisational level* three elements are often identified as leadership and governance, adequate and sustainable resources (staff, finance, information, infrastructure and maintenance) and communication and networks (Green and Gadsby, 2007). The three elements clearly overlap and are inter-dependant. For example, resources are needed to establish communication between actors and effective communication is an important characteristic of good governance.

The *systems level*, referred by some authors as part of the wider contextual environment (Potter and Brough, 2004), incorporates the individual and organisational levels of capacity in a systematic way with an addition of a set of functions related to the system itself which is independent of those performed by the organisations and individuals within it (LaFond et al., 2002). WHO sees the health systems functions to be financing, service provision, resource generation and stewardship (WHO, 2000). Implicit in the WHO definition is the aspect of complex interrelationships between different organisations within a health system. This is particularly important when using the concept of unleashing capacity in the field of health policy processes. Here, for example, the regulatory framework of the MOH may facilitate or prohibit involvement of other actors, despite skills and expertise, in the policy processes.

Elements of capacity

The different *elements* of capacity distinguished in capacity pyramid are: structures, systems and roles, skills, staff and tools (see Figure 2). When it comes to measuring capacity, some elements (such as material resources, skills and inputs) are more tangible and hence measurable than others (such as the effectiveness of organisational structures, adequacy of processes and rational distribution of roles between the different actors and levels of the system) (Green and Gadsby, 2007).

These elements apply in different combinations to the different levels (individual, organization, system) of the capacity. For example, at an individual level the *skills* of an individual contribute towards the person's *role* within the organisation and the combination of these roles contributes towards the organisational *structure.* From an organisational perspective the relative *roles of staff* may be the key element with the *skills* being selected (through employment processes) according to the perceived roles and *structures* established to organise the roles in a systematic way.

Interrelationship between levels and elements of capacity

It is often difficult to distinguish between different levels and the respective elements of capacity. For example, the ability to effectively use evidence in policy decisions is dependent on the availability and timeliness of generation of evidence at the grassroots level of the health system. This is explored in more detail in the next sub-section.

The only framework for understanding capacity in relation to health policies was that of Bowen and Zwi, who distinguished between the three levels of capacity and several categories or elements of capacity (Bowen and Zwi, 2005), as shown in Table 7.

Table 7: Capacities required for policy adoption and adaptation

Derived from: (Bowen and Zwi, 2005 p.603)

Level	Element
Individual	Leadership Knowledge and skills Resources Organisational Partnerships
Organisational	Policy, processes, and procedures Partnerships Resource allocation Leadership Knowledge and skills
System level	Politics Economics Ideology Values

However, there are several disadvantages to the above framework in relation to this study, preventing its use in assessment of MOH capacity to conduct health policy processes in RT. First, the focus of the framework is on broader concept of policy and not health policy *processes.* Second, there is an inconsistent use of elements of capacity at different levels – for example, organisational element of individual capacity or knowledge and skills as element of organisational capacity. Lastly, there is little scope in this framework to accommodate the understanding whether health policy processes are 'good' or not.

At a broad level, up to nine elements of the health system's capacity, are distinguished by some authors, which comprise individual and organisational capacities:

1. *Performance capacity*: Are the resources (including tools, money, equipment, and consumables) available to do the job?

2. *Personnel capacity*: Are the staff sufficiently knowledgeable, skilled and confident to perform properly? Do they need training, experience, or motivation? Are they deficient in technical skills, managerial skills, interpersonal skills, gender-sensitivity skills, or specific role-related skills?
3. *Workload capacity*: Are there enough staff with broad enough skills to cope with the workload? Are job descriptions practicable? Is the skill mix appropriate?
4. *Supervisory capacity*: Are there reporting and monitoring systems in place? Are there clear lines of accountability? Can supervisors physically monitor the staff under them? Are there effective incentives and sanctions available?
5. *Facility capacity*: Are training centres big enough, with the right staff in sufficient numbers? Are clinics and hospitals of a size to cope with the patient workload? Are staff residences sufficiently large? Are there enough offices, workshops and warehouses to support the workload?
6. *Support service capacity*: Are there sufficient laboratories, training institutions, bio-medical engineering services, supply organizations, building services, administrative staff, laundries, research facilities and quality control services?
7. *Systems capacity*: Do the flows of information, money and managerial decisions function in a timely and effective manner? Can purchases be made without lengthy delays for authorization? Are proper filing and information systems in use? Are staff transferred without reference to local managers' wishes? Can private sector services be contracted as required? Is there good communication with the community? Are there sufficient links with NGOs?
8. *Structural capacity*: Are there decision-making forums where inter-sectoral discussion may occur and corporate decisions made, records kept and individuals called to account for non-performance?
9. *Role capacity*: Have individuals, teams and structure such as committees been given the authority and responsibility to make the decisions essential to effective performance, whether regarding schedules, money, staff appointments, etc? (Potter and Brough, 2004 p.340)

Many elements of the above classification such as facility, performance and personnel refer to the organisation and provision of health services whereas the focus of this study on health policy processes.

Three overarching issues are important for consideration of the concept of capacity in the conceptual framework: the need for both ability and willingness, the need to distinguish different levels and different elements of capacity.

The following six broad themes can be distinguished emerge from the literature around the concepts of health policy processes and capacity, as set out next:

1. An important consideration of capacity is the ability of the national government to distinguish, and ensure the transparency of, *different stages of health policy processes*.
2. The *wider context* can provide favourable or prohibiting environment for health policy processes and the application of MOH capacity.
3. *Involvement of actors* in health policy processes is one of the key factors affecting the characteristics of health policy processes and the MOH capacity to achieve these.
4. Although it can be regarded as one type of resource, the *role of evidence* in health policy decisions is important in describing the government's capacity in relation to health policy processes.
5. The main focus of this research is on MOH capacity with issues such as *leadership and governance* of particular importance.
6. It is important to distinguish between generic resources which affect the capacity of the health sector as a whole, and *specific resources in support of health policy processes* such as structures established within the MOH and/or individuals trained in health policy analysis or assigned an advisory role.

These themes provide the background for development of the study conceptual framework, as set out in the next section.

2.4 Conceptual framework for assessing MOH capacity to conduct health policy processes

This section develops a conceptual framework for assessment of MOH capacity to conduct health policy processes. A detailed overview of the state-of-the-art in relation to each of the six themes identified in the earlier section is provided, as a background for the development of the study conceptual framework.

2.4.1 Different stages of policy cycle

One way to classify policy processes is by approach to the derivation of policy decisions, which includes five broad models: incrementalist, mixed-scanning, argumentative, social experiment and interactive learning (Sutton, 1999). An alternative approach is to describe the policy process by its stages (often known as the *stages heuristic*) and this represents an area of particular interest and relevance to this study. In fact, the stages models of health policy analysis are sometimes referred to as different frameworks for policy analysis along with networks and streams (Exworthy, 2008).

It should be noted that '*…no single policy model offers a fully comprehensive description of understanding of the policy process*...' (Exworthy, 2008 p.324) and the above two approaches (policy decisions and stages) are not mutually exclusive. For example, health policy decisions may be closely inter-related with the characteristics and duration of each stage of health policy process.

Although often referred to as linear models (Exworthy, 2008; Sutton, 1999), health policy processes are often seen as cycles with the last stage feeding into the next round of activities and thus contributing towards the continuous nature of health policy-making (Barker, 1996). Furthermore, some authors argue that different stages are often not clearly distinguishable (John, 2000) with policy decisions not made at a single point of time but emerging over a longer period (Walt et al., 2008). Different classifications of policy processes are suggested in the literature which range from relatively simple models involving few consecutive stages to more complex sub-divisions of major stages into sub-processes. The policy stages approaches are helpful as a "*…heuristic device which helps to disaggregate these complex [policy] phenomena into a series of events*" (Tantivess and Walt, 2008 p.330)

The simplest model was suggested by Walt (1994), with the following four stages: problem identification and issue recognition, policy formulation, policy implementation and policy evaluation. A similar model has been suggested by Sutcliffe and Court (2006):

- Agenda-setting - Awareness and priority are given to an issue in order to make it visible (McKee et al., 2000) and increase the likelihood of getting it on the agenda
- Formulation - which includes two key stages to the policy formulation process: determining the policy options and then selecting the preferred option
- Implementation - actual conduct of the activities of the policy
- Evaluation - Monitoring and assessing the process and impact of an intervention

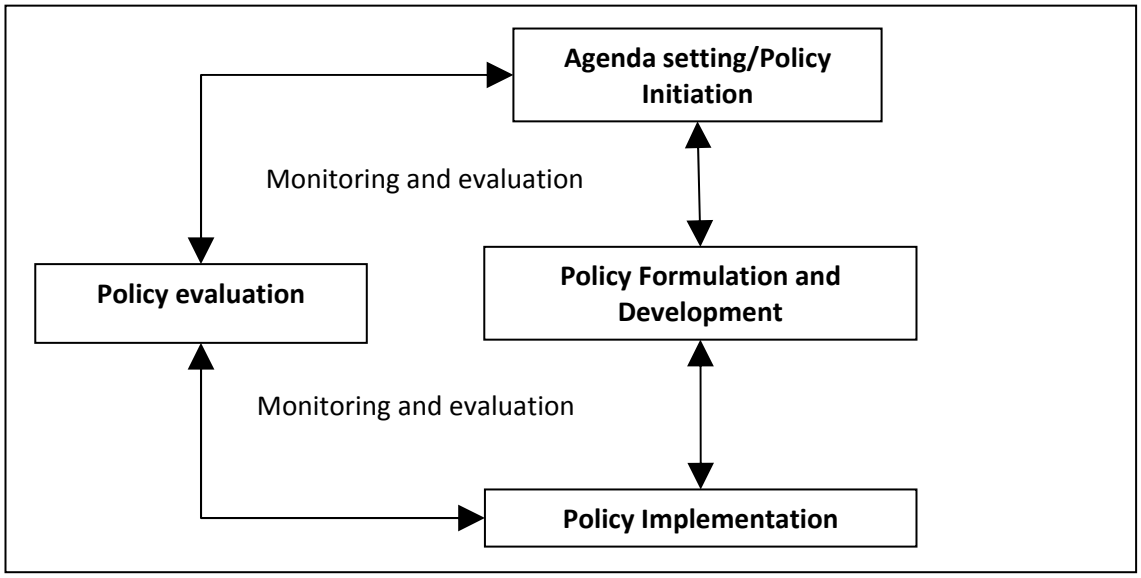
Some authors propose a more detailed cycle of policy processes with six or more stages of policy processes. For example, in the late 1970s, the health policy processes were suggested as comprising seven consecutive stages: initiation, information, consideration, decision, implementation, evaluation and termination (leading to the next policy cycle) (Jenkins, 1978). This broadly corresponds to a more recent description of policy-making cycle where it is seen as a combination of goals, objectives, methods and instruments, activities, performances and evaluation (Parsons, 1995). A seven-stage classification of policy processes was described by Barker, which comprised issue definition, setting objectives, priority-setting, defining and appraising options, implementation and evaluation (Barker, 1996). Probably the most detailed classification of policy processes distinguishes nine stages of the policy process as follows (Hogwood and Gunn, 1984):

1. issue search and agenda setting
2. issue filtration and amplification
3. issue definition
4. forecasting
5. setting objectives and priorities
6. option analysis
7. policy implementation, monitoring and control
8. policy review and evaluation
9. policy maintenance, succession or termination

Many health policies may not have clear milestones to mark the distinction between the different stages of policy process. Furthermore, some stages (such as policy analysis) may never take place due to, for example, a change in the direction of health policies. In this study, when describing the policy cycle, a variation of a four-stage policy process is used as shown in Figure 3. This framework was selected because of its simplicity (compared to more detailed stages) allowing its flexibility and adaptability to different contexts (for example, a more complex classification of sub-stages can be developed if needed).

Figure 3: The policy cycle

Adapted from: (Sutcliffe and Court, 2006; Walt, 1994)



The policy cycle presented above is conceptual. For example, due to the sensitive political nature of health policy processes and the complex interactions between different actors, policy monitoring and evaluation and policy analysis stage are often dissolved within the other stages (agenda setting, policy development and implementation). Furthermore, in many cases policy formulation and development are often merged with, and is not easily distinguishable from, the agenda-setting stage.

2.4.2 Context of health policy processes

Policy processes occur within a wider context, which includes a wide variety of factors, both within and outside the health system as well as whole range of internal (in-country) and external (international) factors (Buse et al., 2005; Walt and Gilson, 1994). The context is defined as a complex set of external factors, along with their interrelationships, which directly or indirectly affects health policy processes or its elements such as the use of evidence (Dobrow et al., 2004). These factors range from wider political and ideological environment to the dynamics of the health system (for example health reforms) and the way in which different elements of the public system are structured (for example how close is the research/academic communities to the policy processes). Two examples of the relationship between the wider context and health policy processes are a) the effect of the wider political and legal frameworks on the power position of the MOH compared to other social sectors and b) the effect of the cultural norms on the health policy decision-making practices within MOH.

The importance of the context in health policy-making is well-understood. Collins *et al* propose a categorisation of the policy context with six broad groups of factors (Collins et al., 1999), with some factors (such as conflict) being applicable only to specific contexts:

1. Demographic and epidemiological change
2. Processes of social and economic change and conflict
3. Economic and financial policy
4. Politics and the political regime
5. Ideology, public policy and the public sector
6. External factors

Similar to the above classification, LaFond and Brown distinguish seven areas of influence of external environment on the organisational capacity: administrative, legal environment, political environment, socio-cultural environment, economic environment, technological environment and stakeholder involvement (LaFond and Brown, 2003).

In this study five broad elements of policy context are distinguished, corresponding to the main contextual issues in the former soviet republics:

1. Political and governance systems
2. Socio-economic environment
3. Health status of the population
4. Dynamics of the wider public sector and
5. Structures (such as health system, research/academia)

Each area contains factors that may cut across the different themes. For example, social hierarchy in the society (part of socio-economic environment) is closely linked with the policy actors and established practices (reflection of structures) inevitable affect policy processes.

2.4.3 Health policy actors, their roles and interrelationships

Actors within the policy processes are interpreted as *individuals and/or organisations who are associated with, and involved or not involved in, health policy processes*. The term *policy actors* is different to *stakeholders*; the latter include those not involved in the policy processes but who may be important for some other reasons (for example, their presence may encourage/stop other actors from being involved).

The involvement of a large number of actors is acknowledged in various definitions of health policy. For example, Buse et al define health policy as "… *courses of action (and inaction)*

that affect the set of institutions, organisations, services and funding arrangements of the health system…" (Buse et al., 2005 p.6).

Actors' roles in health policy processes

Consideration of policy actors has been at the centre of many health policy studies and different authors have examined views and attitudes leading to, or hindering, their participation in health policies (Gilson and Raphaely, 2008). Earlier policy analyses have tended to focus more on the public or government sector thus emphasising (and potentially over-emphasising) policy-making as the government's prerogative. However, over the last decade studies have acknowledged a shift towards involvement of a much larger array of policy actors in health policy processes (Buse et al., 2005; Walt et al., 2008) which in turn leads to more complex methodologies in assessing the relative roles and mechanisms of engagement of various actors in health policy processes.

Policy actors can form networks, including advocacy coalitions and policy and issue networks (see section 2.2.1). For example, in Thailand networks of state and non-state actors, both local and international, have been shown to be crucial in the policy related to the anti-retroviral therapy (ARV) . Although the state has shown its dominance over the initial policy process, policy networks have been involved at most stages of the dynamic and long-term policy processes in the country and non-state actors have been able to become more visible by allying with the media (Tantivess and Walt, 2008). Perkin and Court describe the effects of civil society organisation (CSO) policy networks on policies related to international development. They suggest that that CSO networks are involved in agenda-setting and policy formulation through advocacy, lobbying and supplying evidence to inform policy decisions and in implementation through enhancing the capacity of governments by engaging in the actual provision of health services (Perkin and Court, 2005).

Actors' power in health policy processes

The actors involved in policy processes are diverse and often associated with the concept of power that they bring with them, a key concept in health policy processes (Erasmus and Gilson, 2008; Walt, 1994). The literature defines actors' power as comprising various characteristics such as the rule-making or legal authority, the control over resources particularly finance and staff and the visibility in the public eye (Greer, 2010; Mätzke, 2010). This concept also applies to actors outside central government. For example, front-line health staff, who are normally involved in policy implementation, are described as street-level bureaucrats through their potential ability to influence the reality of health policy in

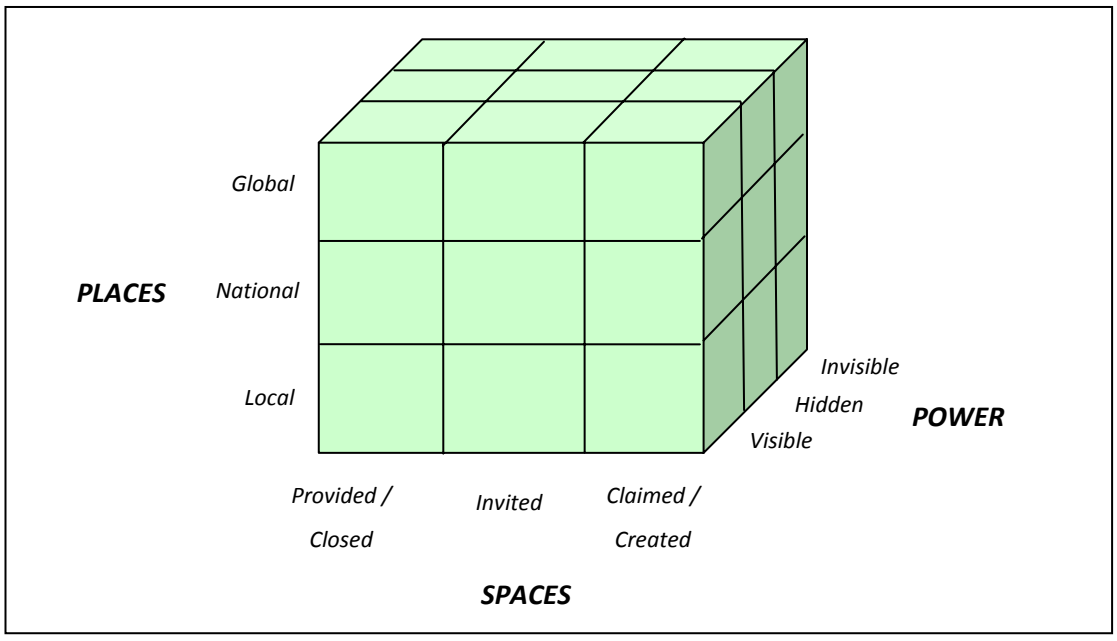
their enthusiasm or otherwise for implementation (Lipsky, 1980). In practice their power may result in resistance to effective policy implementation through the exercise of their own working routines thus resulting in greater control over their patients and tasks and affecting targets set on quantity and quality of services (Erasmus and Gilson, 2008).

Such relative 'discretion' of local staff in implementation is likely to be perceived negatively by policy-makers in the context of a top-down policy-making environment as it may undermine the conformity of policy implementation with pre-determined policy targets and milestones; proponents of 'bottom-up' policy-making may have a more a positive view of such discretionary power (Erasmus and Gilson, 2008). Although policy-making is often see as the prerogative of the state, in many countries there is an increasing acknowledgement of the shifting trend towards inclusion of other actors, including civil society organisations, in policy processes (Tantivess and Walt, 2008).

The 'Power Cube' approach (see Figure 4) is used as one way of analysing spaces, places and dynamics of participation and engagement in health policy processes of one group of actors which is often neglected, civil society (Gaventa, 2005).

Figure 4: The 'Power Cube': Power in Spaces and Places of Participation

Source: (Gaventa, 2005 p.11)



According to the Gaventa's Power Cube there are three broad types of power:

- *Visible or observable decision-making styles* is the most straightforward form of power, particularly in centralised contexts reflected in the formal rules, structures, authorities, institutions and procedures of decision-making
- *Hidden* power is exemplified by the actions of people and institutions that maintain their power not through the direct involvement in the policy processes but by controlling who gets to the decision-making table and what gets on the agenda. These dynamics may operate at all levels to exclude and devalue the concerns and representation of less powerful groups.
- *Invisible power* is the most insidious and determines the psychological and ideological boundaries for actors' involvement in the policy processes. "*By influencing how individuals think about their place in the world, this level of power shapes people's beliefs, sense of self, and acceptance of the status quo – even their own superiority or inferiority*" (Gaventa, 2005 p.15).

The relative influences or powers of different actors and their networks depend on whether they are directly involved in the policy processes or seen as 'outsiders'. In some cases outsiders can gradually shift to becoming insiders as shown by the case of ARV policy in Thailand where the Ministry of Public Health has been exercising its power and providing policy spaces for new members, including CSO networks, allowing them to participate in the public health policy processes (Tantivess and Walt, 2008). This is one example of the growing body of literature on the power of different actors and its effects on the health policy processes (Erasmus and Gilson, 2008; Gilson et al., 2008; Gilson and Raphaely, 2008)

The distinction between global, national and local places is particularly relevant when making a distinction between the balance of global and national priorities; mapping of health policy processes by the different levels (for example national-level development and local-level implementation) and assessing the power of different actors at different levels.

The combination of three types of power with the three types of places (the classification of national, state/province, and district/township may be applied in the context of a country) determine the three types of spaces available for participation and engagement:

- *Closed spaces* refer to spaces in the decision-making processes which are unavailable for participation. Decisions are made behind closed doors without any pretence at broadening participation. Within this context some spaces may be provided for the 'elite', i.e. groups seen as part of the formal decision-making processes (such as bureaucrats, experts or elected representatives);

- *Invited* spaces refer to the efforts from policy-makers to involve other actors – through invitations - in policy processes;
- *Claimed/Created spaces* are those claimed by less powerful actors from or against more powerful individuals/groups.

Spaces can contract and expand as shown in a study from Kenya (Crichton, 2008). Crichton suggests that this dynamic nature of policy spaces is affected by three groups of factors: the *wider contextual environment* which includes external (international) influences, the resource framework, and politics; *decision-making circumstances* which are the ways in which policy-makers' perceptions about a policy issue shape the dynamics of decision-making; and *policy characteristics* which are *"…themselves influenced by policy elites' decisions, but also affect the scope policy makers have for introducing a policy and prioritizing it*" (Crichton, 2008 p.340). This framework is similar to one developed in the early 1990s which described the factors affecting the policy spaces as comprising national and international contextual factors, the circumstances surrounding the policy process and the acceptability of the policy process (Grindle and Thomas, 1991).

Two important points need to be emphasised in relation to exploring the roles of policy actors. First, different techniques exist that attempt to describe and analyse actors in policy processes such as stakeholder analysis (Brugha and Varvasovszky, 2000). However, it is virtually impossible to map out all actors in health policy processes, not least because of the dynamic nature of policy development and implementation. Different actors may be involved at different stages of the policy processes. For example, research organisations may be involved in agenda setting through generation of knowledge from different studies (Almeida and Bascolo, 2006; Court et al., 2005) whereas the private health sector may be involved primarily at the implementation stage (for example, provision of services). Therefore, the conceptual framework does not attempt to be exhaustive and to comprehensively cover all possible groups of actors.

Secondly, as illustrated earlier, different actors have different values, practices and perspectives, which reflect their interpretation of, and engagement in, policy processes (Buse et al., 2005; Walt and Buse, 2006). Furthermore, some actors may have more power than others (Gaventa, 2005; Walt, 1994). All these factors result in complex interrelationships between different actors or even groups of actors (such as coalitions) in the policy processes. The model recognises these interrelationships. From the perspective of capacity this means

that the government should ensure an adequate balance in representation (including, of course, engagement) of all actors in the policy processes.

2.4.4 Use of evidence in health policy processes

The leading organisations in international health policy such as WHO, UNICEF and the World Bank agree that robust evidence can make a significant difference to policy-making in at least five ways: it can help with *achieving recognition* of a policy issue; it can *inform the design and choice* of policy; it may help with *planning or forecasting* the future; it can help with *monitoring* policy implementation and, lastly, it is often used in *evaluating* policy impact (Segone et al., 2008).

Three broad issues can be distinguished in the literature: a) understanding of the concept of evidence and evidence-informed policies, b) factors affecting evidence use including characteristics of evidence itself and c) processes of evidence generation and use. These are set out in the next three sub-sections.

Understanding evidence and evidence-informed policies

The Oxford English Dictionary defines evidence as "*the available body of facts or information indicating whether a belief or proposition is true or valid"* (Soanes and Stevenson, 2005). This is similar to some definitions proposed in academic literature, which define evidence as *"…facts or testimony in support of a conclusion, statement or belief" and "something serving as proof"* (Rychetnik et al., 2004).

However, this broad interpretation of evidence is at variance with some literature-based definitions of evidence-informed health policies, which place opinion-based and evidence-based health policy decisions as two ends of a continuum (Sutcliffe and Court, 2006). This suggests that opinions cannot be considered as evidence. In this study, however, opinions are considered as an informal type of evidence.

Bowen and Zwi proposed five types of evidence that potentially affect health policy-making. These are research, knowledge and information, ideas and interests, and wider political and economic environment (Bowen and Zwi, 2005). Similar classifications distinguished between academic research, personal experiences, and shared norms, values, and ideas in good currency (Solesbury, 2001). Others suggested the addition of government regulatory documents, HMIS-generated data and information from programme monitoring and evaluation, academic research and other informal types such as media reports and advocacy

efforts by the Civil Society (Leeds HEPVIC team, 2009). The following four inter-related and overlapping types and forms of evidence can be distinguished:

1. formal (for example, research findings) and informal types (rumours and personal experience)
2. published and unpublished evidence
3. mainstream such as HMIS data and ad hoc such as one-off surveys/assessments
4. scientific such as research-related and non-scientific such as media publications.

Evidence in this study is interpreted as *information, formal or informal, which may inform, directly or indirectly, the health policy processes*. This broad definition of evidence allows us to incorporate at least three characteristics. Firstly, it allows the possibility of different forms and types of evidence (for example, formal evidence such as government document and informal types such as personal and institutional experiences). Secondly, it allows application of evidence at all three stages of the health policy processes (agenda-setting, development, and implementation) and, thirdly, it allows evidence to be associated with different policy actors such as researchers and academia, civil society organisations and health professionals.

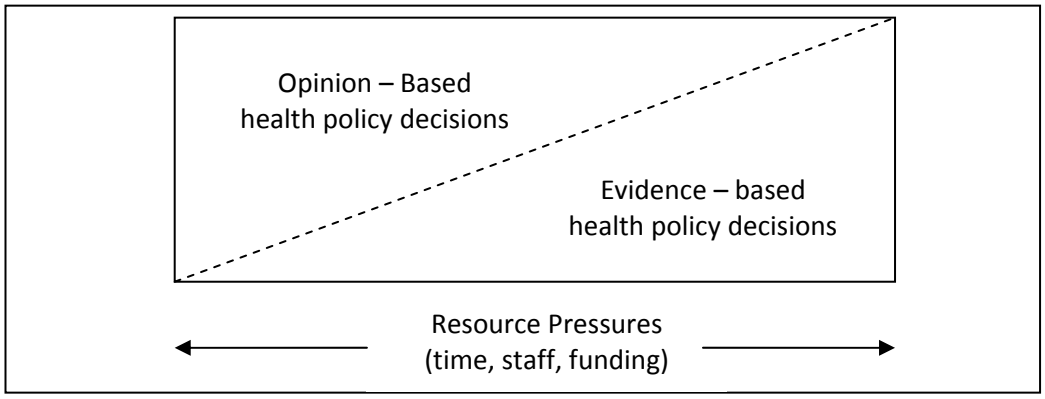
Evidence-based policy - more recently referred to in the literature as *evidence-informed policy* (EIP) - has become a popular term in the recent years (Segone et al., 2008) with many recent attempts to map out its key elements with

> *"…terms such as "informed choice", "considered decision", "rational policy", "evidence-based policy", "strategic research", and "essential national research" have been used to express the belief in the need to build a "bridge" between research and policy."*
> (Almeida and Bascolo, 2006 p.S9)

EIP is an approach that *"…helps people make well informed decisions about policies, programmes and projects by putting the best available evidence from research at the heart of policy development and implementation" (Davies, 2004).* Decisions, including those related to health policy are based on, or informed by, a mixture of the opinions, beliefs and values of the key actors and available and accessible information/evidence. The balance between these will vary; in particular the degree to which evidence is used to inform health policy decisions is a reflection of the evidence-informed nature of the decisions (Sutcliffe and Court, 2006). As shown in Figure 5, another element with an effect on the likelihood of the use of evidence in health policy decisions is resource-related pressures including time, availability and level of expertise of staff, financing and other resources.

Figure 5: Framework for evidence-informed health policies

Adapted from: (Sutcliffe and Court, 2006)



There is often no single 'objective' evidence and the production and interpretation of evidence for health policy decisions often depends on the actors' values, ideologies and beliefs. Therefore the distinction between opinions and evidence may be blurred and the term 'objective' evidence can be taken to refer to the *degree* of bias in evidence rather than the presence of solely fact-based evidence.

Factors affecting evidence use in policy processes

Various factors affect the use of evidence in health policy processes. Hailey describes the main issues that affect the likelihood of utilisation of research evidence in policy and practice as comprising political views (including government philosophy), existing policies, administrative feasibility, timing, and equity (Hailey, 2008). The use of evidence is also affected by the nature of policy objectives/decisions to be made, the skills and abilities of the different policy actors, and decision support tools. In terms of skills and abilities of different policy process actors, ODI (2006) describes how the internal dynamics of civil society policy work often present the main obstacles restricting civil society policy engagement (such as weak understanding and capacity). Contextual factors, such as political interests and resource constraints, also affect the use of evidence (Dobrow et al., 2004). The high "*volatility of policy areas, with rapid turnover of staff and reshaping of administrative structures*" were particularly emphasised as one of the main '*hurdles*' faced by researchers in disseminating their findings into policy and practice (Hailey, 2008 p.2). Although some issues, such as limited budgets for health research, may not be easily amendable, most issues are related to the capacity of policy-makers to utilise research evidence in policy-making and can be improved over time (Jewell and Bero, 2008).

The use of evidence in policy decisions is also affected by the credibility and power of the actor(s) engaged in the production/dissemination of evidence as well as the level of production/dissemination of evidence (national, local) (Dobrow et al., 2004; Shaxson, 2005). In some circumstances the stronger and more powerful groups, particularly at the national level are more likely to generate/disseminate evidence which is utilised in policy decisions whereas in some contexts the reverse assumption may be true with, for example, less powerful groups using evidence in order to be recognised or to demonstrate the rationale to the more powerful actors.

Another set of factors affecting the use of evidence in health policy decisions is the quality or characteristics of evidence itself. The simplest classification of characteristics of robust evidence comprise three main criteria: *relevance* of evidence to what is sought to understand or decide, *representativeness* of evidence of the wider population and *reliability* or degree of well-founded nature, both theoretically and empirically (Solesbury, 2001). Although the quality of evidence may be perceived differently by the different actors involved in health policy processes, there are some common features of robust evidence cited in the literature: reliability, objectivity, credibility, generalisability, relevance, availability, rootedness and practical applicability. There is a clear overlap between criteria and a more detailed description of, and sources for, each concept is shown in Table 8.

Table 8: Characteristics of robust evidence for health policy processes

Based on: (Court et al., 2005; Shaxson, 2005; Solesbury, 2001; Spencer et al., 2003; Sutcliffe and Court, 2006)

Characteristic	Description
Accuracy	Degree to which the evidence correctly describes what it purports to
Reliability	This is often referred to as the ability to replicate the process from a methodological perspective. However Shaxson (2005) argues that, since policy processes are complex and cannot be exactly replicated, there is a need to deploy a narrower approach to reliability as appropriateness of evidence for monitoring, evaluation or impact assessments
Objectivity	This criterion refers to the degree of bias in the evidence. It is worth recognising, however, that there is no single objectivity in policy processes and the ostensibly unbiased nature of evidence may in reality be a reflection of either researcher(s) or key respondent(s)
Credibility	Credible evidence relies on a strong and clear line of argument, tried and tested analytical methods, analytical rigour throughout the processes of data collection and analysis, and on clear presentation of the conclusions
Generalisability or transferability	This refers to the applicability of evidence for similar decisions but in new contexts.
Relevance	Whether evidence is timely, topical and has policy implications
Availability	The existence of evidence for particular policy decisions at a given time

Characteristic	Description
Rootedness	The degree to which evidence is grounded in reality. This criterion is also described as being about more than context, process, bias and the quality of information. Rather, it is about understanding the nuance of the evidence, exploring assumptions with an open mind, encouraging others to question the status quo as it if interpreted, and thinking about who uses what evidence for what purpose
Practicalities	Whether policymakers have access to the evidence in a useful form and whether the policy implications of the research are feasible and affordable

It has to be noted, however, that the relative weighting of the above criteria for robust evidence depends on the characteristics, values and agendas of different actors. For example, objectivity of evidence may be key for civil society whereas reliability and methodological rigor may be seen as key by academia.

Policy decision support tools normally consist of a) evidence hierarchies about the quality of scientific evidence, b) decision principles such as principles of feasibility (technical, financial, organisational, social, cultural) or principles of equity, congruence with wider policies and c) stakeholder representation, which broadens perspectives and where discussion might focus on appropriateness and applicability of evidence locally, how to create buy-in and reach consensus on how, inter alia, to apply the evidence (CMPS, 2006; Sutcliffe and Court, 2006).

Processes of evidence generation and utilisation

Different processes/models of utilisation of evidence in health policy-making have been suggested ranging from rational models, which include systematic assessment of the strength of the evidence for its use in policy decisions. through to the models which completely ignore evidence in policy processes (Bowen and Zwi, 2005; Hanney et al., 2003). Trostle et al summarise those models in three main approaches (Trostle et al., 1999):

- the *rational approach* in which policy-makers identify the need for, and collaborate with researchers in generating, evidence for its use in health policies
- the *strategic approach* where policy-makers and researchers use evidence selectively to support or contradict certain policy directions thus prompting or delaying policy action
- the *enlightenment* or *diffusion approach*, in which interaction between research and policy takes place over a longer period of time where research results have better chances to be used in policy decisions.

About two decades earlier Weiss, considered as a pioneer of the main models of utilisation of research evidence in policy decisions (Almeida and Bascolo, 2006), suggested seven models, which broadly correspond to Trostle's three approaches: *knowledge-driven* and *problem solving models* (corresponding to the rational approaches)*; political* and *tactical models* (similar to the strategic approach) *and interactive, enlightenment and intellectual enterprise* (enlightenment or diffusion approach) (Weiss, 1979).

More recently, some authors have gone further and recommended, among others, the establishment of a closer collaboration mechanism between actors and increasing the transparency of the process (Lavis et al., 2008a). Two examples of a recognition of the need to improve use of evidence in health policy processes include the establishment of EVIPNet, the Evidence-Informed Policy Network which *"… arose from the Ministerial Summit on Health Research in Mexico City in 2004 and a resolution adopted by the 58th World Health Assembly in 2005*". (EVIPNet, 2008 p.1130) and the study of alignment of inputs of eight donors into national research systems in order to inform health policies in five African countries by the Council for Health Research and Development (COHRED, 2008).

Dobrow *et al* (2004) suggest a three-stage framework for the process of generating and using evidence for policy decisions:

1. *Introduction of evidence* – the means by which evidence is identified and the channels through which evidence is brought into the decision-making process;
2. *Interpretation of evidence* – a stage where evidence, after it has been introduced, is collated and assessed on its quality and generalisability for policy processes;
3. *Application of evidence* - where evidence, that has been introduced and interpreted earlier, is being applied to support or justify a policy decision.

This framework is similar to that suggested by Bowen and Zwi (2005) whose three-stage model comprises a) sourcing the evidence, b) using the evidence, and c) implementing the evidence. They termed this process as "*adopt, adapt, and act*". The time-consuming nature of an evidence-informed approach to health policy-making suggests that more efficient processes that are 'quick and clean enough' are needed to ensure the wider utilisation of evidence in health policy processes (Lavis et al., 2008b).

Much of the work done in the area of use of evidence in health policies has focused on the generation and utilisation of formal types of evidence and, in particular, different forms of research. A recent example is a series of 18 detailed tools to ensure evidence-informed

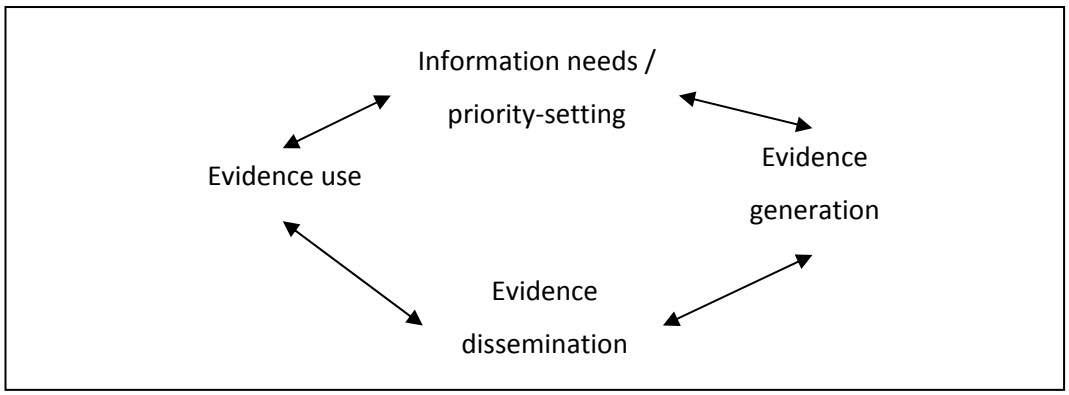
nature of health policies, drawing on three-stage evidence processes including identifying needs for research evidence, finding and assessing evidence and going from research evidence to decisions (Lavis et al., 2009). The research process itself comprises several consecutive stages including identification of research priorities, knowledge generation and dissemination, evidence filtration and amplification and its application in policy processes (Green and Gadsby, 2007).

Lastly, evaluating evidence for health policy decisions is not simple (Rychetnik et al., 2002). Health policy decisions are not value-free (Barker, 1996) and this suggests the possibility of different policy decisions emerging from the exposure of policy-makers to the same evidence. In fact, this argument is supported by the context-based nature of the evidence (Dobrow et al., 2004) and has been demonstrated by the use of evidence on use of alcohol in England (Marmot, 2004).

In this study a four-stage model of the use of evidence in health policy processes is used (see Figure 6), which largely follows the stages of the policy cycle and draws on literature.

Figure 6: Use of evidence in policy processes

Based on: (Bowen and Zwi, 2005; Dobrow et al., 2004)



It is recognised that the above evidence cycle may be repeated at each stage of health policy processes.

2.4.5 Leadership and governance arrangements

Leadership and governance represent an important element of MOH capacity to conduct the health policy processes. The term governance became popular in the 1990s but still remains somewhat intangible (Rhodes, 1996); recently it has been complemented by that of

stewardship (Saltman and Ferroussier-Davis, 2000; Travis et al., 2002). Governance in the literature

> *"… refers to the ways in which the organization is governed – in terms of both internal management systems (financing, personnel management, information management, etc.), as well as its management of external accountability through mechanisms such as boards.*" (Green and Gadsby, 2007 p.49)

Most literature-based definitions of governance are rather broad, similar to that proposed by Siddiqi et al who defined governance as "…*key determinant of economic growth, social advancement and overall development, as well as for the attainment of the Millennium Development Goals in low- and middle-income countries"* (Siddiqi et al., 2009 p.14). The term *Governance* is often used interchangeably with stewardship though some authors argue that governance is a better term and use this instead (Siddiqi et al., 2009). In simple terms *governance* can be defined as the process of making and implementing decisions in relation to health policy processes. Much literature on elements and principles of good governance exists outside the health system. For example, the European Commission in their Governance framework distinguish three dimensions of the governance concept, including *core governance issues* (rules, interests, resources and power), *governance principles* (participation, inclusion, transparency and accountability) and several *governance clusters* (EC, 2008 p.11). The World Bank distinguishes six *functions* of governance, including generation of intelligence, formulating strategic policy direction, ensuring tools for implementation: powers, incentives and sanctions, building coalitions/partnerships, ensuring a fit between policy objectives and organisational structure and culture and ensuring accountability (Kaufmann et al., 1999). These are similar to UNDP's 5 *principles* of good governance: legitimacy and voice, direction, performance, accountability, fairness (UNDP, 1997). However, the terminology in relation to composite elements or principles of governance is inconsistent, as illustrated in Box 1.

Box 1: Inconsistency of governance terminology – example of accountability

Accountability is a *function* in WB's model, is a *principle* in the UNDP framework and seem to overlap between *principles* and *clusters* in the EC framework. Accountability was also described as "…*the process through which an organisation makes a commitment to respond to and balance the needs of its diverse stakeholders in its decision making processes and activities, and delivers against this commitment*." (Lloyd et al., 2008 p.10)

The most detailed overview of governance principles and processes in relation to the health sector is provided by Siddiqi et al, which draws on various frameworks for stewardship and

governance by WHO, UNDP and WB and comprises ten aspects: strategic vision, participation and consensus orientation, rule of law, transparency, responsiveness, equity and inclusiveness, effectiveness and efficiency, accountability, intelligence and information, and ethics (Siddiqi et al., 2009).

Leadership is understood as "*… providing direction to, and gaining commitment from, partners and staff, facilitating change and achieving better health services through efficient, creative and responsible deployment of people and other resources*" (WHO, 2007a p.1) thus suggesting the need for both individual and organisational capacities. In simpler terms, leadership can be interpreted as government's oversight function (Beaglehole et al., 2004). Over 400 definitions of leadership are referred to in the literature (King and Cunningham, 1995). There are also numerous frameworks for understanding leadership styles and approaches. Examples of these include a four-way typology of leadership styles (see Figure 7), and theories such as great man theory, trait theory, situational theory and interactional theories (King and Cunningham, 1995).

Figure 7: Typology of state-owned enterprises

Source: (Goodwin, 2000 p.56)

		Low	High
Degree of political orientation	Low	Controversy-Minimiser	Commercial – Goals- Maximiser
	High	Political-Goals-Maximiser	Social-Welfare-Maximiser

Degree of Business Orientation

One framework of particular relevance to this study is based on the distinction between two broad leadership styles - transformational and transactional leadership (Aarons, 2006; Hater and Bass, 1988; Stordeur et al., 2000). *Transformational leadership* inspires and motivates followers, whereas *transactional leadership* is based more on reinforcement and exchanges (Aarons, 2006 p.1162).

Some authors further sub-divide the above leadership styles into their composite elements. For example, transactional leadership was thought to include three complementary aspects: active management by exception, passive management by exception, and contingent reward (Hater and Bass, 1988; Howell and Avolio, 1993). Through management by exception, leaders focus on mistakes, delaying decisions, or avoiding intervention until something has

gone wrong; and the primary distinction between active and passive management by exception is the timing of the leader's intervention (Stordeur et al., 2000). Through contingent reward, leaders reward (for example, through bonuses) their followers for accomplishing agreed-on objectives (Howell and Avolio, 1993).

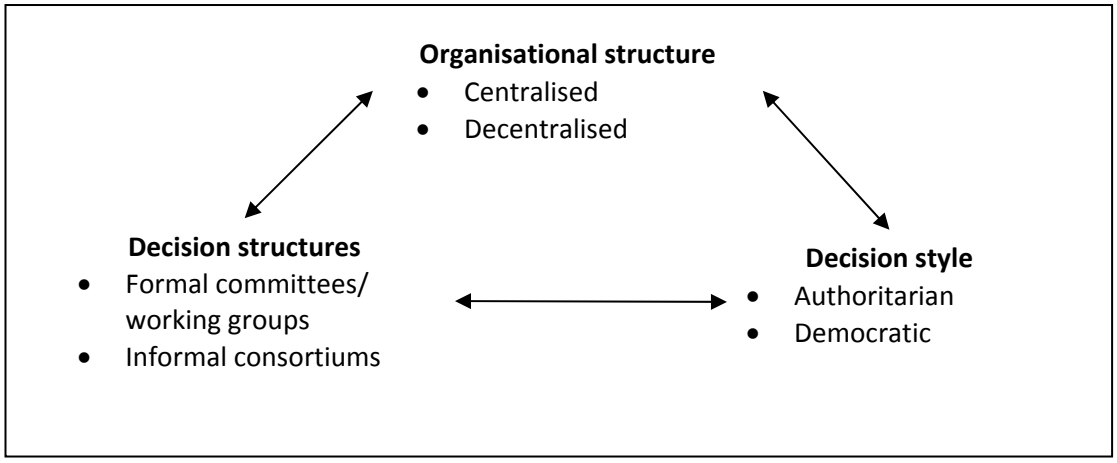
'Transformational' leaders are described as change agents who concern themselves with long-term objectives, and transmit a sense of mission (of an organisation or a system) to others (Dunham and Klafehn, 1990). These type of leaders "…*instil faith and respect (charisma), treat each employee as an individual (individualized consideration), arouse innovative ways of problem solving (intellectual stimulation), transmit their values and ethical principles (idealized influence), provide challenging goals and communicate a vision of the future (inspirational role)"* (Stordeur et al., 2000 p.38).

The issues shown in brackets in the above quote broadly correspond to Bass's, four categories of transformational leadership: charisma, inspiration, individualised consideration and intellectual stimulation (Bass, 1985) as well as the 'skills repertoire' of a good leader: powerful influential operator, strategic and reflexive thinker, knowledge developer and a process consultant (Antrobus and Kitson, 1999). The literature also acknowledges that the existence and the degree of application of the above skills are dependent on the wider contextual environment, as demonstrated by the case from the UK health service (Goodwin, 2000).

Leadership has been also described by some authors as one style of management (Green and Collins, 2006), which contributes further towards the fuzziness of the terminology that has been used in describing these concepts. The concept of health management, however, needs to be distinguished from that of leadership. Management can be defined as "*… a process of making decisions as to how resources will be generated, developed and used in pursuit of particular organisational objectives*" (Green and Collins, 2006). One way of distinguishing leadership from management is to draw a line between "…*the application of learning already in hand to address situations in which that learning is sufficient to meet the challenges*" in case of management and facing "…*adaptive challenges where new learning is required*" in case of leadership. (Edmonstone and Western, 2002).

As shown in Figure 8, governance and leadership in this study is interpreted as a combination of the three sub-elements, which are set out next.

Figure 8: Elements of governance and leadership



Organisational structures

Organisational structures in this study are interpreted as a reflection of the composition of the wider health system. In some frameworks, this element may be perceived as part of the wider context, but in this study this is seen as closely related to the governance arrangements that affect health policy processes.

Two distinct systems are recognised nowadays that represent the two ends of a continuum: *centralised* system with the strong command and control from the national level and *decentralised* system with empowered local levels where authority to make decisions or manage resources is at the local level (Collins, 1994). Authors distinguish different types of decentralisation, with the most common being devolution, deconcentration (functional or integrated) and delegation (Collins, 1994; Green and Collins, 2006). Pure centralised or decentralised models are rare with most health systems incorporating elements of both centralised and decentralised arrangements. Different types of decentralisation can co-exist within a single system thus contributing further to the complexity of organisational structures.

Decision structures

Decision structures in the current study are interpreted as formal or informal entities which are established in support of health policy decisions. Examples of formal decision structures include government committees, task forces for particular issues or working groups established in support of a particular initiative (Fryatt et al., 2010; Goodwin, 2000; Thomas and Gilson, 2004). The main distinction between formal and informal decision structures is that the former are established as part of mainstream policy decisions (normally by policy-

makers such as MOH) whereas informal structures affect policy decisions indirectly (for example, policy changes as a result of lobbying).

Informal decision structures may include networks established amongst narrow specialists in order to oppose the elements of the PHC strategy or regular feedback/update sessions between the key actors who are involved in policy processes.

Decision-making styles

The decision-making style refers to how decisions are generally made within society. This depends on the:

- type of political regime (authoritarian versus democratic),
- hierarchy of actors and degree of their involvement (for example participatory nature and transparency of policy decisions)
- composition of health system (such as level of decentralization),
- degree of integration of health policies within wider public sector policies (for example whether MOH is involved in developing Poverty Reduction Strategy Paper)
- other contextual factors (such as religion or culture), which directly or indirectly affect decision-making styles

Decision-making styles can also be seen as part of the wider context, for example, as part of governance in the public sector.

Different types of decision-making are known nowadays, which range from rational (similar to rational policy-making) evidence-informed decisions with widest possible participation through to status quo decision-making (following historical patterns). According to the literature, the characteristics of rational policy-making are: clear and transparent policy processes, adequate use of evidence, widest possible participation of actors and integrated nature of health policies (Peabody, 1996; Walt, 1994).

From the perspective of relationships between the different levels within the health system the decision-making styles could also be described as ranging from *inclusive* which involves widest consultation and best possible use of evidence to *centralised* where decisions are made by limited number of people/actors, normally at the central level.

There appears to be a link between organisational structures and decision-making styles. Decentralised systems have been described as allowing better responses to the local needs

through the enhanced participation of local actors (Collins, 1994; McIntyre and Klugman, 2003). In contrast, centralised systems permit little involvement of local actors in the centrally-made decisions. Ironically, the decision-making styles of different Central Asian Republics have been described as '*decentralised authoritarianism*' implying that in reality the authoritarian decision-making style has been decentralised to the periphery (Engvall, 2006).

2.4.6 Resources in support of health policy processes

There are different types of resources within the health system, which can be grouped in five broad categories: financial resources, human resources, supplies, transport and information (Green and Collins, 2006). Two types of resources are seen as affecting the policy-shaping role of the ministries of health in different European countries: the size of budget and staff numbers and skills (Greer, 2010; Mätzke, 2010).

Whereas the governance and leadership may be interpreted as the 'software' dimension of the technical capacity of the MOH, the resources and infrastructure are the 'hardware' component of the government's capacity. There is always a need to achieve an optimal balance between these two dimensions of capacity recognising that none of the elements operates in isolation. In fact, many developing countries over-emphasise the importance of 'hardware' components of capacity, thus undermining the significance of 'software' elements in the health reforms (Mirzoev et al., 2007).

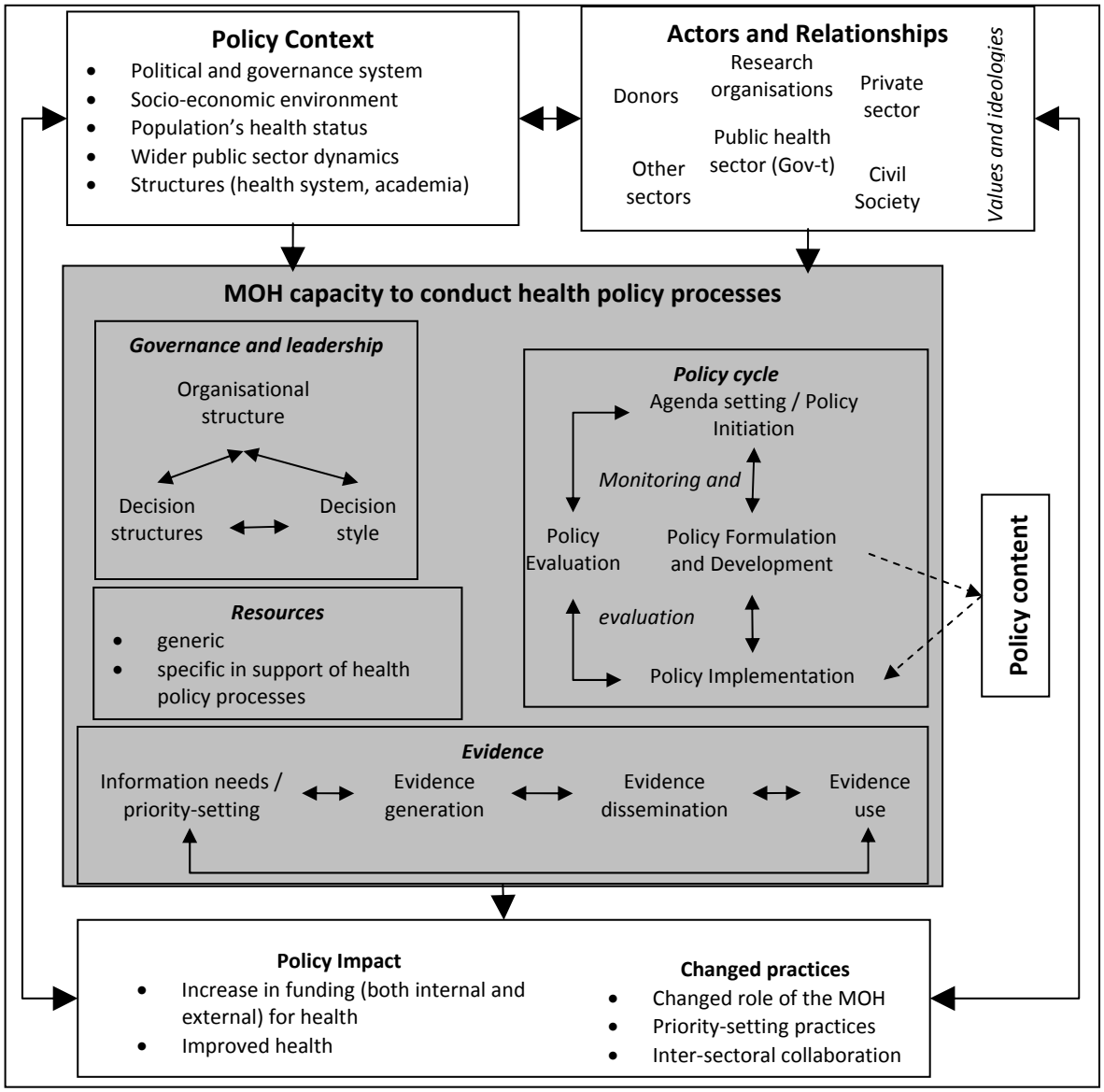
The resource framework affects both development and implementation of heath policies. In many transitional countries resource levels depend largely on volumes of external aid (Bodart et al., 2001; Jeppsson, 2002; Peters and Chao, 1998; Ulikpan et al., 2008) which, in turn, is dependent on the processes and contents of national health policies.

In this study two types of resources are distinguished: *generic resources* (such as the overall health budget, human resources in the health system, infrastructure) and specific resources aligned *in support of health policy processes* (for example, targeted funding for policy-related meetings, staff skills in policy analysis). The former are outside the scope of this study; examples of the latter also include permanent entities/units such as the HPAU, or expertise from internationally-funded WB Health Sector Reviews or individual consultancies.

2.4.7 Conceptual framework for assessment of MOH capacity to conduct health policy processes

Figure 9 provides a diagrammatic representation of the study conceptual framework.

Figure 9: Conceptual framework of MOH capacity to conduct health policy processes



The framework particularly draws on Walt and Gilson's policy triangle comprising health policy processes, actors, context and contents (Walt and Gilson, 1994). The conceptual framework distinguished between its different components, elements of MOH capacity and characteristics of robust health policy processes, as shown in Box 2.

Box 2: Components, elements and characteristics in the conceptual framework

The following five main ***components of the conceptual framework*** are distinguished.

- The *MOH capacity to conduct health policy processes,* shown as the shaded area in Figure 9, is the primary focus of the study.
- Different roles and interrelationships of *policy actors* in health policy processes affect MOH capacity to ensure the inclusive nature of health policy processes.
- All above occurs within the wider *policy context.*
- *Policy contents* or different policy documents are a result of the policy development stage and guide the implementation of policies; exploring these is outside the scope of the current study.
- The *results* of application of MOH capacity include policy impact and changed practices. Although parts of the latter are an implicit part of the study (as an indication of changes in MOH capacity), the study does not aim to explore policy impact in detail.

The *MOH capacity* component of conceptual framework comprises four ***elements of MOH capacity***:

- recognition of policy cycle or different stages of policy processes,
- use of evidence,
- ensuring good governance and effective leadership, and
- establishing and effectively using resources in support of policy processes.

The six ***characteristics of robust health policy processes****,* identified in section 2.2.2, are implicit and provide the background for assessing MOH capacity to ensure robust health policy processes in RT

The first three components (MOH capacity, actors and context) are included in this study. The MOH capacity to conduct health policy processes comprises four elements and different sub-elements are distinguished in relation to governance and leadership. The capacity dimensions of each component, element and sub-element are explored in the study as a way of addressing specific study objectives (see 1.4), as shown in Table 9.

Table 9: Capacity dimensions of components and (sub)elements of the framework

Component	Element	Sub-element	Capacity dimension	Study objective
MOH capacity to conduct health policy processes	Policy cycle		MOH capacity to recognise and manage different stages of health policy processes. Implicit in this is MOH capacity to ensure characteristics of robust policy processes	Objectives 1 and 2
	Use of evidence		MOH capacity to ensure the evidence-informed nature of health policy processes, through recognition of different stages of evidence processes and managing actors' involvement in generating and disseminating evidence	Objectives 1 and 5

Component	Element	Sub-element	Capacity dimension	Study objective
	Governance and leadership	Organisational structures	MOH capacity to take into account existing, or to change, organisational structures within the health system to ensure robust health policy processes.	Objectives 1 and 6
		Decision structures	MOH capacity to ensure availability of effectively-functioning decision structures in leading and governing health policy processes	Objectives 1 and 6
		Decision styles	MOH capacity to adapt decision-making style in order to ensure robust policy processes	Objectives 1 and 6
	Resources		MOH capacity to establish and effectively use resources in support of health policy processes	Objectives 1 and 7
Policy actors			MOH capacity to effectively communicate with, and manage involvement of, different actors in order to ensure the participatory nature of health policy processes	Objectives 1 and 4
Policy context			MOH capacity to take into account the wider contextual framework in health policy processes.	Objectives 1 and 3

Four issues need emphasising in relation to the conceptual framework. *Firstly,* although MOH capacity is shown as primarily comprising four main elements, it also comprises the MOH capacity to consider, in health policy processes, the wider contextual environment and to recognise and manage involvement of different policy actors.

Secondly, the four *elements of* MOH capacity to conduct health policy processes may be interpreted as *factors affecting the* MOH capacity. For example, MOH capacity comprises ability to establish and effectively use available resources and, at the same time, the resource framework affects MOH capacity.

Thirdly, the distinction between the different components may be blurred as the same issues may migrate from one component to another. For example, the policy document (*content*) once approved may be perceived as part of the wider *context*; some international actors can be perceived to represent part of the *context* and inevitably affect *processes.*

Lastly, as discussed earlier, the different components are engaged in a complex interplay. For example, involvement of actors determines the shape of the different stages of health policy processes as well as the different stages of evidence processes.

2.5 Conclusion

This Chapter developed a conceptual framework for assessing MOH capacity to conduct health policy processes, drawing on the available literature on policy analysis and capacity. The following components of the conceptual framework are distinguished: MOH capacity to conduct health policy processes (comprising elements of policy cycle, evidence, leadership and governance and resources), actors, context, contents and results. The capacity dimensions of the first three components (MOH capacity, actors and context) are explored in this study.

The elements of MOH capacity, being the key *areas of* MOH capacity to conduct health policy processes, may also be interpreted as *factors affecting* MOH capacity. The distinction between different components is blurred and interrelationships exist between different components and elements.

Next Chapter sets out the study methodology.

3 STUDY METHODOLOGY

3.1 Introduction

Although there have been little guidance in the past as to *how* to perform policy analysis, and what theories, research methodologies and frameworks best inform health policy-related research (Walt et al., 2008), this body of knowledge is growing. Authors increasingly address the practicalities of conducting policy research through exploring individual elements of health policies in conceptual frameworks (Exworthy, 2008; Walt et al., 2008). Example of these elements include assessing policy processes (Sutcliffe and Court, 2006; Sutton, 1999) or different actors and their power (Erasmus and Gilson, 2008; Tantivess and Walt, 2008; Walt, 1994). This Chapter provides the details of the study methodology, including the author's reflection on the data collection and analysis and the study limitations.

It starts with an overview of the broad methodological framework for the study, drawing on literature-based methodological considerations in conducting health policy-related research and assessing capacity. This will be followed by an overview of the study design, including detailed descriptions of data collection and analysis and the main considerations applied in summarising the findings. The Chapter concludes by reflecting on the methodology, including the study strengths and limitations.

3.2 Broad methodological framework for the study

This section provides an overview of the literature on the methodological considerations in conducting health policy research and assessing capacity, as a background for summary of broad study design.

3.2.1 Key methodological considerations in policy-related research

Little methodological guidance exists for analysis of health policy processes, possibly due to the applicability of most methodological considerations of broader policy analysis to analysis of health policy processes. Gilson and Raphaely suggest that health policy analysis is often ad hoc with the assumptions on which it is grounded rarely identified clearly (Gilson and Raphaely, 2008). This may be attributed to the dynamic nature of the policy environment and the complex nature of the policy itself (Tantivess and Walt, 2008), resulting in methodological difficulties associated with, for example, capturing the power dynamics between different actors (Walt et al., 2008).

Most health policy studies have focused on retrospective assessment of various aspects of health policies (Gilson and Raphaely, 2008). The alternative, prospective policy analysis, remains under-explored in the academic literature, not least because of the complexity of the nature of policies and the need for involvement of researchers as part of the on-going policy (Buse, 2008).

The literature suggests that policy decisions may not take place at a particular point of time but can develop over lengthy periods of several months and even years (Exworthy, 2008; Walt et al., 2008), which makes such decisions particularly difficult to unpack and understand within what is frequently time-restricted research. Some authors suggest a decade or more as a minimum of most policy cycles, from agenda-setting through to any visible impact and policy evaluation (Sabatier, 2007) although 'short horizon' studies may be more appropriate for fast-paced policies (Walt et al., 2008).

A case study approach has been suggested as one way of identifying a clear focus in studying health policies assuming that such case studies may reflect the wider health policy processes (Bird et al., 2007; Grbich, 1999; Macintyre et al., 2001). However case studies may not always be easily identifiable at the inception of the research and may be (re-)constructed during the course of the policy analysis as the different characteristics of health policies are revealed. Furthermore, generalisations are not always possible from a limited number of case studies unless the number of cases is increased which is often not feasible in policy research (Walt et al., 2008). Therefore, the case study approach was not used in this study.

The value of comparisons of health policy processes cannot be over-estimated. For example, cross-country comparisons can be based either on similar or different case studies, and have a potential to help researchers in understanding the messages from individual country contexts (Lee et al., 1998; Leeds HEPVIC team, 2009; Walt et al., 2008). For example, a cross-country study of family planning policies found that the formation of coalitions among policy elites, spread of policy risk, and institutional and financial stability had important effects on the adoption of strong population policies (Lee et al., 1998). However, cross-country comparisons require more resources and are done best in similar contexts; both being reasons for not considering cross-country comparison in this study.

One important policy research challenge is gaining access to the organisations and individuals who are in power; this can be difficult for researchers (Exworthy, 2008). Furthermore, when researchers *are* able to gain access to policy-makers they often face the dilemma of

maintaining a balance between independence and either desire or need to engage with the study subject(s) (Walt et al., 2008). Being an 'insider' means easier access, ability to ask more complex and sensitive questions and understand non-verbal clues and thus develop more holistic and context-grounded findings (Merriam et al., 2001) but insiders may be accused of being inherently biased. Buse suggests some advantages of involvement of policy actors, such as advocacy coalitions, in policy analysis, which can provide a) researchers with a better understanding of the processes and relative roles of different actors and b) the advocates with a better knowledge base to define their involvement in the policy processes (Buse, 2008). On the other hand, 'outsiders' are particularly useful for persuading the respondents to expand on fuller explanations than they may otherwise feel as appropriate (Walt et al., 2008) and may be particularly useful for interviewing senior policy-makers in cross-country policy research. Resulting from this, Walt et al call for "*greater reflexivity on the part of researchers, that involves an analysis of their own institutional power*." (Walt et al., 2008 p.315).

Conventional qualitative data collection methods such as observations, documentary analysis, focus groups and in-depth interviews seem to be applicable to health policy analysis. Building rapport and gaining trust from respondents before embarking into more controversial issues that policy actors may find threatening is also key (Gaskell, 2002). Documents may also provide important clues on the policy discourses, involvement and relative powers of different actors in the policy processes (Babbie and Mouton, 2001). Meeting minutes, official memoranda and government correspondence can be especially helpful in defining the positions, roles and resources of different networks of actors as shown by the study of antiretroviral policy in Thailand (Tantivess and Walt, 2008). However, due to the sensitive nature of health policies, the above methods need to be adapted to suit the policy environment. Issues such as the ethical considerations in observations and interviews are important and are fundamental in good quality policy research (Erasmus and Gilson, 2008).

Lastly, there are some policy-specific methodological tools and techniques. For example, in the late 1990s, a software package was developed for policy analysis and use by those involved in health reforms to understand better the influences, values and positions of different actors in the policy processes (Buse, 2008; Reich and Cooper, 2001). Techniques such as stakeholder analysis also exist to support the assessment of roles of actors in policy processes (Brugha and Varvasovszky, 2000). However, the complexity and context-specificity of health policy-making, the changing involvement of actors at different stages of health

policy processes and the addition of the dimension of capacity, revealed the need for significant adaptation of above tools in this study.

3.2.2 Key methodological considerations in assessing capacity

Assessing or measuring capacity has received increasing attention during the last decade (Brown et al., 2001; Development Assistance Committee, 2006; UNDP, 2006). Close to thirty different tools can be distinguished in the literature focusing on capacity assessment (see Appendix 1), which can be described as follows:

- *Self-assessment tools versus tools for external assessment.* Most tools for capacity assessment rely on self-assessment, despite the arguments in the literature that external assessment are more reliable (Brown et al., 2001).
- *Tools for assessing different levels of capacity (individual, organisational, system).* Most tools appear to focus on organisational capacity and few focus on capacity of individuals or the whole system.
- *Quantitative versus qualitative methods of assessment.* The majority of tools appear to deploy quantitative methods of assessment with less focus on qualitative methods.

Many tools which focus on organisational capacity include assessment of capacity in various areas such as financial and technical management or use of evidence in decision-making (Brown et al., 2001; Gonzalez Block and Mills, 2003; Green and Bennett, 2007; Pappaioanou et al., 2003). Furthermore, some tools for assessing or mapping capacity have been proposed as part of initiatives to monitor and evaluate capacity development (LaFond and Brown, 2003).

Some authors propose specific attributes of capacity as a way of recognising some of the challenges in assessing capacity at different levels. Examples of these attributes include interpretation of capacity in terms of specific organisational objectives, the dynamic and multidimensional nature of capacity at different levels and context-specificity of understanding of capacity (LaFond and Brown, 2003). The balance of ability-willingness and the interrelationships between the different levels represent other important methodological considerations in assessing capacity.

The understanding of the concept of capacity of an organisation also needs to take account of the stage of organisation's development (such as nascent, emerging and mature stage (MSH, 1996)), which comprises both development of individual staff members and

organisation as a whole (Brown et al., 2001). This suggests that the concept of organisation's capacity comprises both capacity of its individuals and organisation as a whole.

The issue of benchmarks and criteria for assessing capacity has also received attention in the literature, as shown by the numerous quantitative tools for measuring capacity (see Appendix 1). There is, however, a recognition that there is no agreed set of standard indicators for measuring capacity (LaFond and Brown, 2003), not least because of the dynamic nature and context-specificity of capacity.

The assessment of capacity in relation to health policy processes adds further complexity to the methodology, with three broad considerations. Firstly, it is important to identify explicitly the level of capacity being assessed, i.e. whether it is individual, organisational/institutional or systems. As argued earlier, the three broad levels are related to each other (for example, organisational capacity includes combinations of capacity of individuals), therefore, combinations of the above levels may also need to be identified. Secondly, it is helpful to have an explicit area of application of capacity with clear criteria or characteristics allowing the assessment of capacity. The characteristics of robust health policy processes (see 2.2.2) provide this opportunity. Lastly, the balance between ability and willingness in understanding the concept of capacity needs to be taken into account when addressing complex topics such as health policy processes.

The concept of iterative mapping of capacity, proposed to monitor and evaluate capacity strengthening initiatives (LaFond and Brown, 2003), appears to be relevant to this study. It relies on identification of findings in relation to each level (such as organisational and individual) and stage of capacity (such as inputs and processes). The disadvantages of this approach include the fact that it does not explicitly recognise the hierarchy of capacity elements from the capacity pyramid (Potter and Brough, 2004). Furthermore some indicators proposed for the different stages of organisational capacity are measured in simple 'yes' or 'no' format with little consideration as to whether these areas are good or need further improvement. For example, indicators such as 'existence of mission statement' or 'presence of coordination with other organisations' provide little scope for assessing whether the mission statement is consistent with the practice of an organisation or whether coordination mechanisms are effective. This study attempts to overcome these challenges through the development of a conceptual framework which incorporates characteristics of robust health policy processes alongside capacity.

3.2.3 Broad study design

There are two broadly different approaches to research: qualitative and quantitative studies. The differences in the underlying theories of, and anticipated outputs from, these approaches are summarised in Table 10 though it is recognised that the distinction between the two is often conceptual (for example, quantitative studies can also classify phenomena) thus leading to the existence of mixed methods comprising elements of both qualitative and quantitative research.

Table 10: Comparison of qualitative and quantitative research

Adapted from: (Greenhalgh and Taylor, 1997)

Comparator	Qualitative research	Quantitative research
Social theory	Action	Structure
Question	What is X? (classification)	How many Xs? (enumeration)
Examples of methods	Observation, interview	Experiment, survey
Sampling method	Theoretical	Statistical
Strength	Validity	Reliability

Qualitative techniques are flexible and innovative. They offer a good opportunity to study the complex interrelationships between the concepts of capacity and health policy processes. On the other hand, quantitative techniques may be more appropriate for exploring policy contents, for example assessing the impact of policies on health indicators.

Whereas "*…quantitative researcher might seek to know what percentage of people do one thing or another the qualitative researcher pays much greater attention to individual cases and the human understandings that feature in those cases*" (Schostak, 1995). The enumeration-based primary questions behind quantitative research are appropriate to cover larger samples with high a degree of probability whereas qualitative studies tend to have smaller samples but attempt to develop deeper understanding of fewer cases.

Policy analysis is a complex subject which requires a deeper understanding of the issues; and this is best done through qualitative research techniques (Greenhalgh and Taylor, 1997). Furthermore, everyday experiences are particularly important for studying policy processes (Flick, 2006), which is best explored through qualitative techniques.

Whereas quantitative techniques often use standard tools (such as survey questionnaires) to collect statistical data, the interaction between the researcher and objects of the study is considered a key element of qualitative enquiry. The answers to 'why' questions from

qualitative research, although time-consuming and less generalisable, allow deeper understanding of the reasons behind various issues (for example, policy decisions), rather than merely reflecting on patterns and numbers of those decisions.

Based on the above considerations, the study research questions (see 1.4) were addressed through a qualitative study.

The primary focus of the study was the MOH capacity to conduct health policy processes in RT. Other levels of the health system were however included to understand the MOH capacity, for example, in relation to involvement of different actors in policy processes or generation and dissemination of evidence to inform health policy processes.

The study covered changes in MOH capacity during the period since RT's independence (1991) until the time of the data collection (August 2008). Although this was primarily a retrospective study, observation of some ongoing policy events was included as part of the data collection, to aid the understanding of the current MOH capacity.

The next two sections set out the details of data collection and analysis methods used, which is followed by a summary of specific study methodological considerations.

3.3 Data collection methods

At the core of robust qualitative research is a continuous dialogue between tradition and innovation, ideas and observations, theory and data, and interpretation and action (Ezzy, 2002). This suggests that there should be more than one data collection method allowing different insights to the study.

There are six common data collection methods applicable to policy research, shown in Box 3.

Box 3: Six common data collection methods in policy-related research

Based on: (Britten, 1995; Brugha and Varvasovszky, 2000; Flick, 2006; Grbich, 1999; Greenhalgh and Taylor, 1997)

1. *Document reviews* — study of documentary accounts of events, such as meetings or policy documents, which contain information on policy processes
2. *Observation* – observing the dynamics of policy events. This has two forms depending on whether researcher(s) intervene with policy processes or not:
    a. *Passive observation*—Systematic watching of behaviour and talk in natural occurring settings
    b. *Active observation*—Observation in which the researcher also occupies a role or part as a participant of the process in the setting, in addition to observing
3. *Narratives* – eliciting a complete story from the respondent which covers different aspects of health policy in a narrative format
4. *Stakeholder analysis* – maps out potential actors in policy processes and assesses their position in relation to the policy issue as well as other actors
5. *Interviews* — discussions face-to-face with the purpose of exploring issues or topics in detail. Interviews could be structures (such as questionnaires) and unstructured (similar to narratives) with semi-structures interviews (SSIs) being between the two.
6. *Focus groups* — group interview which explicitly includes and uses group interaction and behaviour to generate data

A combination of the following three data collection methods were identified as most appropriate for this study, given the research questions and based on the considerations discussed in relation to each method later in this Chapter (see 3.3.2-3.3.4):

1. In-depth semi-structured interviews with key informants (n=37);
2. Review of existing documents (n=58);
3. Observation of policy events such as policy-related meetings (n=2).

Furthermore, a simple variation of stakeholder analysis, using existing documents and author's experience of being involved in health policy processes in RT, was performed to identify the study respondents.

The use of (written) narratives was discarded because of the low probability of respondents (many of whom are busy high-level policy-makers) filling their 'stories' and the perceived complexity of the topic requiring probing and prompting of respondents.

The possibility of conducting 1-2 focus groups was explored at later stages of the data collection (i.e. after about half of the in-depth semi-structured interviews were conducted) in order to explore the interaction (for example, power relationships) between health policy actors. However it was rejected due to respondents' preferences for individual interviews.

The next four sub-sections provide details on the sampling and inclusion criteria and provide details of each of the data collection methods used in this study.

3.3.1 Sampling and inclusion criteria

Convenience or purposive sampling – one of the distinctive characteristics of qualitative research (Miller and Alvarado, 2005) – was applied to identify respondents, documents and policy events. The choice of convenience sampling is justified by the limited number of key policy actors involved in health policy processes as well as the limited number of key documents or outputs of national-level health policy processes.

The choice of respondents, documents and events in the current study was guided to allow a) identification of different perspectives and views of MOH capacity (for example, different types and levels of respondents) and b) current and past experiences of actors' involvement in health policy processes in RT.

The initial list of respondents was developed using a simple stakeholder analysis. It was recognised that due to the incremental nature of the development of some policies (detailed implementation strategies are being developed several years after some health policy documents), the composition of actors, the shape of policy events and even the nature of policy outputs/documents are changing. To address this, a snowballing technique was used to continuously identify further key respondents, documents and policy events that may be relevant to the study.

3.3.2 Semi-structured interviews with key informants

By definition, interviews are aimed at obtaining in-depth information on a particular issue from a single individual (Greenhalgh and Taylor, 1997). Interviews could be structured and unstructured with semi-structured interviews (SSIs) being in the middle of the continuum (Britten, 1995). SSIs were used in the study, representing a series of open-ended questions around the main components of the conceptual framework.

SSIs were the primary data collection method with 37 interviews in the study. An initial list of respondents was developed, following mapping of the main policy actors in RT, to guide the initial stages of the study (see Appendix 2 for initial and final lists of respondents). A snowballing technique was used to identify further respondents during the data collection.

Informed consent was obtained verbally in the beginning of each interview, following the format shown in Appendix 3. No signatures were sought from the respondents on the informed consent because there was a sense that this would have formalised the interview to the point where agreement was difficult to obtain from most respondents. Four different types of questions were used in combination in each interview (see Table 11)

Table 11: Different types of questions in an interview

Adapted from: (Stanfield, 2000)

Types of questions	Purpose	Example
Objective	Begin with data, facts, external reality	"What did you actually see, hear or read?"
Reflective	Evoke immediate personal reactions, internal responses, sometimes emotions or feelings, hidden images, and associations with the facts	"What was your reaction?"
Interpretive	Draw out meaning, values, significance, implications	"What new insight did you get from this?"
Decisional	Bring the conversation to a close, eliciting resolution and proposing a decision about the future	"What do you think should be done?"

All interviews lasted 1-1.5 hours, were audio-recorded and transcribed by the author. The respondents' identities were removed from the transcripts to preserve anonymity. Instead, the transcripts were coded by the types of respondents and the key was stored separately from the transcripts. Only the author had access to the key for coded data. The transcripts were stored in accordance with the code of conduct in relation to research at the University of Leeds.

A generic SSI guide was developed covering the key content and process-related issues for the SSIs (an example is provided in Appendix 4). Prior to each interview the generic guide was revisited, to identify the key areas applicable for the particular type and level of the respondent.

Box 4 summarises the different types of study respondents, which guided the analysis and presentation of findings from SSIs.

Box 4: Different types of study respondents

1. A distinction was made between *national* and *international* policy actors.
2. The term "*national policy actors"* used in this document refers to the government and non-government policy actors which are originally from the RT.
3. The term "*national-level policy actors"* refers to the policy actors which were involved at the national (country) level in the RT.
4. The views of MOH (current and former officials) were distinguished from other national policy actors.
5. The distinction was made amongst the following international policy actors, as their views and roles differed:
   a. *Donors*, for example parts of the foreign Embassies in the RT such as DFID.
   b. Development Agencies which included UN organisations (WHO, UNICEF)
   c. International Agencies which included International NGOs and various Project Implementation Units for internationally-funded projects.
6. A distinction was made between national and expatriate staff within both national and international policy actors.

3.3.3 Document reviews

Document reviews have particular strengths that are not captured in other qualitative research methods, which provided the rationale for their inclusion in the study. *Firstly*, unlike speech and action, documents persist beyond the local context of their production (Miller and Alvarado, 2005). As documents are produced before the research, they are unaffected or un-reactive to the research process. *Secondly*, documents can provide information which is simply not available in other forms (Abbott et al., 2004) and may also contribute to understanding the characteristics of the document's producers (such as knowledge, interests) as well as processes involved in developing the document.

The documents reviewed in this study included published and unpublished documents. Examples of published documents are formal policy statements, regulatory documents from the MOH and other parts of the RT's Government (for example laws, government decrees and MOH orders). The unpublished documents included project/consultancy reports and other grey literature of relevance to the MOH capacity.

Two broad approaches are suggested for documentary analysis, including *content analysis*, which focuses on the document itself and *context analysis*, which views the document as a reflection of the wider contextual environment (Atkinson et al., 2001). Miller and Alvarado (2005) also suggest a third approach, analysis of documents as *social actors*. Since this study did not include analysis of policy contents, content analysis was not used in analysis of documents. The context analysis represented particular relevance to, and was mainly used in, this study. The documents were reviewed with a view to identify explicit and implicit

interests and ideology of policy actors (Abbott et al., 2004) as well as their position in, and reflection of, health policy processes.

The documents were identified and reviewed continuously throughout the whole research process. For example, different documents were available for review before the period of in-country data collection (July-August 2008) and during each interview the respondent was asked to recommend any further key documents of relevance to the project.

3.3.4 Observation of policy events

Observation of policy events can provide useful insights into the current interactions between the different actors, for example, at a meeting. This study, being mostly retrospective, used observation to a limited extent, mainly to compare and contrast findings from the interviews and document reviews.

Observation relies heavily on the personal experiences of the researcher and may include both passive and active methods of observation (see 3.3). However, the extent of researchers' participation in policy events can be perceived as a continuum with different options available between the above two extremes (Genzuk, 2003). Although preference was given to passive observation of policy events, in reality various attempts made by former colleagues from the MOH to engage the author in the discussion (for example, through asking opinion) made complete passive participation unfeasible.

The three methodological principles, described as key elements in conducting observation in qualitative research (Genzuk, 2003), were considered in planning and conducting the observation:

- *Naturalism*, which refers to the necessity of blending with the background and not disrupting the natural dynamics of the particular event
- *Understanding* refers to the ability of the researcher to follow the flow of the event, for example use of specific terminology and roles of actors.
- *Discovery* refers to the idea of inductive or discovery-based research. In the context of this study this means the ability of an observer to derive messages that may contribute towards research question, an assessment of the capacity in health policy processes

Two policy events were observed as part of the data collection: 1) a monthly review meeting (collegium) within MOH with participation of sub-national health authorities and other relevant policy actors and 2) a monthly health coordination meeting organised by the MOH

with WHO support. Verbal permissions to observe these events were obtained from the organisers (deputy minister of health in case of collegium and MOH reforms department in case of monthly coordination meeting).

Two broad methodological issues, recommended for researchers observing a policy event, provided the basis for the proforma developed for summarising the notes from the observation (see Appendix 5):

1. the "physical" structure of the observed event, that is, what happens in space and time, the characters, the scenes, the plot.
2. the "meaningful" structure of the policy event, i.e. the themes, motives, underpinning values and ideologies, images, metaphors, the emotional movement. (Boeree, 1998):

The observed events were not audio-recorded. During the observation a diary of notes were kept. The notes also included reflection on the experience after the event. The observation notes were not analysed separately and were used to triangulate the findings from other methods (SSIs and documentary reviews). The minutes of the monthly coordination meeting were obtained and were included in document review.

The next section provides a description of the approach and methods for, data analysis.

3.4 Data analysis

Data analysis is *"…most complex and mysterious of all of the phases of a qualitative project, and the one that receives the least thoughtful discussion in the literature"* (Thorne, 2000). This section provides the details of the approach for the data analysis, drawing on existing experiences from the literature.

3.4.1 Underlying theories of qualitative data analysis

Analysis of qualitative data can and should be done using explicit, systematic, and reproducible methods (Greenhalgh and Taylor, 1997). The aims of qualitative analysis can be four-fold (Green, 2005):

1. Describe complex phenomena and develop conceptual definitions
2. Develop explanations of why phenomena occur
3. To find logical associations through comparing patterns in the data
4. Describe classifications and develop new ideas and theories

However, material collected through the qualitative research is often described as unstructured and unwieldly (Flick, 2006; Ritchie and Spencer, 1994). This means that the role of the researcher in the process comprises a variety of functions including the need to provide coherence and structure to the dataset while retaining a hold on the original ideas, accounts and observations. Six functions of qualitative research are distinguished in the literature, as shown in Table 12.

Table 12: Functions of qualitative research

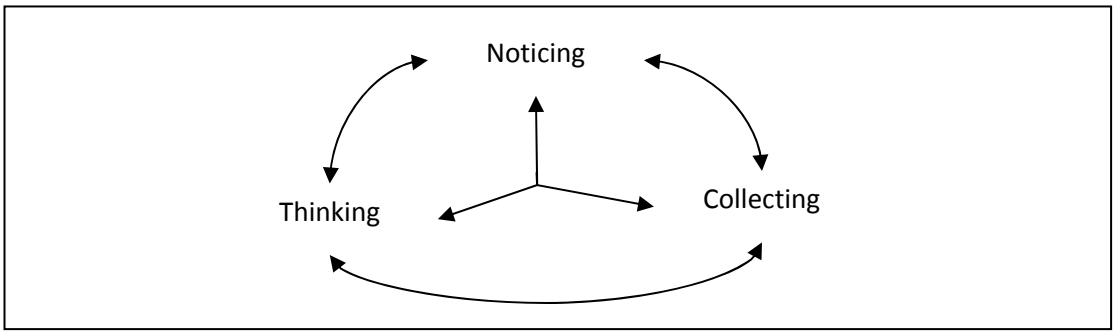
Based on: (Ritchie and Spencer, 1994)

Function	Key aspects
Defining concepts	Understanding internal structures within the datasets
Mapping	Identification of the range, nature and dynamics of phenomena
Creating typologies	Categorising different types of attitudes, behaviours, motivations
Finding associations	Between experiences and attitudes, between attitudes and behaviours, between circumstances and motivations
Seeking explanations	Explicit or implicit between the associations
Refining framework	Developing new ideas, theories or strategies

The process of qualitative data analysis involves three broad elements: noticing, collecting and thinking (Figure 10).

Figure 10: Elements of qualitative data analysis

Adapted from: (Seidel, 1998)



However, the process is not a simple combination of three steps resulting in writing a research report and the following characteristics are typical of any qualitative data analysis (Seidel, 1998):

- *Iterative and progressive* – various iterations of the three steps result in the cycle being repeated on regular basis during the data analysis. For example, the thinking process often results in noticing further aspects in the data and, potentially further data collection. In theory, the process may be an infinite spiral

- *Recursive* – any step of the cycle can recall researchers to a previous step. For example, the data collection may result in researchers noticing further aspects and thus contribute towards further/additional data collection.
- *Holographic* – the process is holographic in that each step in the process contains the entire process. For example, the process of noticing some aspects may result in researchers mentally collecting and thinking about those aspects.

It is important to distinguish inductive from deductive inquiry processes in qualitative analysis. Generally, inductive reasoning uses the data to generate ideas (hypothesis generating), whereas deductive reasoning begins with the idea and uses the data to confirm or negate the idea (hypothesis testing) (Thorne, 2000). The deductive approach could be interpreted as a move from a general framework to specific cases whereas induction is a journey from specific examples to a generic framework (Ezzy, 2002). The two approaches can be interrelated (Bird et al., 2007). One example of this might be when a study starts with the conceptual framework and pre-set hypotheses (deductive processes) whereas allowing the possibility of generation of further research hypotheses/questions from the data itself (inductive approach). Some authors also distinguish an abductive approach to qualitative inquiry which is sometimes reported as a combination of elements of the former two (Frankfurt, 1958). Ezzy (2002) referred to abduction as having "*produced a form of synthetic knowledge that introduced new ideas through the generation of new hypotheses".* A combination of inductive and deductive approaches was found useful for this study.

The major approaches for qualitative data analysis (QDA) can be categorised into five groups as shown in Table 13.

Table 13: Main approaches for qualitative data analysis

Adapted from: (Thorne, 2000):

Approach	Description
Constant comparative analysis	Originally developed for use in the grounded theory methodology of Glaser and Strauss (1967), this strategy involves taking one piece of data (interview, statement or theme) and comparing it with all others that may be similar or different in order to develop conceptualisations of the possible relations between pieces of data
Phenomenological approaches	There are numerous forms of phenomenological research; however, many of the most popular approaches derive from modes of awareness (epistemology) and the modes of being (ontology). As such this type is of limited use in policy research.
Ethnographic methods	Ethnographic research methods derive from anthropology's tradition of interpreting the processes and products of cultural

Approach	Description
	behaviour. In theory some elements of this method might appropriate in combination with various forms of observation for the policy research.
Narrative analysis	Narrative analysis is a strategy that recognises the extent to which the stories we tell provide insights about one's experiences. Depending on the preference of some respondents the unstructured interviews may be considered as an option with particular application of narrative policy analysis.
Discourse analysis	By contrast with narrative analysis it recognises speech not as a direct representation of human experience, but as a reflection of numerous social or ideological influences. This may particularly be useful in focus groups or during observation.

The above approaches are not mutually exclusive; for example elements of constant comparison may exist as part of ethnographic studies and discourse analysis. A combination of elements from the last two approaches (narrative analysis and discourse analysis) was used in the study in the application of framework approach (see 3.4.3). More specifically, In-depth semi-structured interviews included some elements of both these approaches and elements of discourse analysis were used to analyse data from observations.

3.4.2 Framework Approach

A *framework approach* was considered as the most appropriate for this study, based on its key features allowing both application of an existing framework and inclusion of further emerging themes from the data (see Table 14), in contrast with grounded theory which is based exclusively on principles of inductive inquiry (Ezzy, 2002; Glaser and Strauss, 1967).

Table 14: Key features of the framework approach

Based on: (Ritchie and Spencer, 1994)

Feature	Brief notes
Grounded or generative	It is based in, and driven by, the original accounts and observations of the people it is about
Dynamic	Open to change, addition and amendment throughout the analytic process
Systematic	Allows methodical treatment of all similar units of analysis
Comprehensive	Allows a full, and not partial or selective, review of the data collected
Enables easy retrieval	Allows access to, and retrieval of, the original data from the database
Allows between- and within-case analysis	Enables comparisons between, and associations within, cases to be made
Accessible to others	The analytic process, and the interpretations derived from it, can be viewed and judged by people other than the primary analyst

The following stages of framework analysis are described in the literature (Ritchie and Spencer, 1994) and were applied in this study[4]:

1. Familiarisation with the data
2. Identifying a thematic framework: coding to reflect the aims of the study and what is emerging from the data
3. Indexing and Charting: rearranging data by index – for example, tabular presentation of themes in columns, cases in rows, summaries/quotes in cells
4. Mapping and interpretation: revising charts to look for patterns and associations in the data, developing explanations, mapping the range of phenomena.

The next four sub-sections discuss these four stages.

Familiarisation

As its name suggests, the objective of this stage is to develop a grasp of the whole dataset through immersion into the range and diversity of the collected material. This is particularly important when the data collection is performed by a research team where each member possesses knowledge of a particular sub-set(s) of data.

Although desirable from a theoretical perspective, in reality it is not always possible to perform familiarisation with the whole dataset at once – often because of the volume of the data but also due to the phased nature of many studies where the subsequent datasets are informed by preliminary stages of the data analysis and become available at later stages. In those cases the familiarisation is conducted with selected parts of the dataset only.

Thematic framework

The outputs of the familiarisation stage (notes on key issues, concepts and themes emerging from the data) provide the basis for the identification of a thematic framework (or index) for the analysis.

The construction of the thematic framework is normally based on two broad aspects (Ritchie and Spencer, 1994):

1. A priori issues (those informed by original research objectives and introduced into the interviews via the selection of questions for the interview guides);

[4] Indexing and charting, originally referred to by Ritchie and Spencer as separate stages, were combined in this study

2. Additional issues which may be raised by respondents which might include further details of existing components of, or new elements, in the conceptual framework.

The process of identification of a thematic framework involves the development of analytical themes which arise from the recurrence or patterning of particular views, experiences or attitudes. The thematic framework is a dynamic structure around which the data was sifted and sorted. This means that it inevitably underwent revisions at different stages of the analysis involved. The early versions of this dynamic index are normally descriptive and are grounded on existing priority issues. This broad framework was then applied to a few transcripts when categories (codes) were refined and were more flexible towards emergent issues from the data. The later versions of the index were based on the conceptual framework emerging from the study which may or may not correspond to the pre-set conceptual framework.

Lastly, as Ritchie and Spencer describe, it is not a mechanistic process of constructing a structure; it involves logical and intuitive thinking, making judgements about meaning, about relevance and relative importance of issues from the data.

Indexing and charting

Indexing is a logical progression from the thematic framework where the index is systematically applied to the datasets. The textual forms of data are often referred to as the primary target for indexing although recent advances in technology allow indexing the audio and video fragments of the data. The process of indexing is often referred to as coding of the data and the whole dataset is annotated according to the thematic framework. In practical terms, the specific passages, sentences or even phrases may be assigned specific codes according to the (sub-)themes in the index. Furthermore, single passages may contain different themes with more than one code being applicable to a sentence or paragraph.

Charting is a process of rearranging the data based on its relevance to the particular elements of the thematic framework. In other words, the data is 'lifted' from the original context and categorised according to the appropriate thematic reference. Charts may contain headings and sub-headings and can be based on research questions as well as the considerations of study outputs such as research report or an academic paper. Charting involves two aspects: a 'cut and paste' dimension whereby the specific parts of the data are grouped together, distilled and analysed from the perspective of their relevance to the theme (code) and a tracing aspect where the same passages are traced back where necessary

to the original context and assessed from its relationship with the adjacent 'neighbouring' issues.

As in the case of other stages of the data analysis, numerous judgements on the relevance and significance of the specific passages need to be made throughout this stage. The process is also not linear and for consistency purposes should be repeated more than once and, where possible, by more than one researcher. The latter, however, was not possible in this study.

Mapping and interpretation

Mapping and interpretation is a logical progression from the previous stages of the qualitative data analysis where the data, indexed and charted according to the coding framework, is pulled back together by its key characteristics and interpreted as a whole.

Although part of the mapping of data is implicit in other stages, particularly indexing and charting, it is at this stage that the categories, themes and associations are pulled together in a systematic way in order to address the research aims. At this stage the researcher explicitly brings back the study objectives and the study conceptual framework. Ritchie and Spencer refer to the difficulty of describing this stage of the analysis without being 'mechanistic'. This stage is normally driven by a combination of the framework, emerging themes and the study research questions.

3.4.3 Qualitative data analysis software

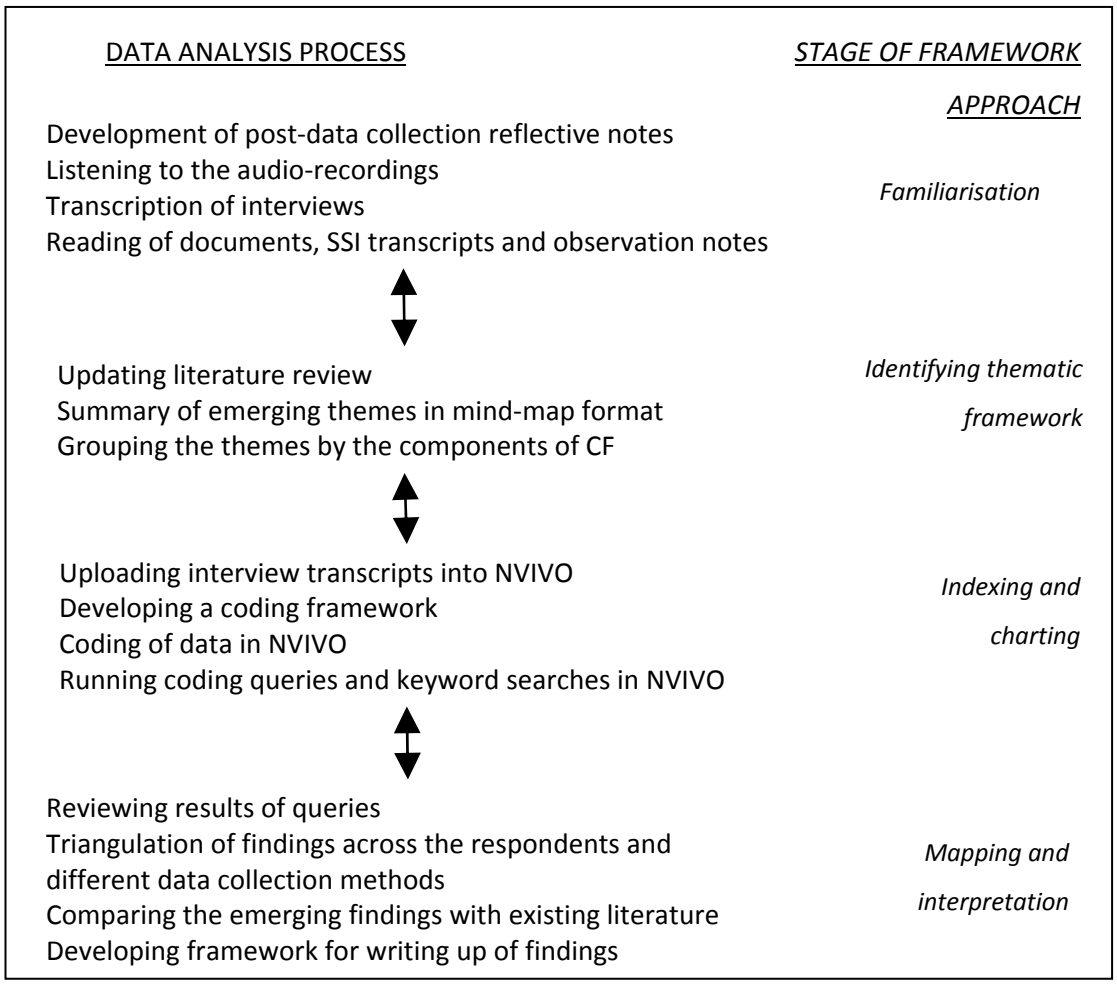
Computer-assisted tools are being increasingly introduced in support of the qualitative data analysis, particularly when a unit of analysis is a word, phrase or idea that can be linked to a group of words (Ezzy, 2002; Weitzman and Miles, 1995). There is a recognition, however, that qualitative data analysis goes beyond 'mechanistic' analysis of the text (words) and ideas and meanings of words.

Qualitative data analysis (QDA) software such as NVivo are seen as an integral part of many research studies (Bazeley, 2007). Doubts have been expressed with regards to the contribution of QDA software towards the efficiency of the analysis within small-scale projects. For example, the time-consuming nature of obtaining the text in computer-readable format (transcription) and setting up the programme so it will not attribute traits to incorrect characters (coding and verification) often outweighs the advantages of automating the process of code-and-retrieve function of the QDA (Ezzy, 2002).

3.4.4 Main features of the data analysis process used in this study

The data outputs from the three data collection methods used in this study typically comprise quotations (from respondents), descriptions (of policy events), and excerpts of documents (Genzuk, 2003). The process for data analysis corresponded to the main stages of framework approach and included different stages, as shown in Figure 11. The process was not linear and iterations occurred both within and between the different stages.

Figure 11: Use of framework approach in the data analysis process



Post-data collection reflective notes were developed in September 2008 following the in-country data collection and covered both the contents and the process of the data collection. Although the data collection and analysis was performed by the author, familiarisation was still considered an important stage and, among other techniques, also included the transcription of all SSIs by the author. This, although adding nearly 9 months to the time of the data analysis, was a useful investment for the later stages of data analysis.

Mind-mapping software was used to aid the development of thematic framework for analysis, which was based on the themes emerging from the data across the different components of CF. The thematic framework for analysis was also informed by existing literature - for example, it was felt important to also reflect on the issues not raised by the respondents and not evident in the reviewed documents.

Although the latest version of NVivo (v.8.0) provided the possibility of using audio- and video-files as part of the dataset, the time-consuming nature of working with audio-files compensates the time spent for transcription. Furthermore, initial testing revealed that the filesize of the v8 is much larger than from the previous version, therefore NVivo v7 was used to aid the analysis of interview transcripts in the study.

A three-tiered coding framework reflected the thematic framework for the study and is included in Appendix 6. These codes were revised alongside the data analysis and the coding queries were run on the last version of the coding framework. It is believed that the combination of coding queries and searches by keywords (including synonyms) improved the quality of the analysis as only one researcher was involved in the process.

The interpretation stage of the analysis process was informed by discussions with supervisors and was driven by the study conceptual framework whilst allowing flexibility for data-driven findings, including the identification of further areas not raised by respondents.

Lastly, the framework for writing up the findings in Chapters 4-10 was also informed by combinations of a) existing theories and models of both capacity and health policy processes, b) the study conceptual framework and c) emerging findings from the data.

3.5 Specific methodological considerations

Besides the general methodological issues that apply to health policy-related research and assessing capacity summarised in sections 3.2.1 and 3.2.2, different study-specific methodological considerations arose as part of the development of the study methodology and methods. These included issues related to language and translation, degree of bias, validity and triangulation, piloting and ethical considerations. This section describes these methodological issues, which will then be followed by the author's reflection on the study methodology.

3.5.1 Language/Translation

The interviews with the majority of national policy actors were conducted mostly in Russian or Tajik whereas data collection from international respondents were in English[5]. The bi-lingual data collection posed an important methodological question: at what stage of analysis should translation occur. The QDA software used did not pose any technical challenges as both Cyrillic and English fonts were supported in NVIVO. After consideration of implications on quality, and eases, of analysis, as well my trilingual ability, all Russian and Tajik transcripts were translated into English to allow single-language data analysis.

3.5.2 Degree of bias

Two issues need to be distinguished in the understanding of degree of potential bias: factors related to the author and factors related to the study respondents.

Bias related to the author

Up to ten "*pitfalls in interviewing*" can be identified (Britten, 1995), with a possibility of bias due to existing preconceptions or experiences being particularly relevant to this study. The relationship between the interviewer and the participant is important, especially when they are from different backgrounds or social groups (Green and Thorogood, 2004). Two particular advantages of differences between the researchers and respondents have been suggested:

1. interviewees may find it an empowering experience to be an expert on a subject that the interviewer is interested in (Miller and Glassner, 2004)
2. interviewees may elicit more detailed explanations because researchers do not make assumptions about their inside knowledge (Taylor et al., 1995).

On the other hand, different social backgrounds of researchers require substantial background reading and more thorough preparatory work for the contact with respondents. Furthermore, access to high-level respondents is known to be an issue in policy-related research with 'outsiders' likely to require additional support in obtaining access to respondents.

The author, being the former MOH official, had generally unobstructed access to the various respondents, including the MOH. On the other hand, the tension between being a former colleague and a researcher needs recognising. Although thorough knowledge of the context

[5] The author is fluent in all three languages.

of the RT helped to explore various issues in sufficient detail and avoid follow-up data collection, there was a clear possibility of bias informed by existing pre-conceptions.

It is believed, however, that the author's affiliation with the University of Leeds for several years before the time of the data collection helped to change some existing pre-conceptions (for example, in relation to government-donor relationships) and to reduce some of bias from the study. However it is recognised that this may still exist.

It is also recognised that use of conceptual framework to guide data collection and analysis contributed to author's bias (for example, a more grounded approach). However, it is believed that a possibility to add further emerging themes, measures to ensure validity of data (see 3.5.3) and comments from supervisors (who were not 'constrained' in the conceptual framework) helped to minimise this.

Bias related to the respondents

One of the most delicate areas of any qualitative research is to elicit information from the respondent in an unbiased way. For example, the absence of references by the respondents to various aspects of capacity and policy processes could be interpreted as potential combinations of either:

- Absence of the issue in the RT in health policy processes;
- Lack of conceptual understanding by the respondent, despite indications (by other respondents and other methods such as documents) that the issue may exist in RT;
- Reflection of interviewing techniques, i.e. absence of questions on a particular issue.

No issues from the conceptual framework were identified as not being relevant to the context of RT. Some issues (for example, the concept of actors' networking) reflected the lack of respondents' conceptual understanding though in reality some actors' experiences indicated the application of these concepts.

The interviewing technique was considered important in the interpretation of existence or absence of references to different issues. Whilst precautions were made in avoiding biased questions, various probes and prompts were used in the SSIs. It also appears that a) the conceptual complexity of the topic and absence of established tools to study capacity in relation to health policy processes, coupled with b) the limited availability of many respondents leading to the need to prioritise questions in the interviews and c) the nature of respondents' involvement in different aspects of health policy processes in RT also

contributed to the absence of some references by various respondents. It is believed, however, that the triangulation of findings helped to address this, as discussed next.

3.5.3 Validity of data and triangulation

The validity of data is an important aspect of any qualitative research and validity of qualitative data is more challenging (Boeree, 1998; Creswell and Miller, 2000; Ezzy, 2002; Flick, 2006; Grbich, 1999; Ritchie and Spencer, 1994). The literature distinguishes between different considerations of validity, which can be subdivided into primary and secondary considerations or criteria, as shown in Table 15.

Table 15: Different criteria of validity in qualitative research

Source: (Whittemore et al., 2001 p.534)

Criteria	Assessment
Primary criteria	
Credibility	Do the results of the research reflect the experience of participants or the context in a believable way?
Authenticity	Does a representation of the emic perspective exhibit awareness to the subtle differences in the voices of all participants?
Criticality	Does the research process demonstrate evidence of critical appraisal?
Integrity	Does the research reflect recursive and repetitive checks of validity as well as a humble presentation of findings?
Secondary criteria	
Explicitness	Have methodological decisions, interpretations, and investigator biases been addressed?
Vividness	Have thick and faithful descriptions been portrayed with artfulness and clarity?
Creativity	Have imaginative ways of organizing, presenting, and analyzing data been incorporated?
Thoroughness	Do the findings convincingly address the questions posed through completeness and saturation?
Congruence	Are the process and the findings congruent? Do all the themes fit together? Do findings fit into a context outside the study situation?
Sensitivity	Has the investigation been implemented in ways that are sensitive to the nature of human, cultural, and social contexts?

Addressing the issue of validity in qualitative research involves "*…processes collectively described as triangulation methods... These techniques may include using multiple data sources…, multiple data collection methods…, multiple disciplinary perspectives…, and comparison with existing theory*" (Cook et al., 2001 p.470S). Some authors distinguish between the techniques addressing the lens of researchers (for example, reflexivity), study participants (for example, collaboration) and people external to the study such as reviewers

or readers (for example, debriefing or degree of detain in the document) (Creswell and Miller, 2000 p.126).

In this study the validity of data was ensured through a) testing preliminary findings on the key respondents during the later stages of the data collection and b) triangulation. Two types of triangulation were used in this study: *triangulation of methods* through obtaining similar data using different data collection methods and *triangulation of findings* through confirmation of results by different sources. Both these types were considered appropriate though the primary focus was on the triangulation of findings across the different datasets (for example, SSI transcripts and document reviews) as part of the data analysis.

3.5.4 Piloting

Piloting is used as a means of testing the appropriateness of data collection tool(s) in order to identify any potential difficulties with both the process and contents of data collection. One detailed interview guide was piloted in a telephone interview with one policy actor from RT. After piloting, minor adjustments were made to the order and depth of questions as well as the projected length of the interviews. As the piloting of the SSI guide was done with a policy actor in RT, the data from this interview was included in the analysis.

3.5.5 Ethical issues

Ethical issues informed the procedures for data collection and analysis. More specifically, the processes of the development of tools, data collection and analysis took into account the following ethical issues:

- *informed consent* was obtained from all study participants according to the format shown in Appendix 3. In case of refusal alternative means of data collection were planned to be explored (for example, document reviews as opposed to semi-structured interviews). Fortunately, there were no refusals for interviews.
- *anonymity* of study respondents was preserved during data collection, analysis and presentation of the study findings. Unnecessary collection of personal data was avoided. Where personal data (such as respondent's position, previous experience) was gathered as part of the data collection it was coded and removed from, and stored separately from, the interview transcripts. Upon completion of the study the codes linking the respondents to the datasets will be destroyed.
- *data protection issues* were given particular emphasis, which include security of the data storage and access rights to the data. Only the author had access to the full primary dataset and the supervisors saw an example of a transcribed interview.

Normally health system-related research projects in Tajikistan are approved by an ethical committee which is chaired by the MOH Department of Science though in practice only projects requiring MOH funding are scrutinised in detail. Prior to the data collection an e-mail enquiry was made to the MOH and the minister's verbal agreement was received prior to the start of the data collection.

Lastly, the project also complied with ethical procedures for conducting research from the University of Leeds. The project protocol was reviewed and received ethical approval from the ethical committee of the Leeds Institute of Health Sciences, University of Leeds.

3.5.6 Reflection on study strengths and limitations

Reflection formed an important part of the study methodology. A set of reflective notes on both the process and contents of individual interviews was developed following each SSI and reflective notes were developed following the in-country data collection in September 2008. These enabled the identification of strengths and weaknesses of this study, as set out in this section.

The rest of this section provides an overview of issues with implications on both strengths and limitations of this study. It starts with broad issues (such as those related to the scope of the study) and continues through to specific methodology-related issues (such as the consent for audio-recording of SSIs).

Two points apply to most issues: first, the same issues can be interpreted as both strengths and limitations (for example, the broad scope of the study) and various interrelationships exist between the various issues raised in this section (for example, between views of national and international respondents and respondents' trust).

Originality of the topic

Possibly the most important strength of this study is related to its originality and includes the development and the successful testing of the conceptual framework for assessing MOH capacity to conduct health policy processes in RT.

However, the absence of tested frameworks at the beginning of this study resulted in the need to develop a model for assessing MOH capacity. Apart from implications for time, the integration of the two large topics (concept of capacity and concept of health policy

processes) resulted in methodological challenges related to focusing on a) policy *processes* and not wider policies and b) assessment of *capacity* and not assessment of policy processes per se.

Studying capacity in relation to health policy processes in RT

Almost all respondents acknowledged the complexity of the topic and mentioned that they were glad to see someone studying this delicate issue. Many were in agreement that the feasibility and the depth of this study are largely possible due to author's former experience working, and contacts, with various government and international agencies and the current advantage of being currently outside the country.

However, many respondents also reflected on the rapid pace of changes in the health system of Tajikistan as possibly affecting the relevance of the study recommendations which are produced two years after data collection.

Scale of the data collection

An attempt was made to avoid unnecessary collection of data. However, 37 SSIs were conducted, largely because of the complexity of the topic, the large number of health policy actors in RT, further emerging topics/ideas and snowballing technique for identification of further respondents.

Obviously, the larger dataset allowed more triangulation of findings across the respondents. On the other hand, this added significant time to the data transcription of the interviews and analysis of data.

Balance between depth and breadth in the analysis

There was a need to decide on the balance between a broad (holistic) study covering all components of the conceptual framework or an in-depth focus on one or two elements. The current study was initially designed as a broad study covering all six areas of the conceptual framework initially individually and then in integrative discussion. The balance between depth and breadth of the data analysis arose about half-way through the data analysis with main arguments against the broad approach being the word limit and the possibility of superficial analysis.

A conscious decision was taken to test the broad analysis on selected Chapters with careful planning of the word budgets and not compromising on the depth of the analysis. As a result

of this testing, a broad study approach was found feasible and was applied in the thesis. It is believed that this broad approach is a particular strength of this study, allowing the policy actors in the RT and wider to see the 'whole picture' as well as to understand the particular issues in relation to each of the six components of the conceptual framework.

Part-time nature of the study

Possibly one of the most important challenges for this study is its part-time nature and the lack of unfunded time. The lack of unfunded time is related to the decision to undertake a study not as part of on-going projects but as parallel research. This, coupled with increasing workload in full-time employment, made it virtually impossible to devote significant time during working hours to the study.

The lack of 'booked' time for the study during the working week has obviously affected the social aspects of author's life and resulted in an ever-increasing pressure to complete the study in a shortest possible period of time. Though there was a potential danger of efficiency at the expense of quality, it is believed that the structured approach to the writing has allowed systematic analysis of the data and adequate quality for the data analysis.

Structured approach to writing

A relatively ambitious target deadline was set for the submission of this thesis, which was delayed, due to various reasons, by about a year. One reason for this was the structured approach to the writing, suggested by the supervisors, which resulted in time needed for developing, commenting and discussion of outlines/sketches (the term 'skeletons' was used) of all findings and discussion Chapters before writing the first drafts.

Reflecting on the experience, such initial development of Chapter outlines has made the writing of the thesis more structured. However, the need for the Chapter outlines was perhaps a result of less detailed discussions of the preliminary findings produced in a mind-map format and ultimately added to the amount of writing time. On the whole, however, it is believed that the structured approach to writing resulted in an easier to read document, which is particularly important if parts of the document will be translated into Russian/Tajik for dissemination in RT and wider.

Presentation of study findings

As in many other qualitative research studies, it was difficult to avoid including discussion in individual findings Chapters. Therefore, a decision was made to include discussion sections

alongside the findings in Chapters 4-10. Related to this, there are at least two possible sources of discussions throughout the document:

- Respondents' interpretation of particular issues; usually supported by related quotes in the text. An example of this is various instances where a respondent or a document directly referred to high/low MOH capacity, for example, in relation to use of evidence in health policy processes.
- Author's interpretation of the data, i.e. where respondents did not directly raise or refer to the issue but their responses can be interpreted in specific ways. For example, a reference to absence of any follow-up by MOH on project reports submitted by respondent's organisation can be interpreted as a reflection of MOH capacity (either ability or willingness) to ensure utilisation of evidence in health policy processes.

Where possible and appropriate the distinction between the two is made explicit throughout the document. However, it is recognised that the two are closely inter-related and it is virtually impossible to clearly distinguish between the above sources in every single finding in a non-repetitive way.

In theory, a third option is also possible (conclusions where there is no data); for example, when the respondents did not raise the issues. This is related to the range of issues raised by respondents, which are discussed later in this section.

Consent for audio-recording of interviews

All but one respondent provided consent for audio-recording of discussions. The timing for obtaining the informed consent was intentionally changed which is believed to have also helped with obtaining respondent's agreement.

According to the initial study design voice recording was due to start from the beginning of the SSIs and the respondent would be asked to confirm her/his agreement to the audio-recording before the actual questions. The first two interviews were conducted with respondents who knew the author well and who had some research background where audio-recording of qualitative data was conventional.

However, glimpses of hesitation from the first respondents prompted the following changes. In subsequent interviews the recorder was not started from the beginning of our interview but after several introductory questions, and briefing on the focus of the research (most respondents asked for a verbal summary of the project). It was felt that reassuring the

respondents that their anonymity would be preserved before asking permission to start recording resulted in all respondents consenting to audio-recording.

Respondents' trust

Prior to the in-country visit there was a perception that most respondents in RT, particularly the local actors such as MOH staff, would not be open or happy with audio-recording of the interviews. This feeling was based on the fact that the author had been out of the country for several years and may have lost the sense of trust from the former colleagues to speak freely. In reality, however, this may have had the opposite effect, possibly similar to the issue of social differences in the earlier section. The respondents were open and did not object on audio-recording, maybe because the author was not part of the system and was not seen as a potential 'threat' to the respondents.

'Cautious' or more successful respondent?

One respondent asked to stop the recording during the interview; this respondent is one of the few high-level people within the Tajik health sector who did not change position for the last nine years. In fact, the interview was not stopped but when more sensitive issues were covered (such as the respondent's assessment of MOH capacity) the respondent requested switching off the recorder and hand-written notes were taken.

This case on the one hand suggests that more 'careful' people stay longer within the system and on the other suggests the methodological dilemma of deciding on the balance between recording as a means of ensuring the completeness of data and non-recording of interviews as a way of obtaining more 'honest' responses. This is also supported by another case where another national respondent reflected more critically after the formal end of an interview, i.e. after the recorder was turned off. However, none of the above respondents requested confidentiality of the findings, as long as anonymity is preserved.

Different views of national and international respondents

Linked to the above, it was found that the national respondents drew more positive pictures in the interviews, compared to their international counterparts who were far more critical of health policy processes in general and MOH capacity in particular. At the same time, as discussed in Chapter 7, international actors seem to be associated with more flexibility and power. On the other hand, the lack of stability and high turnover of staff in the MOH and other national agencies were linked to the working culture which included issues of not criticising the manager and the culture of not making mistakes.

Reflecting on this, it appears that international actors, including national respondents within the international organisations, were feeling more secure and less obliged to describe a more positive picture in the interviews. The difference between national and international actors may also indicate that international respondents are generally more critical of the government and MOH practices and policies. Though this might be an indication of openness, it also suggests that existing pre-conceptions that government is inherently 'bad', coupled with lack of familiarity with the context of RT, may provide the background for the negative tone of various responses, especially when the opposite views were often supported by different examples and case studies.

3.6 Summary and Conclusions

This Chapter provided an overview of the study methodology and the detailed methods for data collection and analysis. Different challenges in studying both capacity and health policy processes are acknowledged in the literature. The two concepts, however, were never brought together in a single framework. The understanding of the methodological implications for assessing MOH capacity to conduct health policy processes guided the development of a broad framework for the study, drawing on the conceptual framework for assessing MOH capacity to conduct health policy processes.

The study involved qualitative methods. The data was collected through 37 SSIs, reviews of 58 documents and observation of 2 policy events in RT. A framework approach was used for data analysis which was performed with the aid of QDA software. Different methodological challenges were encountered throughout the study and the Chapter discussed the methodological responses to these. Examples included consequences arising from the originality of the topic, degree of trust from the respondent and degree of author's bias. Various strengths and limitations of the study were identified and many characteristics can be interpreted as both strengths and limitations. Furthermore, many are inter-related for example, degree of author's bias and the range of issues raised by the respondents.

We now turn to the findings of the study. The concept of MOH capacity is the main focus of this study and next Chapter provides an overview of the interpretation of the concept of capacity to conduct health policy processes in RT.

4 UNDERSTANDING MOH CAPACITY TO CONDUCT HEALTH POLICY PROCESSES IN THE RT

4.1 Introduction

As shown earlier, the literature provides different interpretations and understandings of the concept of capacity. This Chapter summarises the interpretations of the concept of MOH capacity to conduct health policy processes as perceived by policy actors in RT. It starts with an overview of actors' perceptions of the concept of capacity, followed by an identification of the main perceived elements of MOH capacity, including associated features, in RT.

4.2 Understanding of the concept of capacity in the RT

Although the concept of capacity is generally well-understood in the literature (Brown et al., 2001; LaFond et al., 2002; Potter and Brough, 2004), its application to MOH as an institution and to health policy processes is limited. The research explored the understanding of the term 'MOH capacity to conduct health policy processes' in RT. Despite frequent referral in grey literature to the need for capacity development, no documents were found, in RT defining and/or exploring the MOH capacity in relation to health policy processes.

Most documents found referred to capacity development in a functional way – for example, coordination capacity, financial management or budgeting capacity – within individual projects (Clary, 2002; Mahon and Tediosi, 2007; Mira, 2002; WB, 2007). Similarly, most respondents defined MOH capacity as comprising different functions, as with the statement below:

> *"…capacity to negotiate, convening the parties in the dialogue, leading the process forward, forms of communication from proposal formulating and creating but at the same time implementing… and …the kind of marketing of what they suppose to do. … capacity of networking means also your capacity of looking at a system as a whole, you know, not only ministry of health but to other sectors, basically the population."*
> (Expatriate Staff, International Agency).

Most respondents perceived the concept of capacity as being similar to the definition developed earlier in this document *(ability and willingness of individuals, institutions or systems to successfully perform tasks, either individually or as part of the wider network, in a sustained way)*. Four specific aspects of this definition of capacity were shared by most study respondents and are set out in the next four sub-sections:

a) the need for both ability and willingness to perform tasks;

b) the importance of sustained efforts in addressing tasks;

c) the different levels of capacity (for example, individual or organisational);

d) different elements of capacity (for example, knowledge, skills, structures).

4.2.1 Combination of ability and willingness

The importance of distinguishing between ability and willingness to carry out certain tasks was particularly emphasised by the national actors, in contrast with their international counterparts such as INGOs.

From the different responses three groups of factors can be distinguished as affecting the willingness and ability of Tajik MOH to conduct health policy processes. These are: *wider contextual issues* (both within RT and wider); *relative powers between the organisations and respective individuals* (international and national) and *individual values, agendas and interests* involved directly or indirectly in health policy processes.

Respondents felt that the wider contextual issues - for example, the availability of funds to carry out specific reforms - may affect willingness to apply existing ability. One officer from an international agency referred to the importance of political context and the fact that a '*struggle period*' in reforms is unpopular because radical changes are often not desired by politicians so the existing MOH ability cannot be applied.

The issue of relative powers was the second factor affecting the combination of ability and willingness, as shown below:

> *"Another issue is their power or ability to influence the health policy. You can have strategic unit within the organisation but if their recommendations won't be accepted then there is no point of having that unit. This means that ministry or any organisation should look at the broader picture and this strategic unit should have ability and power to do this work.*" (National Staff, National Agency)

Individual agendas and interests represent an important group of factors affecting the combination of ability and willingness. Examples of these raised by different respondents include vested interests of government officials in implementing certain reforms and desire to establish a new management style. The latter is illustrated by a recently-appointed minister's criticism of the international community:

> *"I don't know what was driving him, but he was definitely not happy [with work by the international community]… He was a new person and wanted to show himself as a*

leader – it happens every time when a person gets appointed to a new position." (National Staff, Donor Agency)

Many respondents referred to the dynamic context of RT's health sector, implying that the balance between willingness and ability can change. Most respondents emphasised the importance of sustained efforts in their interpretation of capacity, as set out next.

4.2.2 Importance of sustainability

The importance of sustained efforts to carry out tasks was recognised by both national and international respondents. One frequently-raised example of poor attention to sustainability was the MOH decision to dissolve the SOMONI group[6]:

"…there was SOMONI project supported by WHO which was set up to provide support to the MOH in developing the policy for change/reforms…[and] to some degree the same project was involved in initial steps of implementing that policy. At that time there were about 10-15 people who had skills and abilities. However, they were dissolved. At that time I think it was possible to utilise their skills and transfer their knowledge into the [MOH] health reform department…" (Ex-MOH, International Agency)

Respondents saw different factors as affecting the sustained efforts in the application of MOH capacity. The factor most frequently-referred to was the high turnover of MOH staff, coupled with the absence of effective mechanisms for retaining institutional memory within the MOH:

"the biggest element [of lack of sustained efforts] *is independent administration… There needs to be a body….. a professional secretariat. They need to have a stable secretariat……which does not change when the ministry changes."* (Expatriate Staff, International Agency).

Other factors were related to the wider contextual environment, with negative implications on a)*the lack of staff motivation,* contributing to staff emigration from the public sector (for example, within the projects transferred from the INGOs to the public sector) and b)*the*

[6] This MOH-affiliated group was established in 1999, with the support of WHO, to develop the Health Sector Reform Conception.

limited resources and the lack of equipment maintenance, for example constraining the seemingly robust design of HMIS in Gorno-Badakhshan Autonomous *Oblast*[7].

4.2.3 Different levels of capacity

Chapter 2 set out four levels of capacity in the health system: *individual* (knowledge and skills), *organisational or institutional* (leadership and governance arrangements, sustainable resources and communication and networks), *systems* (cumulative capacity of all institutions within health sector) *or wider contextual (enabling) environment* (capacity of other governmental sectors as well as international community).

Most respondents referred to the individual level of capacity with only 1-2 references - all from the international community - made to the organisational and the system levels. However, no references were made to the wider contextual environment.

One respondent emphasised the importance of *systems* capacity, as a reflection of the cumulative capacity of all administrative levels of the RT's health sector.

> *"Many people talk about capacity at the central level but the capacity of the whole system is very important. The special emphasis should be put on establishing and strengthening the capacity of all levels so all staff at the central, oblast and rayon levels who are involved in management decisions could be continuously trained. The whole system should be improved."* (National Staff, International Agency).

The capacity of *individuals* was referred to most frequently. Different individuals - ranging from MOH technical staff through to the heads of department and the minister himself - were seen as important in understanding the MOH capacity:

> *"Individual factor was important [in MOH capacity] – including Natalia Babayevna*[8] *and, afterwards, the absence of individuals like her.."* (Current MOH official).

Many respondents, especially the international community, referred to the lack of integration within the MOH where *"… there is always minister who decides [and] there is no intermediate management…"* (Expatriate Staff, Donor Agency). One donor – in contrast with the findings from documents (Mira, 2002; WB, 2007) – saw exclusion of the MOH from the capacity development within externally-funded projects:

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[7] One of the RT's regions

[8] Former head of MOH economics and finance department

"The only thing we heard is building capacity at rayon level, management training for districts and those are given some resources but I never heard about something at the national, policy, MOH level…" (National Staff, Donor Agency).

4.2.4 Different elements of MOH capacity

In Chapter 2 we identified four interrelated capacity elements: structures, distribution of roles, skills and relevant tools.

Most respondents identified more than one element of capacity, as shown below:

"…well, it's physical resources, infrastructure, ability to implement complex tasks, leadership role of MOH, there are different issues here. Also, the role of MOH within the health sector – coordinator, leader, legislator, normative-issuing and so on. There are various elements of capacity in my opinion which come to my mind." (National Staff, International Agency).

Different respondents referred to the different elements of capacity, ranging from technical skills and abilities (for example, in relation to policy analysis) to the degree of effective use of available resources. The elements of capacity are explored in more detail further in section 4.3, including perceived associated features of MOH.

4.2.5 Discussion

Three capacity levels can be identified from the different responses though, compared to the individual level, the systems and the organisational levels were referred to less frequently. This suggests that powerful individuals are valued in RT and wider contextual or systems issues may be perceived as given within this still centralised society. The absence of references to the wider contextual/enabling environment may suggest that respondents either were unable to distinguish this capacity level or may perceive the wider contextual environment as a set of factors affecting capacity at individual, organisational and system's levels rather than a separate level in itself.

Although there is insufficient direct evidence to support this, it appears that the different capacity *levels* – identified in Chapter 2 – are inter-related. For example organisational roles and structures may affect the individual initiatives within the MOH.

The different *elements* of capacity, identified by the respondents, suggest their recognition of the importance of all four elements of the capacity pyramid (structures, systems and roles;

staff and infrastructure; skills and expertise and, tools). The question is whether there is a foundation or central element of capacity. For example, whether the structures, systems and roles (corresponding to *organisational and system levels of capacity*) represent the foundation elements of capacity (Morgan, 2006; Potter and Brough, 2004) and hence may be the 'entry point' for capacity development or the *individual capacity* (skills and expertise) should be seen as a foundation of all other levels of capacity. The study findings suggest that the latter may be true at least in the RT though it is recognised that similar research in different contexts is needed to confirm or otherwise this assumption more widely.

An adequate distribution of roles and tasks across the whole health system was seen as important in understanding and strengthening the MOH capacity. The perceived lack of capacity at an intermediate (*oblast*) level in the context of RT suggests two possible options for capacity development: a) ignoring *oblasts* and developing skills and abilities at central (MOH) and peripheral (*rayon*) levels or b) recognising *oblast*-level for capacity strengthening and assigning *oblasts* with explicit roles and tasks in relation to health policy processes.

The chain-like relationships between the different levels and elements of capacity (Green and Gadsby, 2007) may also affect the degree of sustained efforts. For example, frequent changes to MOH staff are likely to impede the development of individual skills and abilities and may negatively affect the retention of institutional memory within the MOH.

The recognition of sustainability as an important issue in relation to MOH capacity can be interpreted as a positive sign as it suggests the recognition of the long-term nature of health policy processes. This may also reflect a wider RT's transition from short-term decisions to a longer-term vision within health policy processes.

The next section sets out the interpretation of key perceived elements of MOH capacity, including associated features.

4.3 Key elements, and associated features, of MOH capacity in the RT

Different approaches exist in understanding the elements of capacity. The capacity pyramid (see Figure 2) comprise four levels of capacity: structures, systems and roles; staff and infrastructure; skills and expertise and tools and will be used as a framework to summarise perceptions about the elements of MOH capacity in RT.

When asked to identify the key elements of MOH capacity, most policy actors referred to a range of inter-related issues:

> *"I understand capacity as human resources with expertise and skills to work at this level... secondly, I understand internal structure of MOH – what are the main priorities and what units need to be created for these tasks. Thirdly, their* [MOH] *communicability and recognition of each other not as rivals but as co-contributors towards reforms. In my opinion the MOH should comprise highly competent people with good knowledge in the field of public health; these people should be appropriately paid to avoid them leaving their posts…"* (Ex-MOH, National Agency).

Most emphasis was on the *skills and expertise* of individuals, compared to the *appropriate structures* and the *relative roles of policy actors*. *Tools* did not feature at all in the responses. The next sub-sections set these out, including associated features. The effective use of resources, though potentially part of skills and expertise, was frequently referred to by many respondents as a separate element and, therefore, is discussed as a separate sub-section.

4.3.1 MOH skills and expertise

The skills and expertise of individuals were identified by virtually all respondents, many also emphasising the importance of having '*the right skills at the right levels and at the right time*' (current MOH official).

Some international agencies were associated with thematic policies or particular stages of policy processes (for example, INGOs working on MCH policies or PIUs involved in policy implementation). These respondents identified a limited number of specific skills of importance to MOH capacity, for example, expertise to effectively use evidence in health policy processes and skills to consider implementation challenges during policy development. However, policy actors involved in all aspects of the health policy process suggested that a combination of a range of different skills is important for MOH capacity.

Two types of skills and expertise can be distinguished in the responses: s*ubject-specific skills and expertise* (for example, expertise in health economics or health planning) and *generic skills* (for example, coordination and/or communication skills), as shown below:

> *"As capacity, I see strong analytical capacity of MOH staff, good vision of the reforms and processes in the health sector… strong leadership, strong ownership of the process, good coordination … English language would of course be desired … and also I think there should be some trainings in terms of advanced presentation skills … sometimes*

it's too long and you just lose the point… still I think they lack these communication and presentation skills." (National Staff, Donor Agency).

Respondents' perceptions of the MOH subject-specific and generic skills are summarised next.

Subject-specific skills and expertise

Many respondents felt that the MOH staff members are often lacking subject-specific skills. Commonly referred-to skills were expertise in health policy, planning, management and health economics – often seen as very different to the clinical background of most MOH staff, as shown below:

"…for the organisational and managerial positions, you want to get real managers, real economists and financial experts... but … you get is a doctor minister, doctor deputy minister, doctor head of department … and they talk about organisational and methodological issues of the health system in the country…" (National Staff, International Agency).

One respondent identified a lack of technical skills and expertise in developing a clear and comprehensive policy as a major factor affecting its subsequent implementation:

"…They just say we have to do [in Health development Strategy] but they don't say where do you want to arrive, so you still miss the big decision, you know, the political decision, this is not policy, this is political decision – what kind of system you want for your population – you want public, you want private, what do you want?" (Expatriate Staff, International Agency).

An opinion was expressed, by some international respondents, that MOH staff do not fully understand some policies drafted by the international community. Particular examples of policies were health financing, HMIS strategy. A more recent example was the idea of a health SWAp (Mahon and Tediosi, 2007). The MOH was described as lacking a strategic vision to consistently bring thematic policies (such as health financing or HMIS) together in an overarching document.

A number of reasons were identified as contributing to the perceived lack of subject-specific skills and expertise within the MOH. Examples of these included low MoH salaries, lack of motivation, and overwhelming burden of MOH routine work. One policy-maker referred to

the ineffective recruitment practices within internationally-funded MOH structures as possible reason for the lack of subject-specific skills:

> *"I am not very happy with the approach of selecting… experts … for health policy analysis unit. They [WB] had criteria – not older than 35 years and knowledge of English. I'd say we need a person with large amount of experience and the knowledge of English is not essential … I am a bit cynical but overall …this is what happens. They get young, without experience, they are green and they need time to ripen…"* (Current MOH official).

However, this view was not shared by other respondents and the internationally-funded structures were seen as a potential source of useful (but non-affordable to the MOH) expertise and skills.

Generic skills

Two types of generic skills and expertise were frequently raised: coordination and communication skills (including presentation skills). Less frequently-raised skills included language proficiency, time management skills and the ability to chair meetings effectively.

Coordination was perceived differently by respondents, with national policy actors – in contrast to their international counterparts - seeing *control* as synonymous with *coordination*. International respondents suggested that there are no effective coordination mechanisms in the MOH:

> *"…the first thing that comes to my mind – you get the information too late… even a few hours before it's [meeting] going to happen. Of course, people cannot often re-group and join the meeting. So, things are not being planned and communicated ahead of time…"* (National Staff, International Agency).

Some respondents related the degree of effective coordination to MOH capacity to effectively utilise available resources/expertise in a sustained way:

> *"…after the SOMONI group was dissolved the [MOH] coordination has been badly affected. …the WHO role should have been acknowledged, since then they invested a lot of efforts to facilitate MOH coordination efforts..."* (National Staff, International Agency).

Many respondents felt that the MOH needs to develop capacity in effective communication. The specific skills raised by the different respondents ranged from broad approaches to

communication (for example, formal letters were described as being inefficient compared to e-mails) through to the information presentation skills (the MOH presentations were sometimes described as '*data rich but information poor*' (National Staff, International Agency)).

Overall, most respondents felt that the MOH capacity in relation to subject-specific and generic skills is gradually improving though differences were identified amongst different respondents in the perceptions of degree and pace of improvements.

Some respondents referred to most improvements in relation to national-level capacity whereas others identified the *rayon*-level as improving their capacity more. Most respondents described *oblast* level as having the least skills in coordination.

4.3.2 Appropriate structures

The importance of appropriate organisational structures was raised by both national and international respondents:

> *"…It is important for MOH to have external relations department; it is important to have a clear idea of what help can be received in implementing health policy... There is an MOH statute, which is updated every 2 years by the Government of RT... I feel that internal structure of MOH should reflect the policy priorities but also should be flexible to allow changes when needed…"* (Ex-MOH, National Agency).

Three types of structures in support of health policy processes can be distinguished:

1. *Structures for decision-making*, for example the MOH collegiums[9];
2. *Structures for technical advice* such as the Health Policy Analysis Unit and the thematic working groups in the health sector;
3. *Structures for specific functions related to policy processes* such as policy dissemination, consultation with the other policy actors or implementing specific policies/projects. Examples of these are relevant MOH departments (health services, external relations), MOH press-centre and project implementation units.

[9] Regular (monthly, quarterly and annual) meetings with local policy actors such as *oblast* and *rayon* health authorities to discuss and review progress in developing and implementing health policies in RT. International organisations are invited for relevant collegiums, including annual reviews.

Most respondents felt that a large number of structures exist in support of health policy processes in RT. However many respondents, particularly international actors, felt that the MOH is unable to effectively utilise the available structures. The lack of MOH ownership of ideas was referred to as an important factor affecting the MOH capacity to effectively use the available structures. Examples raised by respondents in support of this view included WB financing of the establishment of the MOH HPAU and SWAp secretariat:

> *"I am getting kind of upset with this trying to set the working groups and secretariats and sub-secretariats... each time you know we have these brilliant idea, OK, since Tajiks are unable to do anything let's bring the consultant and establish the secretariat, the health sector … machinery – did you see the budget for that? 1.6 million US dollars… I mean after they invested 120 US million in project aid – it's OK, stop now…"* (Expatriate Staff Donor Agency).

Appropriate structures were seen by many respondents as important in ensuring the specific functions within policy processes such as rational decision-making (as part of leadership and governance), adequate information generation and dissemination (as part of evidence-informed nature of health policy processes) or consultation with other policy actors (as part of inter-relationships between different policy actors). A more detailed discussion of the MOH structures in support of policy processes is provided in Chapters 7-9.

4.3.3 Relative roles of policy actors

The relative roles or an '*adequate mandate*' (Expatriate staff, International Agency) of policy actors were mentioned by many actors as an important element of MOH capacity. According to the MOH statute, the MOH role in policy processes is defined as leadership and ownership of policy agenda, stewardship and coordination (GOT, 2008). Differences were identified in actors' perceptions of the degree of success of the MOH in carrying out these roles, as set out next.

The MOH role in health policy processes was seen as ineffective by many international and national respondents. Many respondents, including MOH officials, suggested that the MOH should shift away from routine to strategic issues:

> *"Everywhere the patients' complains and reviews of individual cases of diagnosis and treatment are dealt with by professional associations, i.e. highly-competent specialists who are experts in these fields and not by MOH as it is the case here. The MOH is overwhelmed by this routine and should spend far less time on these operational issues"* (Current MOH official).

Many respondents referred to the importance of having a formal mandate though it appears that this is also linked to the organisation's power. For example, WHO was referred to as a '*formally recognised*' policy actor in RT. The formal MOH's mandate includes the development and submission of draft Laws and other Normative Acts (policies and regulations) as well as the coordination with all government and non-government organisations in relation to implementation of RT's Health Law (GOT, 2005, 2006a).

Most respondents felt that the MOH needs to lead in health policy processes, as reflected in its statute (GOT, 2006a, 2008). However, some respondents suggested that this role was performed by the Department for Health of Executive Administration (EA) of the President or Deputy Prime-Minister on Social Issues, with the MOH being "…*very scared about taking any decision or start talking or to initiate something*" (National Staff, Development Agency*)*. The centralised government structures in RT were identified as mostly determining the limited MOH role in policy processes (compared to higher government levels) – a phenomenon also applicable to the distribution of roles between the MOH and the *oblast* and *rayon*-level health authorities.

Another factor, contributing to this seems to be vagueness in the formal recognition of policy-making functions between MOH and EA. For example, according to the RT's Health Law the MOH is responsible for *developing* health policies whereas the EA is responsible for *establishing* comprehensive health policy in the country (GOT, 2005). The relative power of actors was referred to as an important factor affecting the MOH role in policy processes, for example in inter-sectoral working groups.

> *"…in non ministry of health - initiated groups or committees the role of the ministry of health is really weak. They are not able to deliver their messages, to push their messages…"* (National Staff, International Agency).

Many international policy actors – in contrast with the most national counterparts - were critical of the centralised and bureaucratic approaches within the MOH itself in leading health policy process.

> *"Part [of] the problem with the ministry is that I think the minister takes personal interest in everything, he wants to sign off everything. … there is an odd interest going on about the seminars and training… "I think there is too much training going on, too many different organisations deliver too much training" - so every organisation has to submit a letter to the ministry saying this is what we want to do the training on, here*

are the participants and here are the prices…. and that has to get signed off by the ministry. It's [a] bureaucratic process to try to control something and which is just nonsense." (Expatriate Staff, International Agency).

Overall, most respondents felt that the MOH capacity to successfully perform their roles within policy processes is improving; for example, the MOH is becoming more receptive to the comments and suggestions from other actors and the MOH is given more voice by the government.

The different roles of health policy actors in the RT are explored in more detail in Chapter 7.

4.3.4 Effective use of available resources

Different types of resources were identified. Human and financial resources were the most frequently identified, followed by infrastructure and modern technologies. A few respondents, mostly international organisations, referred to additional tools in support of MOH ability to effectively use resources – for example, staff projection models. Information (as part of the broader concept of evidence) was not explicitly referred to as a separate resource.

"I think many young and interested and educated people are around now, more professionally educated and … the ministry could benefit … from those people. And, of course they are not in the ministry because they are not so attracted to the ministry of health financially… and surviving technically in the ministry of health is not easy. I think that is the resource that has been neglected and not many being used." (National Staff, International Agency).

Most respondents identified generic health systems resources with only a few policy actors referring to specific resources in support of health policy processes such as the MOH HPAU or thematic working groups.

There was a wide perception of the generally low levels of generic and specific resources in RT and, therefore, the effective utilisation of available resources was seen as an important issue. Some international respondents expressed concerns that the available resources – often significant within donor-funded health reform projects – were not used effectively by MOH:

"…I think there were good attempts by the World Bank project to improve this process in policy work through creation of the Health Policy Analysis Unit at the ministry of

health but it's been really I think struggling [to effective use HPAU]…" (National Staff, International Agency).

National policy-makers, generally agreed with the above view, and identified the complex conditionality and the lack of flexibility within externally-funded projects as the main reasons preventing more effective use of available resources.

A more detailed discussion of the existing levels, and degrees of effective use, of resources in support of health policy processes is included in Chapter 10 and the next sub-section sets out the perceived changes in MOH capacity.

4.3.5 Perceived changes in MOH capacity

Although different documents were found that reflect on the changes in capacity of the RT's health system as a whole, for example, in resource management or health reforms (Akhmedov and Mirzoeva, 2000; Cashin, 2004; Dzalaeva, 2007; Eohcs, 2000; Mira, 2002; WB, 2007), no documents were found referring to the changes in MOH capacity to conduct health policy processes.

Overall, the respondents felt that the MOH capacity had improved since independence. However, there were differences in opinion, most notably between national and international respondents.

The opinions also differed with regards to the capacity changes across the levels of RT's health system, as illustrated by the two statements below:

"I think things are improving at rayon level. I think the staff at the rayons who don't tend to change so much and have endured the processes are learning. Ministerial level I am not so sure, it seems when the minister changes everything changes again and goes round in circles…" (Expatriate Staff, International Agency).

"I think the capacity at the central level seems to be very high, fairly robust. But in rural areas, at district level I think we have seen diminishing capacity, the districts see large brain drain in the country…" (Expatriate Staff, International Agency).

It was suggested that the factors contributing to better improvements at *rayon* level are less frequent staff changes, ultimate accountability for results and grassroots-level flexibility with

finances. The improved national-level capacity was thought to be due to the different capacity strengthening initiatives at a country level.

4.3.6 Discussion

Three of the four elements of the capacity pyramid were identified by respondents; tools were not mentioned. These three elements broadly correspond to the three areas of capacity identified by Briatte in relation to French MOH; for example, skills and expertise overlap between *technical* and *institutional capacity*, appropriate structures and effective use of resources are part of *institutional capacity* and MOH role in policy processes can be interpreted as a reflection of its *political capacity* (Briatte, 2010).

The effective use of available resources featured explicitly in the responses. This suggests increasing attention to the rational use of resources in a resource-constrained RT.

No documents were found providing a comprehensive definition of MOH capacity or its elements in relation to health policy processes. This suggests that this concept is not recognised and understood (or seen as important) in the RT. In other words, it seems as there is '*…no capacity to understand the concept of capacity'* (Current MOH official). This finding is also in line with the limited recognition of health policy processes as an issue, as discussed in Chapter 5.

Appropriate structures, systems and roles are seen as the foundation of the capacity pyramid. Three types of structures were distinguished by respondents and the relative roles of policy actors were seen as important in policy processes. However, the systems part of the capacity pyramid was absent in responses. This may be a reflection of a rather fragmented capacity strengthening by individual projects with little attention to the capacity of the health system as a whole – though the latter may be especially important (LaFond et al., 2002).

The three types of structures (decision-making, technical advice, other functions) may overlap and their functions are clearly interrelated. For example, the donor-funded PIUs are primarily involved in implementing specific policies and may also be involved both in the provision of technical advice for policy development (WB, 2007).

Formal recognition of the policy actors' roles appears important in understanding the application of ability within the concept of capacity. The vagueness found in the documents

in relation to the recognition of policy-making functions between the MOH and the Executive Administration (EA) in a centralised system is likely to be interpreted by the EA as undermining the MOH role and significance in health policy processes.

The four elements of MOH capacity have different degrees of similarities to those identified in the study conceptual framework. Some elements (for example, effective use of available resources) are very similar, whereas others (for example, governance and leadership skills or ability to recognise the different stages of health policy processes) are implicit in the key skills and abilities identified by the respondents. None of the elements of the conceptual framework were absent from respondents' interpretation of the concept of capacity.

However, the recognition of the different elements of capacity is dependent on the nature of policy actors themselves. For example, more detailed/specific elements such as the effective utilisation of resources or the skills and expertise to enable the use of evidence in health policy processes were suggested by those actors who were involved in the respective aspects of health policies. This, coupled with a lack of recognition of system-wide capacity identified earlier, suggests that there is a lack of policy actors in RT who are able to see the 'broader picture' and relate project-based capacity strengthening to the whole health system. Ideally, one would expect the MOH to take on this role and, indeed, this is reflected in various regulatory documents such as the MOH statute and the RT's Health Law (GOT, 2005, 2006a) but this does not appear to be occurring in practice.

The four elements of capacity in RT appear to be closely inter-related though this was not explicitly mentioned by respondents. For example, skills are needed to ensure effective use of resources and the relative roles of policy actors can be interpreted as related to the different decision structures. The same argument can also be applied to the individual elements of capacity and effective communication can, for example, be seen as a prerequisite for robust coordination.

Conceptually, some elements of capacity identified by study respondents (for example, the relative roles of actors or appropriate structures) can be perceived as factors affecting capacity rather than its elements per se. Whilst this distinction might be interpreted as being too theoretical, the understanding of elements of capacity and factors affecting it can be important in planning MOH capacity strengthening interventions.

Overall, respondents shared perception about improvements in the MOH capacity. Actors' opinions with regards to capacity changes at different levels of Tajik health system appear to reflect respondents' relationships with, and roles within, the respective levels. National-level policy actors referred to the improvements at the MOH level whereas the *rayon*-level improvements are referred to by many grassroots-level international NGOs.

4.4 Conclusions

The understanding of the concept of capacity in RT is broadly similar to its definition in the conceptual framework and existing literature. Four broad issues were identified in the actors' interpretation of the concept of MOH capacity: the need for both ability and willingness, the importance of sustainability, the different capacity levels, and the different elements of capacity. The increasing emphasis on sustainability may be a reflection of the wider RT's transition from the relief to the development stage. Most emphasis in the responses was on the capacity of individuals with less attention to other capacity levels.

The following four elements can be identified as comprising MOH capacity: MOH skills and expertise; appropriate structures; the relative roles of policy actors; and the effective use of available resources. The elements of capacity, identified in the literature, have differing degrees of similarity with the conceptual framework. Overall, respondents shared a view of positive changes in MOH capacity since the independence.

There appears to be a clear distinction between the views of the international and national respondents with the former being far more critical of the MOH capacity. The attitudes of the national respondents may stem from a culture of not criticising the leadership, as discussed later in Chapter 6. The responses from many national respondents appear to be defensive of policies and values of their own organisations.

This Chapter summarised understanding of the concept of MOH capacity to conduct health policy processes. The next six Chapters explore the three components of the conceptual framework (MOH capacity including its four elements, context and actors). The next Chapter summarises the understanding of health policy processes and their effects on MOH capacity.

5 HEALTH POLICY PROCESSES AND THEIR IMPLICATIONS ON MOH CAPACITY

5.1 Introduction

The clear and transparent health policy cycle was seen as one of the four key elements of the MOH capacity in the conceptual framework. This Chapter explores the perceptions of health policy processes in RT and their implications for the MOH capacity. First, views on the importance of health policy processes are reported. This is followed by an overview of actors' interpretation of different stages of health policy processes. The Chapter concludes by summarising the perceived characteristics of robust health policy processes and the MOH capacity to achieve these in RT.

5.2 Perceived importance of health policy processes

Respondents were asked to identify the most important elements of a health policy. Neither the national nor the international policy actors identified health policy *processes* in their initial responses. Instead, most responses focussed on the different issues related to the *contents* of health policies such as the pro-equity focus or the degree of gender considerations. Similar findings were identified from the document review (Rakhmatullaeva et al., 2003; WHO, 2007b).

When asked to comment on the importance of health policy processes, all respondents shared a view of the importance of robust health policy processes. For example, one international respondent interpreted health policy processes as:

> *"…the only way to secure deep understanding and to stimulate the necessary attention of the health authority, to have a transparent approach regarding the changes induced by policy dialogue and the process is the guarantee that all factors should be considered in the policy dialogue."* (Expatriate Staff, International Agency).

International policy actors had different reasons in support of their statements in relation to the importance of health policy processes. The most commonly-referred reasons were:

- The need to have adequate *means of monitoring* implemented changes;
- The need to have a *long-term vision* within health policy processes, along with a *sufficient flexibility;*
- The need for *clear and transparent health policy processes* by the government, contributing towards the *wider involvement* of policy actors;

- The need to carefully *plan both the development and the implementation stages* within health policy processes, for example through *piloting*.

National policy actors, although sharing the view of the importance of health policy processes generally, raised fewer specific reasons to support this statement. However, one common reason from national actors was the need to learn from previous experiences to avoid repeating past mistakes, both their own those and of other countries.

5.2.1 Discussion

The term health policy is associated in the RT as mostly with policy *contents* (such as the provision of health services) and less with health policy *processes*. This interpretation, in addition to the challenging methodological considerations in studying policy processes (Walt et al., 2008), may have also resulted in a greater emphasis on policy contents in the literature-based policy analyses (Gilson and Raphaely, 2008; Schouwstra and Ellman, 2006).

International policy actors raised a more comprehensive set of reasons for the importance of health policy processes, compared to the national actors. Many reasons appear to be particularly important for the RT where, for example, the long-term strategic direction is often overlooked in favour of short-term vision in the donor-funded projects.

The culture of learning from the previous experiences was referred to by many national respondents. It is particularly important in a context where frequent changes to the MOH leadership raise questions regarding the MOH institutional memory and consistency in relation to previous commitments.

The main implication for MOH capacity relates to recognition of importance of robust health policy processes. Different characteristics of the latter are implicit in the discussions of their importance: for example, clarity, transparency or integrated and consistent nature of the process. These are discussed in more detail later in this Chapter and the next section explores the understanding of the different stages of policy processes and the resultant implications on the MOH capacity.

5.3 Stages of the health policy process as perceived in the RT

The government officials often referred to the formal government procedure in describing the different stages of health policy processes:

> *"…what we talked about* [health policy processes] *is the formal government procedure, which is written in the Laws. There is a Law about the government of Tajikistan which describes the procedures and protocols. Also, MOH statute …, the statute of Executive Administration of the President – these are all describing distribution of roles at different levels and all of those are in line with the Law I mentioned."* (Current MOH official).

An opinion expressed by international actors was that MOH officials, guided by the formal protocol, are unable to a) clearly distinguish the different stages of a rather dynamic health policy process and b) recognise the potential differences between the formal government procedure and the complex reality of many policy processes.

When asked to describe the different stages of health policy processes in the RT, many respondents identified historical stages of health systems development. However, when probed further, most respondents distinguished the following three stages: *agenda-setting*, *policy development* and *policy implementation* (including policy dissemination and monitoring), as shown in the following two statements:

> "*…first of all it is situational analysis, we need to see where we are. Then we need to develop normative document or … prikazes*[10]*, decrees, charters. After that we need to develop implementation plan and define financial costs … The next step is information awareness, we need to make them aware of what we want and implement [the policy]."* (National Staff, International Agency).

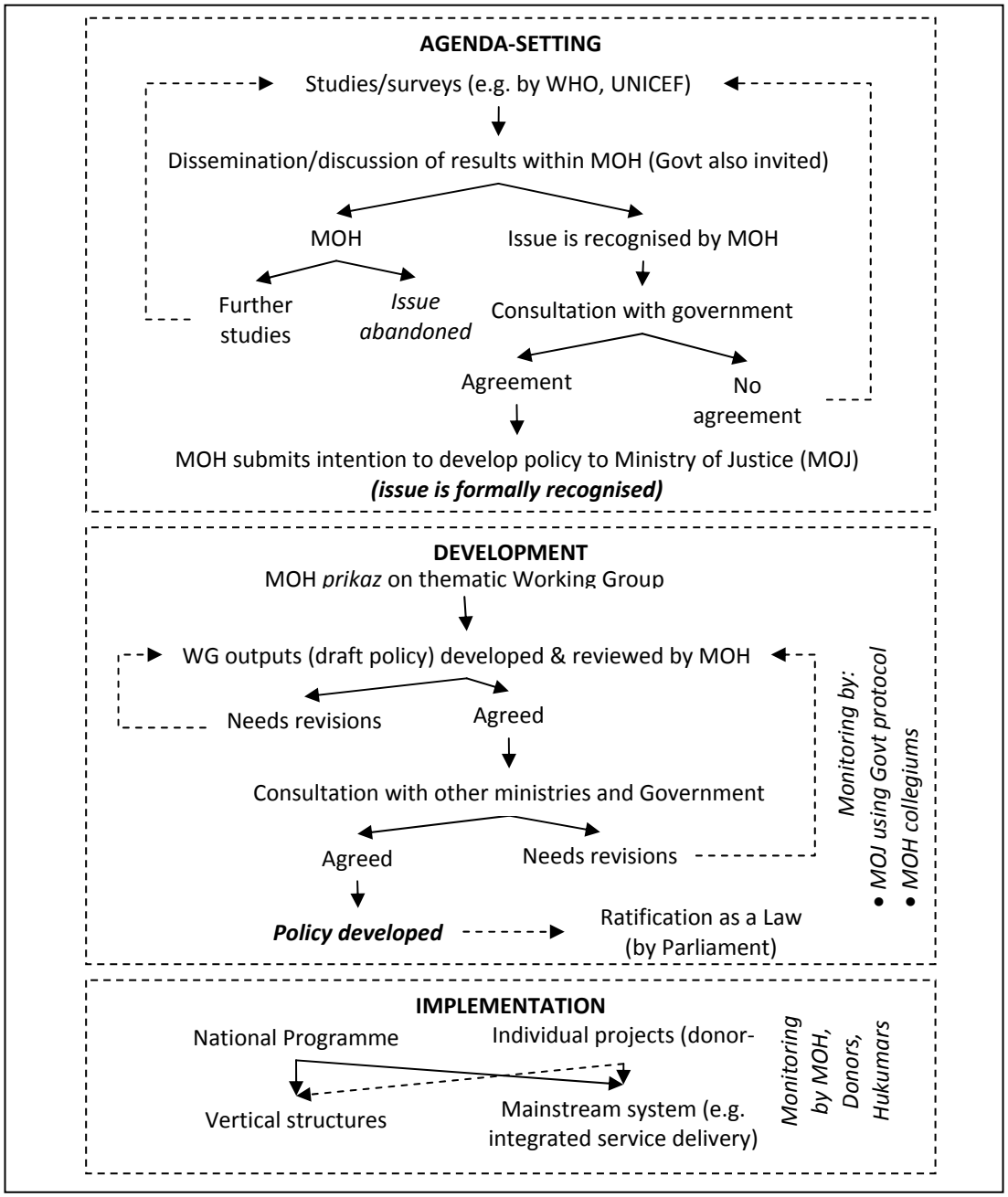
> *"We should have a cycle: we see the problem, we develop a document to deal with the problem, we then implement the document and monitor how well we are implementing the document."* (Current MOH official).

As shown in Figure 12, the *agenda-setting* stage involves situational analysis, often conducted by international organisations who then raise MOH awareness of the issue. The MOH then formally recognises the issue and, following agreement with the government, lodges the intention to develop a policy to the Ministry of Justice (MOJ).

[10] Prikaz is a Russian term for order by the MOH

Figure 12: Formal government protocol for health policy process in the RT

Based on: (GOT, 2005, 2006a, 2008)



The MOH then initiates *policy development*, typically through the organisation of thematic working groups (WGs), often with financial and technical support from the donor-funded projects. Once the policy document is drafted, the MOH is normally required to consult with other relevant ministries, as determined by the MOJ. After this consultation and subsequent revisions the draft policy is submitted for approval to the President's EA. The draft policy may be approved as a national programme or as a draft Law (and submitted for ratification by Parliament). The monitoring of policy development is done at two levels: first, by the MOJ, which uses government-approved milestones as a framework (for example, draft policy

should be sent for comments by other ministries within two years) and second, by the MOH, through the inclusion of agenda items in its regular collegiums.

Policy implementation is normally conducted as part of a national programme, often with the support of donor-funded projects. It is usually the responsibility of sub-national *(oblast, rayon)* health authorities.

The next three sub-sections provide a more detailed overview of actors' perception of these stages of health policy processes.

5.3.1 Agenda-setting

The agenda-setting stage - referred to by some respondents as the '*idea development*' - is the first stage of health policy processes. This sub-section explores the perceived understanding of the agenda-setting stage and main factors affecting this stage of health policy processes.

Most respondents identified *situational analysis* – some form of formal evaluation, often as part of ongoing or planned projects – as part of the agenda-setting stage. Stand-alone (i.e. not related to development projects) academic studies were rarely mentioned by national actors, particularly current and former MOH officials and were mentioned mostly by international policy actors such as international NGOs. Most respondents perceived the situational analysis as a sub-stage of the agenda-setting. On the other hand, a few respondents described the situational analysis as a separate stage of the process, either informing, or being as a result of, agenda-setting.

The national and international respondents identified different factors triggering the agenda-setting though one factor was particularly emphasised. Most policy actors mentioned that the main condition for agenda-setting is the existence of a powerful actor who will be able to initiate the process and to 'sell' the idea to key decision-makers:

> *"…in order for this idea development to happen we need political figures who play particular role in the health system and wider so they could apply their knowledge, power and skills to recognise the issue themselves and to make others to realise the importance of the policy agenda"* (ex-MOH official, National Agency).

Many international actors, in contrast with current MOH officials, reflected that agenda-setting and resultant policy development are often done within the donor-funded projects, rather than initiated by the MOH:

> *"…the health policy was forming not from the understanding of the necessity of its development but it was prompted by external circumstances. When the country was signing up external agreements for the receipt of different types of assistance, the sectors were set conditions to fulfil. And the ministries started forming some strategies in a hurry, often fragmented both within and across sectors…"* (National Staff, International Agency).

Externally-funded projects were regarded as promoting international influences and reflecting the significant power of the international community. The severity of the policy issue was raised as one domestic factor triggering agenda-setting. This was particularly emphasised by respondents associated with thematic policies or working with specific programmes/issues. For example, the problem of unofficial payments, combined with 'formally free health care', was acknowledged in the literature (Falkingham, 2004), and catalysed the development of RT's health financing strategy and respective changes to the National Constitution.

Many respondents shared the view that agenda-setting can be complex and time-consuming. For example, in the late-1990s many policy actors, including the MOH, recognised the fragmenting nature of project-based external aid and the need for better coordination. However, a lengthy period was spent justifying the importance of this to the President's EA, before this has been formally acknowledged in RT's efforts to initiate dialogue on implementation of a health SWAp.

5.3.2 Health policy development

All respondents interpreted policy development as a separate stage. Study respondents were asked to identify the key issues, and main characteristics, of health policy development. The involvement of actors and the appropriate mechanisms were referred to by most policy actors as the key issues during the policy development.

According to policy-makers, the formal government procedure outlines the mechanism for developing and approving policies in RT, including the relative roles and responsibilities of different government bodies. For example, the MOJ is seen as the overall coordinating body for development of all policies whereas the sectoral ministries, such as the MOH, drive the process at the technical level:

> *"…Ministry of Justice… regulates what happens with the draft of policy. Before that, the MOH has statute* [(see GOT, 2006a)] *which describes its role and defines its role in*

what happens before the draft is developed – all what we talked about earlier today [health policy processes]. *You could also trace how the document on, for example, health financing was developed, what assessments have been done, who was involved and so on…"* (Current MOH official).

The involvement of policy actors in drafting health policies is regulated by the MOH through the establishment of thematic working groups (WGs) such as those in relation to the Health Financing and the HMIS. Each WG is formally established by the MOH *prikaz* which outlines its membership, the nature of expected tasks/outputs and their deadlines (MOH, 2006, 2007, 2008c, d, e). Virtually all WGs are funded by ongoing projects, often with the provision of international technical assistance.

Different WGs produce different outputs with some developing draft policies (such as the Health Financing Strategy) and other WGs playing a more advisory role within the policy processes. The respective MOH departments follow the government procedure for consulting with other ministries and other policy actors. The draft is then passed to the Executive Administration of the President of RT for approval by the President's Decree. Many policies are enforced through the ratification of respective Laws (for example, separate Laws exist in relation to Health Insurance, Reproductive Health, TB control) and thus require ratification by the National Parliament as outlined in the Health Law (GOT, 2005). However, no criteria were found that determine the eligibility of translation of health policies into Laws.

5.3.3 Health policy implementation

Respondents were asked to describe the key issues, and main characteristics, of the implementation stage. Most policy actors, including the MOH, identified policy implementation as an integral stage of health policy processes only after some probing. Many respondents also reflected on the different policy implementation mechanisms. These issues are explored in more detail below.

Local-level public health officials, in contrast with other policy actors, had a clear understanding of implementation processes and mechanisms:

"…the Government decree is issued and [is] then sent to the Hukumat of the rayon. In parallel, the decree is sent to the central MOH. We receive the MOH prikazes [MOH orders] *and the head of Hukumat receives also a copy of the Government decree. We develop Hukumat's decision based on Government decree and MOH prikaz. The*

Hukumat's decision is developed by us if it's related to the health sector… Based on this we issue our own district health sector prikaz. We identify responsible for various components… we then report to Hukumat and to MOH on the implementation of the decree..." (Rayon-level Health Authority).

Some national actors distinguished *awareness raising* of the general public as a possible and related stage of health policy process; particularly important in introducing significant changes. Many international actors related this to the failure of the first phase of implementation of the Basic Benefits Package (BBP) in 2005 and the associated introduction of copayments scheme i.e. when the President stopped the implementation of the programme because of the large number of citizens' complaints covered in the media.

Monitoring and Evaluation (M&E) was perceived by many respondents as important parts of individual projects rather than of the overall national health policy:

"We also need to know if the processes are going well or not to be able to adjust and re-group or re-direct our attention. All these are very important and short-term indicators are very important. The process should be monitored in order to timely react and involve the key stakeholders where needed to ensure that we are moving in the right direction." (National Staff, International Agency).

The above quote also shows an interest in monitoring policy processes. However, most respondents referred to monitoring the effects of health policies or policy *content* rather than M&E of health policy *processes*. Furthermore, only a few international actors saw policy evaluation as a separate stage of the policy process and most national and international actors interpreted policy evaluation as part of the policy implementation stage.

It appears that policy evaluation does not always happen because, as one MOH official stated, "…*possibly in the process of implementation we discover that we need to re-group and we can make changes into our plans*" (current MOH official).

5.3.4 Discussion

The three stages of the policy process (agenda-setting, policy development and implementation) identified by the study respondents are broadly similar to literature-based heuristic models of health policy processes (see Sutcliffe and Court, 2006; Walt, 1994; Walt and Gilson, 1994), reflecting the applicability of this element of the conceptual framework to the RT. Each stage could be sub-divided into further separate stages (for example, situational

analysis within agenda-setting), indicating also the applicability of some of more detailed models such as the seven-stage (Barker, 1996; Jenkins, 1978) or even nine-stage models of policy processes (Hogwood and Gunn, 1984). The references to the policy 'cycle' by many respondents emphasise the numerous iterations within and between the different stages of the policy process – another well-recognised characteristic of policy processes in the literature (Barker, 1996; Walt et al., 2008).

Formal government procedure was emphasised as a dominant framework for policy development in RT. The MOH has little influence over the policy development process, compared to the MOJ and the President's Executive Administration (GOT, 2005). This appears to reflect the distribution of power between government institutions, see Chapter 7.

Despite the numerous references in the literature to the greater involvement of a larger number of policy actors in health policy processes (Buse et al., 2005; Walt et al., 2008) this phenomenon is not evident in the RT. Government officials, guided by the official government protocol, appear to see the health policy process as an interaction mostly between the different government actors with little role for the actors outside the government. This potentially limits the recognition by the MOH of other policy actors within health policy processes (for example, of civil society organisations) and may contribute to the limited involvement of non-governmental actors as explored in Chapter 7.

Different factors were seen as triggering agenda-setting. It appears that Kingdon's (1995) three streams - politics, policy and problem - are applicable to the RT. The policy and the politics streams appear to be more significant in opening the window of opportunity, compared to the problem stream. The importance of a powerful and capable policy champion may represent an additional characteristic of Kingdon's window of opportunity and is particularly relevant to RT where personal relationships are important (see Chapter 6).

Agenda-setting resulting from externally-funded projects, unless well-coordinated and managed by MOH, may fragment health policy. Project-based situational analyses appear to feature in respondents' descriptions of the agenda-setting stage. At the same time, projects can catalyse outbursts of policy activities within what is otherwise a relatively gradual policy process. This is similar to the punctuated equilibrium theory (Baumgartner and Jones, 1993). Many issues prompting agenda-setting and catalysing the other stages of policy processes are related to the wider contextual environment (Dobrow et al., 2004; Shiffman and Smith,

2007) and are, therefore, discussed in Chapter 6. The use of evidence in health policy processes such as in situational analyses is explored in Chapter 8.

The lack of references to the policy implementation stage may reflect that term '*policy process*' is more synonymous with terms '*policy development*' or '*policy formulation*'. Implementation is equated with service delivery and not a policy process per se. Therefore, one can almost regard policy implementation separately from the rest of the policy process. However, influenced by literature on policy processes, in this document policy implementation is interpreted as part of policy process.

The lack of recognition of policy implementation as a separate stage of policy processes may be a reflection of a lack of responsibility of the national-level officials for local-level implementation. At the same time, the MOH is seen as an executive agency from the perspective of the President's EA. Although not explicitly featured in responses, it appears that the MOH role is interpreted as an 'auditor' of local implementation rather than a source of policy development and overall technical guidance, as shown in Chapter 7.

Although the M&E was mentioned in relation to policy implementation, what appears to be absent is M&E of policy *processes*, particularly at the policy development stage. The latter may be a result of lack of recognition of, and interest in, policy processes and may also be due to the sensitivity and methodological challenges in monitoring health policy processes (Buse, 2008; Court et al., 2005; Walt et al., 2008). The official MOJ protocol does not provide a clear framework for M&E of policy processes outside formal government procedure. This could be an opportunity for the MOH to introduce sector-level M&E arrangements, though existing project-based M&E approaches and practices need to be taken into account.

Although were not explicitly mentioned by respondents, different implications on MOH capacity can be derived from the actors' understanding of the individual stages of health policy processes, which are shown in Table 16.

Table 16: Implications on capacity at different stages of policy processes

Stage	Implications on MOH capacity
Agenda-setting	• Recognition and managing factors triggering agenda-setting (e.g. need for a policy champion, using existing projects) • Proactive engagement and advance planning of situational analysis, including interpreting results and using evidence in policy processes • Managing different (and competing) influences in setting agenda for

Stage	Implications on MOH capacity
	health policies (e.g. from international community, general public)
Development	• Efficient managing of formal processes, for example, in engaging with other ministries earlier in the policy development • Ensuring representation of different actors (e.g. CSOs) in WGs • Advance planning of outputs from different WGs including effective monitoring of WG's performance
Implementation	• Effecting monitoring of policy implementation at local level, for example through establishing and maintaining productive relationships with Hukumats who are responsible for the provision of services at *oblast* and *rayon* levels (GOT, 2005) • Disseminating policies widely, in order to ensure clear messages and to reduce resistance to change from general public and other actors

Implicit in the respondents' descriptions of health policy processes were the characteristics of robust health policy processes, for example, the degree of actors' involvement or evidence-informed nature. These are set out next.

5.4 Perceived characteristics of robust health policy processes

Study respondents were asked to describe the characteristics of an 'ideal' or robust health policy process. Most respondents experienced difficulties in distinguishing the characteristics of health policy *processes* from the characteristics of wider policies. However, the following seven perceived characteristics of robust health policy processes were identified from the different responses:

1. clarity of policy processes,
2. transparency of decision processes,
3. participation of policy actors in health policy processes,
4. evidence-informed nature of health policy processes,
5. continuous nature of health policy processes,
6. integrated and holistic nature of policy processes and,
7. clarity of resource framework.

These are set out in the following sub-sections, along with any associated features in RT as a reflection of the MOH capacity in these areas. Although the individual characteristics are explored in isolation, two issues are worth emphasising at this point. First, *different characteristics overlap,* for example, the continuity of policy processes and the clarity of resource framework. Exploring the interrelationships between the different characteristics of the robust health policy process is outside the scope of this study and this may be a potential topic for further studies. Second, *interrelationships exist between the different characteristics.* For example, the participatory nature of health policy processes can be a

result of the transparent process with guidelines providing 'windows of opportunity' for actors' involvement. At the same time, wider participation may contribute towards greater transparency.

5.4.1 Clarity of the process

Clarity of policy processes, referred to by many government officials as a direct reflection of formal government procedure, was mentioned by many international organisations as the first and the foremost prerequisite of a good health policy process. This characteristic refers to the degree of understanding of the policy process by the policy actors, both within and beyond the government.

Most policy actors that are outside government were less clear of the formal government procedure in relation to health policy processes. For example, one CSO representative reflected on the experience of being involved in the M&E of the Poverty Reduction Strategy Paper:

> *"…I didn't have a lot of information on other members* [involved in M&E]. *I knew that the establishment of this monitoring group is a good indication of the importance given to PRSP in the country. I only knew that this group had 3 people, a head and two staff members... They also did not have any further structures and further mechanisms of interaction with mainstream systems in the sector…"* (Former CSO member, International Agency).

5.4.2 Transparency of decision processes

The transparency of policy decision processes was another desirable characteristic. This characteristic was interpreted as related to clarity with the difference being the emphasis on the policy *decisions* taken by the President's EA or the MOH.

Differences were identified as to the current transparency of decision processes. Government officials claimed the highest degree of transparency. In contrast, many international organisations described policy decisions as being behind closed doors, as illustrated by the case of developing the BBP document:

> *"…they [policy-makers] did involve only people they wanted, and whom they wanted were actually older age clinicians. Often, they are well respected but they are clinicians and not management and financing specialists or public health specialists. And I think there were further issues like isolation, not communicating with the external people …*

And everyone was surprised by the product [BBP document] *which was written really bad and then it ended up to be a mess…"* (National Staff, International Agency).

Perceptions as to the level of transparency appear to reflect the relative power of policy actors. For example, one opinion was that the MOH and the WB, especially when working together, were not always transparent with their policy decisions:

"…the World Bank is one of the strongest institutions on the ground … and I think they got some leverage at the government level to promote some of their changes and some of their decisions by the ministry of health … and the process in the ministry is not always transparent …" (National Staff, International Agency).

Many respondents described the transparency of policy decisions as either a prerequisite for, or a result of, the participatory nature of policy processes, which is discussed next.

5.4.3 Participation of policy actors

This characteristic was interpreted by respondents as the degree of involvement of the different policy actors in health policy processes. Three broad themes emerge from the different responses: the perceived importance of participation, perceived benefits of actors' participation and the current MOH practices as a broad reflection of MOH capacity. These are set out next.

Most respondents described the participatory nature as a positive feature of the policy process; however they contrasted it with the current practices. The benefits of greater participation of policy actors in health policy processes were increasingly recognised by the health policy-makers, as shown below:

"…there was very hectic preparation one year ago for GAVI application, for health system strengthening. The time was short [and] *it was prepared by WHO consultants… there is no way the proposal could get funded... in the next application phase in half a year … there was very intense work which involved a lot of different people including different structures not only within MOH but also Centre for Immunisation, different stakeholders WHO, UNICEF …, they improved the quality of the application really significantly… so it was basically a document that used a lot of evidence-based techniques. So, this is some progress and people liked the process after all."* (National Staff, International Agency).

However, some respondents saw potential negative implications of, and preconditions for, the wide participation of actors. These included delays in the process or the need for MOH capacity to effectively reconcile differing views. The perceived need for actors' participation also differed between the stages of the policy process, with many respondents perceiving the need greatest at the agenda-setting:

> *"…there is a saying "If there are too many cooks, the soup can be salty"… At the very early stage, as many actors as possible should be involved because it is kind of a putting the problem on the table. And after clarifying the gaps* [and] *the needed areas relevant persons need to be involved, just relevant ones, or otherwise it will be a mess..."* (National Staff, International Agency).

Lastly, there was a clear difference in opinion between the policy-makers and the international community in relation to the degree of actors' participation. The MOH described its own practices from a more positive perspective, in contrast with the statement below from an international agency:

> *"I think the bad example is all about not getting competent people to working group, trying to isolate yourself from the people to not get into the issues into the programme and trying hide basically you have in your system, and in your programme."* (National Staff, International Agency).

More detail on actors' roles and involvement in health policy processes are included in Chapter 7. Descriptions of the participatory nature of the policy processes often included the references to actors' involvement in generation, dissemination and use of evidence in health policy processes – another characteristic of robust health policy processes which is explored next.

5.4.4 Evidence-informed nature

This characteristic refers to the degree of evidence use in health policy processes. All respondents shared the view that health policy processes should be evidence-informed.

References were made by many respondents to the applicability of evidence at different stages of health policy processes. Examples in support of this view included conducting research/situational analysis as part of the *agenda-setting*, conducting reviews of other experiences in setting policy priorities or appraising policy alternatives during *policy development* and conducting M&E as part of *policy implementation*. A more detailed discussion of the role of evidence in health policy processes is provided in Chapter 8.

There was, as with other characteristics, a clear divide between the opinions of the national and the international policy actors in relation to both the evidence-informed nature of policy processes in general and the MOH practices in particular. Current policy-makers felt that most policies are evidence-informed. In contrast, the international agencies described the use of evidence in health policies as not systematic and also reflected on the poor quality of evidence itself, for example, the HMIS data.

5.4.5 Continuous nature of policy processes

All respondents were in agreement that health policy processes are lengthy. Most respondents suggested that it is important for the MOH to have a continuous and consistent view of, and approach to, health policy processes. Three implications of this are set out in this sub-section: the need to ensure continuity of health policy direction, the need to consider the ever-changing context and, where appropriate, the need to deploy a phased approach.

There were no major differences between the respondents' views concerning the lack of continuity of policy processes due to the frequent changes to the MOH staff. All respondents shared the view that these changes often delay the policy processes:

> *"Our wound is that our management in the MOH is changed frequently. These changes always result in some delays... But the political and strategic documents developed earlier really help. The … new team… do not refuse from these documents, 'the plan was developed before us and let's stick to this plan'"* (Current MOH official).

> *"…you know the very frequent turnover of the staff within the ministry of health. Last few years it was four ministers, completely changing all deputy ministers, this has very big negative impact over the established relationships… you have to start from the scratch again…"* (National Staff, International Agency).

Many national policy actors reflected on the importance of keeping up-to-speed with the changing context within the long-term policy processes. One opinion from an international agency in support of this view was that the nature and quality of evidence is also changing and the MOH was not always able to recognise the nature of those changes and their implications on health policy processes. For example, some 'deterioration' of health indicators was interpreted as a reflection of improved reporting rather than worsening health status.

Some respondents also reflected on another implication of the long-term nature of the policy process on MOH capacity: the need to deploy a phased approach. This was seen as important to 'avoid making big mistakes' but also to identify the relative inputs of the current often fragmented activities towards the wider policies. However, this view was not shared by all respondents with some, including current MOH officials, believing in the need to 'maintain the momentum' as a prerequisite for success (for example, in obtaining approval from the President's EA or ensuring acceptance by the public).

5.4.6 Integrated and holistic nature

Four types of integration can be distinguished from the different responses, as set out below.

Respondents emphasised the importance of *integration within the wider context of RT*. This included consideration of different though inter-related issues ranging from the managers' mentality and the public's expectations through to the resource framework, as shown by the MOH experience of rationalising the network of health facilities:

> *"…you understand that this* [rationalisation] *carries subjective complications – each facility is headed by a person and those people react very negatively on the suggestions of closure... The second one … is the problem with equipment. We found that in 90% health facilities equipment is out-of-date; it was bought 30-40 years ago, it is outdated, in many cases a small failure is a cause for equipment not used* [because of absence of maintenance]. *There have not been supplies of new equipment, in those years investment projects were scarce in Tajikistan and budget resources are not enough to upgrade equipment."* (Current MOH official).

The second type of integration refers to the *consistency with other health-related public policies* such as the Poverty Reduction Strategy or the MDGs. Many international actors described little integration between, for example, the MOH, the Ministry of Finance and the President's EA:

> *"The problem in Tajikistan is again there is no connection between this PRSP [Poverty Reduction Strategy Paper] and the budget, there is no link so the PRSP is not costed or if it's costed it's unaffordable for the Tajik Government to finance and there is disconnection between the policy framework and financial provisions. So, now despite all these investments by the government and donors the health indicators are going downwards, there is no proper connection there…"* (Expatriate Staff, Donor Agency).

The third type of integration, *integration between different health policies*, was also seen as important because of the interrelationships between the different policy areas. There was agreement among respondents that the different policy areas in RT were developed in an isolated way raising the need for integration:

> *"…from the very beginning we were dividing very clearly that we have health financing reforms, we were dividing the directions, primary health care and I think too much time was spent on different categories. We distracted these few people who were working in the ministry of health but I think in the very beginning it should have been a very clear systemic approach…"* (National Staff, Donor Agency).

> *"one big problem of the MOH or the health policies is that they are very fragmented by different programmes and different sectors, departments, not putting altogether in one basket and having a good health policy. Now, let's see TB is completely separate, HIV is separate, MCH is separate, human resources are separate. They have to bring all these fragmented pieces in one place, in one basket and to have very strong health policy"* (National Staff, International Agency).

The fourth type of integration refers to *integration within health policy processes*, for example integration between the development and implementation stages. This type of integration was sometimes mentioned as part of other characteristics of health policy processes such as continuity of policy process or a clear resource framework. However, most respondents identified integration within health policy processes as an important characteristic on its own:

> *"…first of all, appropriate mechanism should be found for implementing this or that strategy. And, of course, the players, the right people should be chosen for that, for managing it, for implementing this strategy. What else? It should be monitored, it should be analysed and reported, you know"* (Expatriate Staff, Donor Agency).

Differences were found in respondents' perceptions of MOH capacity in relation to different types of integration. Policy-makers described a more positive image whereas the international community were far more critical of MOH practices and approaches:

> *"…policy development and its connection to the actual activities is really ignored because it proved to be easy to develop recommendations and making changes in the document but things get much more difficult to make those things come to life, you know"* (National Staff, International Agency).

Consideration of the wider context and the integration of health policy processes with the wider public policies were referred to by some international respondents as '*holistic approaches within health policies*' (National Staff, International Agency). Some respondents referred to a one-way relationship between the context (including various public policies) and health policy processes whereas others suggested that health policy processes may influence the wider context. Often the descriptions of integration included reference to the establishment of a clear resource framework, which is explored next.

5.4.7 Clarity of resource framework

Virtually all actors had a similar view that any policy process should consider resource implications. Respondents' interpretation of resources can be grouped into two broad types: *generic resources,* such as an adequate legal framework and sufficient funding and *specific resources* in support of health policy processes, such as the different thematic WGs and the appropriate communication mechanisms.

One example of the low consideration given to the generic resource framework by the MOH was the Health Reform Conception (approved in 2002) which was widely criticised by many (mostly international community) for rather ambitious resource projections and the lack of a feasible resource-based implementation plan.

The importance of the robust legal basis in the implementation the MOH policy on rationalisation of health facilities was emphasised by many respondents. Different respondents reflected that the legal basis was needed to ensure continued financial commitment to the planned changes, to retain savings within the health sector and to leave the MOH in control of potential savings:

> *"We started sorting out the legal documentation in order to avoid previous mistake[11]. We proposed to the government to leave the MOH in control of resources to be saved as part of this reform. There was government's decree – there was a separate decree stating that the resources saved as part of reform will remain in the health sector. The second stage in developing legal basis we had to shift the approach to financing from ministry of finance from being based on the number of beds to the number of cases treated."* (Current MOH official).

[11] The savings from rationalisation were taken over by the MOF in the past

As discussed in Chapter 10, the specific resources in support of health policy processes (for example, HPAU and WGs) were referred to by only some respondents and often only after probing.

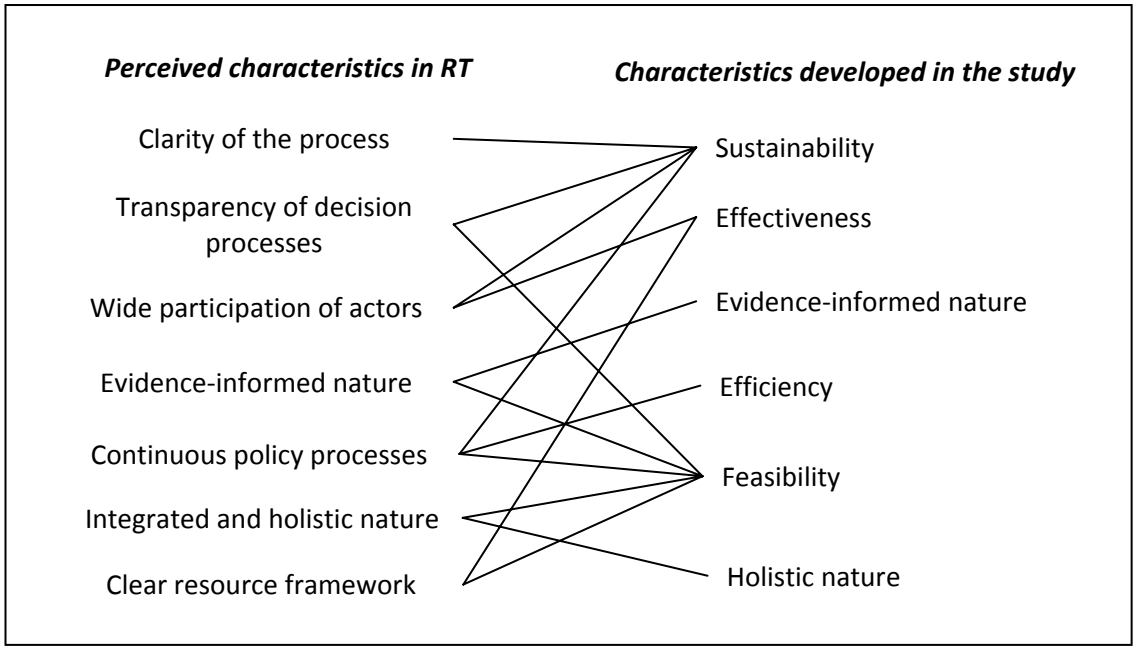
From the capacity perspective, some respondents referred to the improvements in the MOH ability to establish a clear resource framework – largely as a result of learning from previous mistakes such as the rationalisation of health facilities. Many respondents referred to the different constraints affecting the MOH ability to establish and effectively use the available resources in support of health policy processes. Examples of this include the frequent changes of the MOH leadership combined with the culture to make bold political statements (often with little resource commitments) and the uncertainty with external funding in a donor-dependent health sector. These issues are explored more in Chapter 10.

5.4.8 Discussion

The seven characteristics of robust health policy processes, derived from respondents' understanding of robust policy processes, are broadly similar to literature-based characteristics of good wider policies or criteria for assessing policy recommendations. More specifically, McKee et al's interpretation of visibility, ownership and capacity overlap with interpretations of clarity, transparency and participatory nature of policy processes identified in this study; the intersectoral action is similar to the holistic nature; and the understanding of an effective government is an integral part of understanding of transparency and actors' participation in health policy processes (McKee et al., 2000). Macintyre et al's evidence-informed nature and cogent argument-supported recommendations correspond to the evidence-informed nature of health policy processes; and feasibility and costs of implementation are similar to the integrated nature and a clear resource framework in health policy processes (Macintyre et al., 2001).

The perceived characteristics of robust health policy processes also broadly correspond to the six characteristics of robust health policy processes developed in Chapter 2, as shown in Figure 13.

Figure 13: Comparison of characteristics of robust health policy processes



None of the above characteristics operate in isolation and the different overlaps and complex interrelationships exist amongst the different characteristics, as illustrated in Figure 13. Although detailed exploration of those is outside the scope of this study, it represents a potential area for further research in RT and wider.

The different degrees of clarity of health policy processes amongst the policy actors suggest two conclusions. Firstly, *health policies are developed behind closed doors*; therefore only limited policy 'circles' have a clear understanding of the processes, similarly to other findings (Exworthy, 2008). The example of a CSO member not understanding the M&E mechanisms also reinforces the concept of policy 'circles' (comprising mostly the government and the international actors) resulting in a limited involvement of other national actors (such as CSOs) or the private sector. In practice this may contribute to representatives from the international community being more involved in health policy processes than national actors. Secondly, *the mechanisms for raising awareness about the formal government procedure do not exist or are not effective*. The function of monitoring of the government procedure is a prerogative of the MOJ, which may limit the MOH mandate to disseminate the government procedure more widely, for example, to ensure the wider involvement of underrepresented actors such as CSOs.

It is important, to distinguish between the *policy decisions* made by the MOH in consultation with the powerful donors such as the WB and the *technical advice* provided by various INGOs

and working groups with the latter not carrying political weight. The question is whether the current level of transparency is merely a reflection of 'adequate' transparency of policy decisions where the MOH is expected to take the initiative. Even if this is the case the MOH needs to develop capacity to recognise the views of other policy actors and, where possible, consider those views in health policy processes.

Many respondents acknowledged the positive implications of the increasingly wider participation of actors in policy processes. This may be a result of wider shift from the former vertical system of command and control towards the more inclusive policy processes in RT, and is in line with a wider shift towards more inclusive health policy processes identified in the literature (Buse et al., 2005; Walt et al., 2008).

It appears, however, that there is a greater involvement of the international organisations in the different working groups compared to the national actors. This may reflect the inclusion of international actors within the 'policy circles' but may also suggest a greater trust and reliance, by the MOH, on internationally-available expertise. However, there is insufficient evidence to confirm or otherwise this conclusion; this may represent a potential area for further studies.

The need for evidence-informed policy processes was unanimously shared by most respondents. This corresponds with the international tendency to favour evidence-informed policy decisions (Green and Gadsby, 2007; Jewell and Bero, 2008; Lavis et al., 2008c; Shaxson, 2005). However, only a few respondents identified informal types of evidence. This may limit the application of informal evidence in health policy processes, as explored in Chapter 8.

The lengthy nature of policy decisions is acknowledged in academic literature (Exworthy, 2008) and the RT is not an exception. The phased nature of health policy process is, therefore, especially important for the RT where a lengthy bureaucratic process may cause significant delays. For example, the approval of the new health financing strategy was postponed from 2002-2003 until changes were made to the National Constitution in 2005 allowing co-payments from the population. Therefore, skills and expertise in forward planning and critical path analysis (Green, 2007) are important for the MOH to develop and apply in health policy processes.

The different forms of integration are important for the RT where significant changes are introduced as a result of different parallel public sector policies such as the MTEF and the

PRSP. One issue for consideration by the MOH is finding the best way to ensure the different forms of integration, for example, horizontally (i.e. between the different health-related public policies) as well as vertically (i.e. between the health policy processes and the respective public policies).

Lastly, there appears to be a clear divide in the opinions of the national and the international actors in relation to MOH capacity to ensure the above characteristics. National actors, especially policy-makers, were much more positive concerning the different aspects of health policy processes. In contrast, international actors were more sceptical of MOH capacity. National respondents within the international agencies appear to be more critical of the MOH approaches, compared to national policy actors. This may indicate the perceived degree of freedom of expression and the sense of security within international organisations though may also reflect the organisational policies/approaches of those agencies.

5.5 Conclusions

This Chapter explored the understanding and perceptions of health policy processes in RT. The importance of health policy processes is shared by all respondents despite the varying degree of recognition of the different policy stages.

The stages heuristic model can be applied to the actors' interpretation of RT's health policy processes. Other literature-based theories and frameworks are also relevant to the RT though the degree of application varied. The three stages of health policy processes (agenda-setting, development and implementation) can be distinguished. The M&E is interpreted as an integral part of the policy implementation and not as a separate stage. The situational analysis, though sometimes regarded as a separate stage, is perceived to be part of agenda-setting. The different implications on the MOH capacity are distinguished in relation to each stage of health policy processes.

The following seven characteristics of robust health policy processes can be distinguished: clarity, transparency, actors' participation, evidence-informed nature, continuity of the process, integrated and holistic nature and clear resource framework. Different characteristics overlap, are involved in complex interrelationships and may be regarded as a reflection of the MOH capacity to ensure robust health policy processes.

The perceived MOH capacity in relation to the above characteristics was described positively by the national policy-makers, in contrast to their international counterparts. National

respondents within international agencies appear to be more critical of the MOH, compared to the national agencies.

It is clear from the findings so far that health policy processes operate within the wider context. The next Chapter explores the different elements of, and interrelationships between, the wider context and the MOH capacity to conduct health policy processes.

6 IMPLICATIONS OF THE CONTEXT ON MOH CAPACITY TO CONDUCT HEALTH POLICY PROCESSES

6.1 Introduction

The context is a component of the conceptual framework and is defined as a complex set of factors, external to the MOH, both within and outside RT, along with their interrelationships, affecting health policy processes. This Chapter explores the main contextual factors and their perceived implications on the MOH capacity to conduct health policy processes. The structure of this Chapter follows the identification of main groups of contextual factors, as set out next.

6.2 Contextual factors and their perceived effects on MOH capacity

The wider context was seen by virtually all respondents as an important influence on the MOH capacity. This is view was also supported by the key policy documents in RT (see GOT, 2006c; MOH, 2002).

The respondents identified a number of contextual factors, ranging from international initiatives and influences (for example, MDGs) to country-specific issues (for example, political environment or socio-economic status). These can be grouped into the following five broad groups, similar to the classification proposed by Collins et al (1999):

1. *External influences*, including international policy influences
2. *Socio-economic transition*, including demographic and epidemiological changes
3. *Political framework*, including regime, existence of country's political agenda and degree of political support
4. *Public sector policies*, including public sector reforms
5. *Working culture* within the public sector

Only a few respondents and documents explicitly identified the implications of the wider context on the MOH capacity. Some respondents and documents distinguished clear positive and negative contextual effects on the MOH capacity whereas others referred to similar factors as having both positive and negative effects, as set out next.

6.2.1 External influences

The external influences (for example, political, economic and ideological) were identified by most respondents and documents as especially important for the aid-dependent RT. Three levels of external influence can be distinguished: a) wider politics, b) international and

regional (inter-country) influences and trends and c) country-specific changes in relation to international aid, as set out below.

The external politics, such as the on-going instability in neighbouring Afghanistan or the economic sanctions on Iran[12], were seen by many respondents as important and the perceived effects on the MOH capacity were mostly related to a decreased sense of stability by policy actors. Some respondents reflected on more direct effects of the external politics on health policy processes:

> *"Several [project] sites were closed because it became known to USAID that the Tajik side have been procuring either grains or something – as part of the project they were collaborating with Iran – those were closed because supposedly according to their rules they were not allowed to work or buy something from Iran."* (Expatriate Staff, International Agency).

The second level of external influences refers to the different international and regional influences and policy trends. Some respondents reflected that the adoption of the MDGs led to the proliferation of a number of donor-driven initiatives (for example, on HIV/AIDS and maternal health) thus leading to the creation of respective Republican Centres[13]. The main perceived implications of these on MOH capacity include the increasing needs for coordinating a larger number of policy actors in health policy processes.

As for the inter-country influences, RT's health reforms were often described as slower than in other Central Asian Republics (Borowitz and Atun, 2006; McKee et al., 1998). As a result, RT was referred to as "…*is looking at reforms in other countries such as Kyrgyzstan as possible models of reform*' (Borowitz and Atun, 2006 p.435). Some respondents also reported the perceived:

> *"…international pressure to move, fashion in a sense that equity or you know because Kyrgyzstan is doing the reform on this GBP [Guaranteed Benefits Package] because they apply capitation so we also do because all Central Asian countries do so…"* (Expatriate Staff, Development Partner).

Many international policy actors perceived this as an opportunity to strengthen the MOH capacity in relation to, for example, policy analysis. However, the frequent comparisons with

[12] Both Afghanistan and Iran share common Persian roots with the RT

[13] Established to manage respective National Programmes

neighbouring Kyrgyzstan and the resultant policy agenda, 'prescribed' by the international community, caused a negative reaction from the RT's policy-makers with clear implications for their willingness (as one aspects of capacity) to learn from the neighbours:

> *"They often say why in Kyrgyzstan it's happening better, but then they often get irritated when you compare them with Kyrgyzstan. At the last SWAP workshop, I liked when the Deputy Minister pointed that why we always get compared to Kyrgyzstan… it's a different context, and there are different dynamics in this country"* (National Staff, Donor Agency).

Many policy actors identified increasing trust by international community to the health sector in general and the MOH in particular. Respondents referred to this phenomenon as part of the enabling environment for the MOH capacity strengthening. For example, many national policy actors identified an increasing role for the public sector in the coordination of external aid which was previously largely UN-coordinated. This view, however, was not shared by all study respondents and many international respondents were critical of the MOH capacity in relation to coordination, as explored in Chapter 7.

Most respondents shared a view that that there is now greater flexibility to accommodate the emerging national priorities within externally-funded projects. This was thought to provide the MOH with opportunities to develop and apply its capacity in different areas, for example, priority-setting. Some respondents attributed the above shifts to the wider socio-economic transition, which is explored next.

6.2.2 Socio-economic transition

The country's socio-economic transition since independence posed challenges to health policy processes and MOH capacity, including deterioration of socio-economic status, emigration leading to human resource shortages and the need to change the general public's mentality in relation to costs of health services, as set out below.

A most commonly referred to trends since independence is the decline in socio-economic indicators. The RT, being one of the most neglected former soviet republics (McKee et al., 2002), experienced a sharp reversal in the Human Development Index between 1985 and 2003 and in 2005 was ranked 122nd – the lowest amongst the FSU republics (UNDP, 2005). Some documents also refer to the epidemiological transition contributing to the "*double-burden of both infectious and non-infectious diseases*" (Akhmedov and Mirzoeva, 2000 p.3). Poverty became widespread, with about 80% of population living below the poverty line

(World Bank, 2000). Social inequalities have widened with women and children affected the most (Falkingham, 2003, 2004; Veenema, 2000). The out-of-pocket payments within the health sector emerged in many post-soviet economies (Balabanova and McKee, 2002; Thompson and Witter, 2000) and were deteriorating access to health services and fuelled the widening inequalities (Falkingham, 2004, 2005). Nowadays the RT remains socially and economically dependent on the Russian Federation with examples of this interrelationship including academic links and working migrants (Mirzoev et al., 2007).

The interviewed policy-makers stated that the sharp economic decline meant that most resources in the health sector were directed towards addressing short-term service-delivery needs such as the outbreaks of communicable diseases leaving little. As a result, little or no attention was paid to allocating resources to health policy processes and the MOH capacity strengthening.

Some respondents reflected that the socio-economic decline and the resource-constrained framework raise an important area for the attention of policy-makers: the need to achieve a balance between urgent needs and longer-term development priorities within health policy processes. According to respondents, this has direct implications on the need for MOH capacity in ensuring this delicate balance.

As identified earlier, the RT's health reforms have been slower as "*most of the post-independence period was spent recovering from the civil war…[and]… instituting systematic reforms is difficult*". (Borowitz and Atun, 2006 p.435). The emigration of staff, including policy-makers themselves, at a number of levels (from the public sector, from the health sector, from the country) was described by many as an important negative consequence of the socio-economic changes since independence:

> "*…the outflow of health staff was one of the major [contextual] factors…. I also see the issue of whether MOH staff working on donor-funded projects should be considered as civil servants, because their salaries and motivation are very different…"* (Current MOH official).

The emigration of policy-makers was exacerbated by the large outflow of health professionals involved in the implementation of policy processes.

> *"…we have very high turnover/migration of CHPs from PHC level… First of all, it's the level of life, people are leaving for better salaries elsewhere, even going across the river*

to Afghanistan just to earn more money. That's why we are having lots of problems, we train people and they leave next month." (National Staff, International Agency).

Lastly, the new approaches to health policy processes during transition raised the need to address the attitudes of the general public towards the costs of health services. For example, the FSU Constitution entitled all RT citizens to free healthcare up to late 2006. This posed significant problems for the introduction of the Guaranteed Benefits Package (GBP) (some respondents used the term 'Basic Benefit Package'), which assumed co-payments from the public for some PHC services:

"…the implementation [of] the BBP was stopped twice in 2005 and 2006 because of people's unhappiness. The design was beautiful, everything was agreed with everyone but when the President went for his usual pre-elections meetings with the population the most concern was 'why you are introducing charges' but title your initiative as 'guaranteed benefit package – what is our package?'" (Ex-MOH Staff, Development Partner).

According to respondents, the socio-economic transition diminished the MOH capacity, through various implications. These were staff migration and the increasing need to develop skills and expertise to manage effectively the culturally-sensitive changes, to ensure wider consultation (for example, through various information campaigns) during policy development. The policy-makers themselves referred to the case of the halted GPB as a 'learning opportunity' for the MOH. Most policy-makers stated that an effective way of managing culturally-sensitive policy changes is through the wider political and legal framework, which is explored next.

6.2.3 Political framework

The RT's political framework was frequently referred to by respondents and featured in many documents. The following issues were raised by different respondents: the political regime, the existence of a wider political agenda and its relationships with health policy processes and the degree of political support from the country's leadership, as set out next.

The RT's political system – referred to as decentralised authoritarianism - was described as the weakest of the post-soviet systems (Engvall, 2006). The literature suggests that the capability of the political system for self-preservation and adaptation are important characteristics of a robust political system (Almond and Powell, 1966) and improvements in each of above areas were reported in RT (Aliev, 1997).

Another contextual factor potentially facilitating various capacity strengthening initiatives was referred to as an existence of the country's wider political agenda, as described in relation to other FSU republics:

> *"The EU accession process [in another FSU country] was so strong mechanism …that … the government was really making huge steps forward and each line ministry was strongly supported…"* (Expatriate Staff, Development Partner).

However, none of the respondents referred to the wider political agenda originating from within RT and most documents refer to RT's commitment to the various international policies such as poverty reduction or MDGs (Anvarov, 2002; GOT and UNDP, 2003). From the perspective of capacity one international respondent suggested that this may reflect the lack of MOH capacity to initiate policies based on the country's needs and ensure financial commitment from the President's EA and donors.

Some contextual factors, though described as barriers to robust health policy processes, were identified as a reflection of wider government policies. For example mass emigration of both working class and professionals to the other FSU countries was referred to earlier as a clear barrier to policy implementation. On the other hand, one respondent suggested that this might be a deliberate political decision by the RT's Government to maintain the status quo in the country:

> *"…I think it's a deliberate policy … of course it has an important contribution to the GDP, but it also avoids civil upheaval and civil unrest. Having 1 million strong guys working outside, it's better to have them outside than in Tajikistan doing nothing. I think there is a political will to keep a kind of status quo for the time being…"* (Expatriate Staff, Donor Agency).

The same respondent suggested that the MOH should develop ability to align health policy processes with the wider political agenda, to ensure political commitment to health policy processes from the President's EA.

Respondents reflected on one facilitating factor in relation to MOH capacity strengthening as the degree of political support from the country's leadership:

> *"…[the] big plus is initiative of our President. You probably know three times he gathered donor's forum … and there are results of this… This is a huge help and I think not every country managed to involve so many donors"* (Current MOH Official).

The implications of this on MOH capacity were thought to be multiple, including a potentially increased resource framework for policy processes, more opportunities for capacity strengthening and a more systematic dialogue between the national and the international policy actors. A few respondents reflected that the signs of a robust political system in RT may encourage inclusive policy processes and has implications for the MOH capacity to challenge the existing preconceptions (including those of the President's EA) within the policy development and implementation. The latter is related to the working culture, which is discussed further in this document (see 6.2.5).

The next sub-section explores the main public sector policies and changes perceived to have an effect on the MOH capacity.

6.2.4 Public sector policies and changes

The multiple wider public sector reforms were frequently referred to as a favourable environment (financially, structurally and technically) for strengthening the MOH capacity. After the break-up of the USSR most countries initiated large-scale reforms, including in the health sector (Gotsadze et al., 2005; Lember, 2002; McKee et al., 1998). Structural adjustments of RT's public sector started in 1998 with the adoption of the Medium-Term Economic Adjustment and Reform Programme funded by IMF and WB. These reforms moved forward in early-2000s, though the progress was slow in some areas such as the privatisation of health facilities/services (GOT et al., 1999). The early 2000s also witnessed the implementation of the MDG project, supported by the UNDP, which produced a number of recommendations and targets to different ministries, including MOH, in relation to MDGs (GOT and UNDP, 2003). The first Poverty Reduction Strategy Paper was developed in 2000-2002 and the implementation of second PRSP was underway during the data collection.

However, the integration/cohesiveness between health and public-sector policy processes was seen as a challenge, with many respondents suggesting the need for more MOH engagement in the public policy processes:

> *"…concerning those major programmatic documents such as PRSP and national development strategy – these papers have been totally donor-driven. … very few departments [ministries], health or education etc, knew about this… They vaguely knew that there is a document drafted by guys at the presidential level and when it comes to the sectors then no, they don't know…"* (Expatriate Staff, Donor Agency).

Some public policy documents contradicted each other, adding to a challenge for respective ministries to integrate their policies:

> *"…we often have situations when one Law contradicts another… when the document on "Educational standards in Republic of Tajikistan" was developed in 1996 the "Conception of medical and pharmaceutical education" was also developed… The two documents provide contradictory guidelines on some aspects of medical educational standards, despite I was told that these two documents have been approved by the Government nearly on the same day…"* (Ex-MOH Official, National Agency).

An adequate legal framework was described by the many policy actors, especially the policy-makers, as an important factor affecting the MOH capacity. An example of Health Financing reforms was referred as one case study where outbursts of activity – similar to policy 'punctuations' (Baumgartner and Jones, 1993) - occurred after revisions to the National Constitution in 2005 which removed the citizen's rights to free healthcare.

Some public sector-related factors were seen as both positive and negative by different respondents. For example, the inherited system of strong command and control was described by many international policy actors as prohibiting actors' participation in health policy processes. On the other hand, some national actors saw this system as an opportunity to strengthen the monitoring and evaluation mechanisms in policy implementation.

One particular aspect of public sector changes was particularly emphasised by most respondents: the RT's transition from the relief to the development stage, as set out next.

Transition from the relief to the development

The shift from the relief to the development stage is widely discussed in academic papers (Akhmedov and Mirzoeva, 2000; Mirzoev et al., 2007) and government publications (GOT, 2003, 2006c; GOT and UNDP, 2003). This view was also shared by all respondents with many relating this transition to on the dynamic nature of the context:

> *"…[policy process]should be very flexible… to accommodate the changes, the political context, and everything else that is happening in such a developing country"* (Ex-MOH Official, International Agency).

Two broad changes in the above transition affecting MOH capacity can be distinguished from the different responses: changes in the nature of external aid and changes in composition and practices of policy actors, as set out next.

Changes in the nature of external aid were identified by most respondents with more projects addressing issues of capacity of different policy actors though the MOH appears to be ignored in these capacity strengthening initiatives:

> *"…our projects, right after the civil war our projects used to be relief and now they are more development. Under these projects we try to build the capacity of local government or community to advocate or create relationships with the local government and we try to involve all of them in the implementation of our projects"* (National Staff, International Agency).

The view of increasing attention to capacity strengthening in on-going projects was also shared in reviewed documents (Khadjieva, 2008; WHO, 2007b) and findings from the observation of policy events.

The transition also affected the composition of health policy actors. Examples of this include the effects of the reduced availability of relief-oriented funding (for example, ECHO) leading to closure of some relief-oriented INGOs. As discussed in Chapter 7, the 'new' policy actors bring different agendas and practices, posing the need for the MOH to adapt to the different composition of health policy actors.

The transition has resulted in a number of perceived changes to the MOH capacity in relation to actors' coordination - for example, as part of the intention to implement a health SWAp in the RT (Anonymous, 2008; Mahon and Tediosi, 2007; Mirzoev, 2004). One respondent provided a typical view of the effects of the contextual changes on the MOH capacity:

> *"I just go back to where the country was 6-7 years ago… there were too many projects, sometimes these projects were duplicating each other… the MOH… was lacking not only HR in terms of capacities, but funds as well, knowledge on how to work in the change situation. You know very well that the system was changing almost entirely…"* (National Staff, Donor Agency).

It appears that the transition towards development has also contributed to a stronger MOH voice in relation to the quality of externally-available technical assistance:

> *"…if the donor organisation has set a task in the health sector then it has to be prepared and it is very important to ensure the appropriate educational level in order to do something in the country. Often we had situations when donor organisations had a vague perception of the issues for development…"* (Current MOH official).

Other respondents, particularly international policy actors, reflected on the increased trust and reliance from the international community on the MOH and the other national actors in relation to health policy processes (for example, within nationally-led thematic working groups). At the same time, the increased reliance seems to have raised the need to develop the MOH capacity in further areas/disciplines such as health economics or evidence-informed policies (Gaibov, 2004).

6.2.5 Working culture within the public sector

Virtually all respondents reflected on the different implications of the working culture on MOH capacity.

The language and interpretation of key terms and concepts appear to be important in understanding the working culture. For example, the term 'policy' is associated with 'politics' – a much more negative term - in Russian and Tajik. Another example is the interpretation of the term 'coalition':

> *"…we wanted to establish a coalition on the involvement of CS in the poverty reduction strategy. Then, we thought that coalition is a bit cumbersome definition … I don't know how in English but in Russian the word coalition implicitly means opposition. We felt that it would be most important to unite the CS in facilitating the PRSP processes. Therefore, we named this as PRSP facilitation group…"* (National Staff, International Agency).

Four broad issues related to working culture were raised by the different respondents: a culture of not making mistakes, of lack of critical appraisal, of continuous need for approval and of protecting one's area. These are set out next along with perceived implications for the MOH capacity.

Culture of not making mistakes

A commonly mentioned element of work culture was the recognition that staff in national agencies are not allowed to make mistakes as part of their work. This appears to be detrimental in applying the MOH capacity to explore various policy alternatives:

> *"…people are not allowed to make mistakes. Learning from mistakes is a cultural thing that does not seem to exist here. You make a mistake – you are out. So, therefore there is a fear culture, culture is all about protecting oneself and that does not help…"* (Expatriate Staff, International Agency).

The types of consequences/punishments resulting from making mistakes included both individual (such as losing a position) as well as institutional, as illustrated by a case from the education sector:

> *" In the year before last there was a fire in the disabled internat [boarding school]. Several people died. After that, all school teachers got the additional rule to stay on duty 24 hours at every school to avoid similar situations. So, now every school in the country has to have 2-3 people on duty 24 hours"* (National Staff, National Agency).

Some respondents also identified a sense of collective responsibility for making a mistake within an organisation. This may facilitate developing the organisational support to individual staff members but may also contribute towards the culture of '*blaming someone else*' (National Staff, National Agency), rather than seeking solutions to emerging problems.

Some international respondents suggested that the practice of not making mistakes affect negatively MOH willingness to experiment with different policy alternatives and the blaming culture does not help ensuring the complementary of individual capacities at an organisational level. On the other hand, national policy-makers interpreted the culture of not making mistakes more positively and suggested that this practice develops ability to '*choose the right policy option'* (Current MOH official) and the ostensibly blaming culture is instead a reflection of identification of needs for MOH capacity strengthening.

Culture of lack of critical appraisal

The lack of critical appraisal, especially in relation to managers, appears to be common in RT. It may originate from the culture of respecting the opinion of others, particularly older and international guests, and results in little critical appraisal of others, especially internationally known figures:

> *"…once Jeffrey Sachs came here and did MDG assessment, he came up with some figures needed to reach the good health status of people in Tajikistan something like 12 billion dollars …and they [government] just took this figure and inserted this into the health column to meet the health MDGs…. They did not question it."* (National Staff, Donor Agency).

The lack of critical appraisal appears to be related with the degree of actors' participation in health policy processes, with resultant implications on the MOH capacity:

"…people usually do not question what they are told and rarely express their opinions. In extreme cases the people can raise their voices but generally the people don't care, as long as I am not directly affected. The same applies to our leaders – the existing hierarchy of power does not take into account population's opinion as such…" (National Staff, National Agency).

When probed, respondents were unable to clearly identify whether the lack of critical appraisal originates from unwillingness of policy actors to critically appraise others, the absence of critical appraisal skills or both. Most respondents stated, however, that there is a need for MOH capacity development in all these areas.

Culture of continuous need for the manager's approval

Most MOH policy decisions need to be approved by the RT's Government. According to the international respondents, this poses questions of efficiency of policy processes and distribution of tasks between the different levels:

"I think not only in health but broader throughout our country, there is a big problem that our President takes too many functions. Maybe it's the president, maybe his government… We can't have one person to take care of all the issues, it's just physically impossible. We have got the rule that until His Excellency issues his decree or makes his decision – nobody even acknowledges the problem or the issue…" (Expatriate Staff International Agency).

On the other hand, some respondents suggested that the President's approval may provide an opportunity for implementing inter-sectoral policies:

"…you know that every word of the President is a slogan for actions by all public officials. After his speeches the activities are monitored and controlled at central and oblast levels…" (National Staff, National Actor).

Many respondents shared the view that the centralised decision-making, resultant from the continuous need for manager's approval, is also attributable to the MOH:

"I don't think the head of department can give the priorities because then we still have, you know, an hierarchy to respect and I don't think heads of departments can give priorities for the policy analysis. What I will say, the minister will give the priorities just as he did when I arrived." (Expatriate Staff, Development Partner).

The continuous need for manager's approval was identified by one respondent as contributing to limited flexibility within the MOH as well as between the MOH as an institution and to the President's EA. In other words, this culture appears to negatively affecting the presence of *willingness* to apply *ability* of MOH in conducting policy processes.

Culture of protecting own area of responsibility

The culture of protecting one's 'own' area was referred to by many respondents as being applicable to all levels, including regional (cross-country) and sectoral, as set out next.

There appears to be a sense of national pride in RT, which is thought to prohibit the MOH from learning from the experience of the neighbouring countries:

> *"The health reforms implemented in Kyrgyzstan seem to go in a much more progressive way but that then again creates a conflict here because it is not invented in my backyard…"* (Expatriate Staff, International Agency).

At a sectoral level, a case was described referring to the perceived rivalry between the MOH staff and the Health Policy Analysis Unit (HPAU):

> *"…they [MOH] are basically see that [HPAU] as the ministry competitor …. Because while being in the ministry they [HPAU] are not funded by the ministry and they think they are not accountable to the ministry. The ministry understand it and that's why they did not really, they saw it [HPAU] as not really useful for the ministry…"* (National Staff, International Agency).

The above views from interviews, however, were not reflected in the documents. When asked about the implications of the above on the MOH capacity, most respondents referred to the negative effects of the perceived resultant lack of collaboration between national and the international policy actors. Some respondents identified the need for MOH capacity strengthening in the areas of recognising and managing the various tensions between the different policy actors, including those within the MOH itself.

6.2.6 Discussion

Various contextual influences on the MOH capacity were identified by respondents and from the documents. These broadly correspond to the classification of contextual factors suggested in the literature (Collins et al., 1999). Some literature-based groups of factors are combined together in the responses (for example, demographic and epidemiological change and social and economic changes are combined into factors related to RT's transition) and

there is no evidence to discuss the effects of some groups (for example, ideology) on the MOH capacity. Cultural factors were identified as a separate group as a reflection of particular emphasis on this group by the respondents.

Some respondents and documents identified clear positive and negative implications of the wider context on the MOH capacity, whereas others regarded the same factors as having both positive and negative effects. This may be due to prior experiences of policy actors (including those of authors of documents) but may also be related to the different actors' roles in health policy processes. For example, the case study of external politics between the US and Iran was raised by the actors who were involved mostly at the grassroots-level of policy implementation whereas regional policy influences were raised by policy-makers and the international community who work at the national level.

The following three issues emerge from the classification of the contextual factors. Firstly, the perception of facilitating factors and barriers varied across the different respondents, reflecting their experiences and roles in health policy processes. Secondly, the perception of barriers and facilitating factors also reflects actors' values, agendas and interests, as illustrated by the different perceptions of policy actors towards the culture of not making mistakes. Lastly, the same contextual factors may reflect a possible contradiction between the government's political agenda and the perceptions of robust health policy processes, as shown by the case of emigration.

No literature was found that focuses specifically on the contextual implications on the MOH capacity though different authors examined the effects of the political context on the uptake of international policy initiatives (Shiffman and Smith, 2007) or the contextual influences on the evidence-informed nature of health policies (Dobrow et al., 2004) or governance arrangements (Siddiqi et al., 2009). As with the literature, many respondents had difficulty in reflecting upon the interrelationships between the wider context and the MOH capacity. This may be due to the complex nature of the context itself i.e. the intra-relationships within the context itself (as discussed later in this section) as well as the difficulty by many policy actors to understand the concept of the MOH capacity, as discussed earlier.

The same contextual factors may have both positive and negative implications on the MOH capacity. One example of this is the wider political framework. A clear political agenda can be interpreted as potentially facilitating MOH capacity development. However, an opinion that emigration may be part of the government's political agenda suggests that a clear (but

not conducive) political agenda may negatively affect MOH capacity through emigration of skilled and experienced staff.

The culture of a lack of critical appraisal suggests a strong sense of authority of higher-management in the health sector and beyond. At the same time, the need for some statements to be passed through a political leader in order to reinforce the message may be common to many contexts – a phenomenon described as evidence amplification in health policies (Green and Bennett, 2007).

The lack of cohesion and the resultant non-integration between health and public policies is common for other FSU countries. For example, the case of 'governance gridlock' in Russia, where incentives to reduce bed-days in hospitals were counter-balanced by the number of beds-based resource allocation formulae (Sheaff, 2005) is similar to the contradiction of RT's policies in relation to medical education. This suggests that many public policy documents are driven by stand-alone projects (often externally-funded) and thus contribute to the lack of cohesion between different parts of government. Whilst this may be interpreted as normal in many contexts, this phenomenon is likely to limit the MOH ability to engage with, and effectively mediate between, different parts of government in order to move forward health policy processes.

A number of contextual factors (for example, limited resources, emigration of staff) have direct implications on delivery of health services - a major part of the policy implementation stage (see Chapter 4). The implications on MOH capacity relate to its ability to establish and effectively manage available resources, as discussed further in Chapter 10.

The degree of trust from the donor community was seen as important for the aid-dependent RT's health sector. One of the challenges the MOH is facing is the need to ensure this trust, whilst reconciling the short-term needs of individual donor-funded projects with long-term policy priorities.

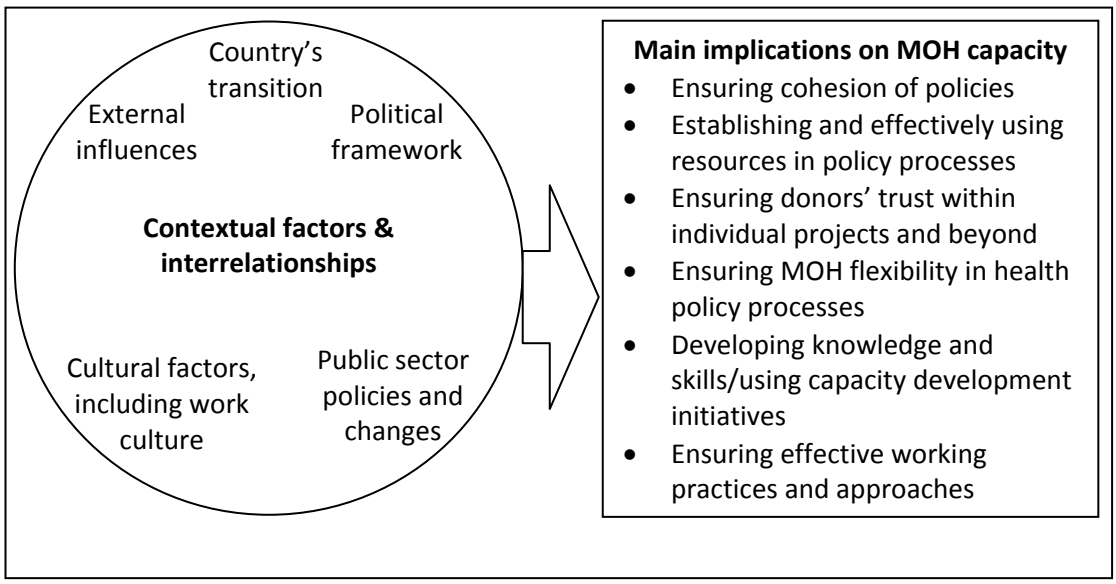
Three specific effects of the RT's transition from the relief to the development stage on MOH capacity can be distinguished. Firstly, the changes in the nature of external aid result in the need for the MOH to accommodate these changes in health policy processes – for example, through priority-setting. One particular shift is the MOH intention to implement a SWAp in the RT. Secondly, the changes in the composition of both local and international actors – who possess different agendas, values and practices – is posing the need for the MOH to

develop ability to effectively engage with more development-oriented policy actors. Lastly, the shift towards development contributes towards the changed attitude and practices of the MOH itself, with sustainability, effective coordination and higher scrutiny of the international actors becoming more explicit on the MOH agenda.

Contextual factors are interrelated. The effects of socio-economic situation on migration are obvious but similar interrelationships may exist amongst other external contextual factors. For example, health policy analyses are increasingly conducted in many FSU countries (as evidenced by studies by Collins, 2006; Duffy, 1997; Sheaff, 2005; Titterton, 2006). In contrast, the hesitation of some donors, such as DFID, to work with the post-war RT (James, 2000) and the resultant lack of technical and financial assistance can be seen as one reason of absence of published analyses of the RT's health policies.

At least six broad implications of the wider context on MOH capacity can be distinguished from the earlier discussion, as summarised in Figure 14. It is difficult to clearly distinguish the *cause-and-effect* relationships between the different contextual factors and the MOH capacity, not least because of the interrelationships amongst the contextual factors. Furthermore, the different effects on the MOH capacity overlap (for example, developing knowledge and skills may be seen as a prerequisite for establishing cohesion between policies) and the same contextual factors may have positive or negative implications on MOH capacity (for example, the political framework may facilitate or prohibit establishing effective working practices and approaches).

Figure 14: Implications of the wider context on MOH capacity



Lastly, clear differences were found between the views of the national and the international policy actors, with the former being less critical of MOH capacity. The greater criticism from the international community may be a reflection of the perceived sense of security of respondents within the international agencies though there is not sufficient evidence to support or otherwise this view. This area represents an interesting area for further studies in RT and beyond.

This Chapter has also confirmed two findings from previous Chapters. Firstly, many policy actors are unable to distinguish health policy *processes* from the wider interpretation of health policies, and often focused on the policy *contents*. Secondly, the concept of capacity to conduct health policy processes is not well-understood in RT, resulting in respondents' difficulties in relating together the concepts of capacity and health policy processes.

6.3 Conclusions

This Chapter has summarised the key interpretation, and implications of, the wider context on the MOH capacity to conduct health policy processes. Most respondents recognised the importance of the wider context in exploring the MOH capacity. The following five broad groups of contextual factors were identified as having either positive or negative effects on MOH capacity: external influences, country's transition, political framework, public sector policies/changes and working culture. Different interrelationships exist amongst the different contextual factors and the context is not static as shown by the RT's transition from relief to development stage.

The implications of the wider context on the MOH capacity are multiple and this Chapter has identified six broad groups: ensuring cohesion between policies, establishing and effectively using resources, ensuring donors' flexibility in policy processes, effective use of capacity strengthening initiatives and, ensuring effective working practices and approaches.

The perception of the contextual barriers and facilitators varied across the different respondents, reflecting their values, agendas, experiences and roles within the policy processes. As in previous Chapters, international respondents were more critical of MOH capacity.

The next Chapter explores the roles and characteristics of policy actors along with the implications on the MOH capacity.

7 INVOLVEMENT OF ACTORS IN POLICY PROCESSES AND IMPLICATIONS ON MOH CAPACITY

7.1 Introduction

This Chapter reports the key findings in relation to the involvement of policy actors in health policy processes and their implications for MOH capacity. It starts with identification of different types and characteristics of policy actors which is followed by an overview of their roles and practices. After exploring the interrelationships between the policy actors, the Chapter concludes with a discussion of the implications for MOH capacity.

7.2 Types and characteristics of health policy actors

Health policy actors in this study are understood as individuals and/or organisations associated with, and involved or not involved in, health policy processes. The importance of wide involvement of actors is well-recognised in various RT's strategic documents, as shown in the Task 17 "Mobilisation of partners' efforts in health" of the Health Development Strategy (GOT, 2003).

The term 'stakeholders' is used more often than 'policy actors' in the RT and comprises "*…government and its sectors, civil society, donor organisations … local authorities, NGOs, …the population itself, MOF, Ministry of Economy …"* (National Staff, International Agency). The interpretation of the concept of stakeholders differed between the respondents. For example, one respondent referred to the stakeholders as those "*…holding funds in their hands…"* (National Staff, International Agency). However, this view was not widely shared and most respondents used the term stakeholders synonymously with the study definition of policy actors. This section identifies the main health policy actors, followed by an overview of their key characteristics and their implications for MOH capacity.

7.2.1 Different types of actors

No documents were found providing a comprehensive overview of health policy actors though attempts were made to summarise the internationally-funded projects in the RT (Khadjieva, 2008; WHO, 2007b) or to explore the roles of governmental or non-governmental actors in health policy processes in isolation (Akhmedov et al., 2003; Anvarov, 2002; Bandaev, 2008; Gaibov, 2004).

Respondents were asked to identify the main health policy actors in the RT. Most responses distinguished two broad groups: national and international actors. Some respondents

subdivided each group into specific institutions and levels, though – as with the document reviews – no comprehensive overview of health policy actors was identified from the interviews.

National policy actors

Most respondents distinguished between the governmental and non-governmental national actors. The following administrative levels were identified amongst the government actors:

1. *The National Government* including the Executive Administration of the President (Department for Health and Maternal Health Issues, Advisers to the President) and the Prime Minister's office[14];
2. *The Cabinet* comprising sectoral ministries, for example the MOH or the MOF. Each ministry, including the MOH, comprises different departments as approved by their statutes (GOT, 2006a) (see Appendix 8 for the MOH organisational structure)
3. *The national-level institutions* such as Republican Centres (for TB control or for Family Planning), educational institutions and tertiary-level health facilities;
4. *The implementing agencies* i.e. Project Coordination/Management Units (PIUs/PMUs) for health reform projects funded by the WB or the ADB. Although the PIUs are established as government entities, many respondents, including the PIU staff themselves, interpreted the PIUs as international organisations;
5. *Sub-national health authorities* at *oblast* and *rayon* levels, including the *Rayons of Republican Subordination* (subordinated directly to the national level).

The following five groups of non-governmental national policy actors were distinguished by the different respondents:

1. *National media* i.e. TV, radio, newspapers as well as the various press-offices established within the National Government and the MOH;
2. *Professional associations* such as Association of Medical Workers (AMWs) of RT;
3. *Civil Society Organisations* such as the local NGOs though this group was referred to by only a few respondents;
4. *General public* was identified as being different from CSOs with the latter taking the shape of more organised forms;
5. *Private health sector* – as in the case of CSOs were mentioned by only few respondents.

[14] In RT the PM office is different from the Cabinet with the former including PM Deputies for various sectors including social issues (Health, Education and Social Protection).

One respondent attempted to distinguish the national health policy actors by their functions or characteristics – for example, professional/technical (for example, Association of Medical Workers of the RT) versus administrative or managerial (President's EA) and policy developers (MOH, President's EA) versus policy implementers (*oblast* and *rayon*-level health authorities). However, no comprehensive overview of the national actors was identified in relation to their functions.

International policy actors

The early-to-mid-1990s witnessed a spread of relief-oriented humanitarian agencies in the RT. In contrast, some development agencies, such as the UK Department for International Development (DFID), were wary of working with the RT's health sector because of their perceived lack of stability (James, 2000). At the time of data collection a large presence of the international community in the RT's health sector was identified. 19 international organisations and 29 implementing agencies were reported (Euro Health Group, 2008; Mahon and Tediosi, 2007). The number of externally-funded projects varied from 52 based on MOH data (Khadjieva, 2008) to 97 according to WHO estimates (WHO, 2007b).

Different respondents distinguished the following groups of international actors:

1. *Foreign Embassies*, who finance often small-scale specific targeted projects as part of their diplomatic mandate;
2. *The Major Financial Institutes*, such as the WB/ADB, who are financing larger-scale health reform projects with direct implications on health policies (for example, PHC project by WB or HMIS reform by ADB);
3. *The development agencies* such as the UN group (WHO, UNICEF, UNDP) and bilateral agencies such as the DFID, are involved in the provision of technical advice and facilitating the provision and use of evidence in policy processes;
4. *The International Implementing Agencies* such as NGOs are involved at grassroots levels in implementing specific projects though some NGOs (for example, ZdravPlus) tend to engage in specific policies such as health financing or family medicine.

However, the above taxonomy was not used by all respondents. The distinction between the different functions was not clear-cut and some respondents referred to the significant overlaps in roles between the above actors.

The respondents reflected that the composition of international policy actors is changing as RT progresses from the relief to the development stage. For example, the gradual

withdrawal of the European Commission for Humanitarian Assistance (ECHO) affects the availability of funding for the relief-oriented INGOs such as Care International and MERLIN. On the other hand, the presence of development-oriented partners such as The World Bank and European Commission is increasing.

Individuals versus organisations

One issue emerged from the data was the balance between the interpretation of actors as individuals versus their organisations/institutions. The importance of individuals in policy processes was recognised, as shown by the perceived importance of policy champions for the agenda-setting (see Chapter 5) as well as the importance of personal relationships (such as the need for manager's approval, see Chapter 6). Furthermore, some respondents used the name of a leader/head of an organisation when referring to a policy actor in the interviews – for example, Dr. Salimov (MOH) or Dr. Severoni (WHO country office) – thus also suggesting the perceived intra-institutional hierarchy of policy actors.

No 'freelance' individuals were found as policy actors and all individuals were identified in conjunction with the national or international organisations. Although it is recognised that some policy decisions may be made by powerful individuals (as discussed in Chapters 6 and 9) in this document policy actors are interpreted as *organisations*.

Most respondents did not identify any implications of different types of health policy actors for MOH capacity. A few, who did, identified the need for the MOH to recognise and, where appropriate, manage the diversity of policy actors, including the different departments within MOH itself.

7.2.2 Characteristics of main policy actors

Different documents referred to characteristics of various national actors as part of their formal roles and responsibilities (GOT, 2008; MOH, 2007, 2008a, c, d, e) or within different initiatives such as SWAp (Anonymous, 2008; Euro Health Group, 2008; Mahon and Tediosi, 2007; MOH, 2008f). However, no documents were found providing a comprehensive overview of the characteristics of the national and international policy actors.

Respondents were asked to describe the main characteristics of policy actors. Virtually all respondents referred to the importance of actors' power within policy processes. Other characteristics were specific to the national (the degree of flexibility in health policy processes) or the international actors (degree of knowledge of local context), as set out next.

Actors' power

The actors' power within policy processes or the "…*ability to influence policy decisions*…" (National Staff, International Agency) was perceived as important by all respondents. Different respondents identified the following three perceived characteristics of actors' power in RT, broadly corresponding to the reviewed literature (Erasmus and Gilson, 2008; Gaventa, 2005; Greer, 2010; Mätzke, 2010): the control over funding, the ability to use the existing power hierarchy effectively and the ability to achieve cumulative power (for example through networking). The degrees of power were found to be different between the national and international actors and power hierarchies appear to exist in each, as set out next.

The power of national actors seems to reflect the administrative hierarchy in the RT. Many respondents emphasised that any major issue needs to be endorsed personally by the President. A similar hierarchy also exists in the MOH – most decisions need to be agreed with the Minister, who, according to the Law, is personally responsible for MOH work (GOT, 2005). The clear hierarchy was also evident from observation of the two policy events: an MOH collegium and a health coordination meeting (see 7.3.1).

MOH power was perceived to be limited in comparison with other ministries, resulting in MOH inability to influence health-related policies in other sectors (for example, related to safe water or education). A similar view was also expressed in relation to the greater power of local *Hukumats* who control local funding and are responsible for the provision of services at the *oblast* and *rayon* levels (GOT, 2005):

> *"…a lot of the finance isn't actually raised by the government, it's raised locally through the local Hukumats and they are the people who have the tax raising powers and the authority. … we found that … some of the Hukumats and rayons take that further forward than the others. I said there seems to be …lack of the national ability to actually influence or manage that…"* (National Staff, Development Agency).

However, many respondents reflected that where the MOH does have power it can abuse it. Two examples were raised particularly by international respondents: a) the unclear criteria for, and lack of transparency in, the appointment of members of different working groups - one respondent suggested the balance between perceived material gains from the membership versus ability/interest to contribute to the outputs; and b) an explicit power hierarchy at the MOH collegiums with the '*public humiliation*' (Expatriate Staff, International Agency) of sub-national health authorities (see 7.3.1).

Donors and development agencies were perceived by many respondents generally as more powerful than national actors. The examples raised by respondents included: references to the dominance of the WB in health reforms through the financing of large projects, the closure of project sites by the USAID because of the perceived relationships with Iran (see Chapter 6) and the numerous references by the PIUs and the HPAU to the MOH as '*them*' not '*us*', reflecting their 'international' status.

Another example of the use of power relationships is a collective letter from a group of donors to the MOH summarising their negative comments on the Draft Basic Benefits Package Decree, which was copied to the Minister of Finance and to the Senior Advisor to the President on Economic Policy (WB et al., 2008). The perceived greater power of the international community can also be due to their ability to use existing power relationships/structures effectively. This is shown in case of INGOs using a memorandum with the MOH as means of obtaining an agreement from the *oblast Hukumats*:

> *"…in the beginning, the oblast had slightly different priorities... When they started the NGOs had really make them understand it's not about equipment it's about the training, mobilising people and etcetera. … how some of them solved it is they concluded memorandum of understanding with the MOH where they laid out what they suppose to do… Once they went to the ground they just showed the paper and said here is MOH paper..."* (National Staff, Donor Agency).

The power hierarchy also exists within the international community. For example, the UN agencies were referred to as *'elite',* reflecting their power status: the WHO mandate defines its overarching role amongst the international agencies, as illustrated in their review of external aid in the RT (WHO, 2007b). Another example is the dominance of the WB within the SWAp process despite the early involvement of Swiss Development and Cooperation Agency (SDC) in advising the MOH on this issue (see Box 5).

Box 5: Dominance of the WB power in the MOH decisions – example of SWAp process

The WB and the SDC were in disagreement over the leadership of the SWAp process. The SDC explored the feasibility of a SWAp in RT in 2006 and expressed its willingness to co-lead the process with the MOH (Mahon and Tediosi, 2007). In 2007 the WB mission visited the RT with one of the objectives being to "*…discuss with the MOH and donors a timetable for the SWAp development process for the next 12-24 months…and …to prepare, with the MOH, the preparation schedule for the Bank supported project that will be implemented through the sector wide approach*" (WB, 2007 p.11). Eventually the MOH accepted the WB recommendations of the specific steps towards the introduction of health SWAp in the RT, including the proposed meetings in January and May 2008 (WB, 2007).

Many respondents referred to the limited MOH power as prohibiting further capacity strengthening. In contrast, some national actors suggested that the limited power may actually develop the MOH capacity in certain areas (for example, to generate more 'convincing' evidence, or to deploy more inclusive policy processes in order to secure the agreement of the more powerful government and international community).

Although respondents reflected that the MOH can learn from the international community's effective use of power structures, many shared the view that the existing hierarchy and the government protocol are important prohibiting factors, for example, preventing the MOH from approaching the President directly.

Degree of flexibility

The degree of autonomy (or '*flexibility*' as referred by many respondents) to make policy decisions independently and to respond to emerging policy needs was seen as important in the MOH capacity to ensure robust health policy processes.

The degree of flexibility was thought to be greater amongst international actors, largely due to the perception of more effective accountability mechanisms. However, a few international respondents referred to the vertical accountability of international agencies as well as the limited scope of their mandate as prohibiting their flexibility to respond to emerging policy needs.

The limited flexibility appears to be a common feature for most national actors, including the MOH. Examples of this included occasional references to the media not being entirely free in the RT and the dual subordination of *oblast* and *rayon* health authorities to the *Hukumats* and the MOH. Similarly, the MOH was referred to as being '*too subordinated*' (National Staff, International Agency) to the President's EA.

Different factors were raised as contributing to the limited flexibility of national actors. The most commonly-referred included actors' perceptions, current values, interests and practices – the latter shown by the case of CSOs:

> *"I think there is lack of trust to the CS skills and abilities, the lack of clarity of the mechanism itself has also resulted in their reluctance. Another factor I think was the issue which is equally important today – the existing mechanism is not very clear."* (Former CSO member, International Agency).

The MOH usually faces a large amount of routine work, with the MOH staff being "…*totally swallowed by the routine…"* (Expatriate Staff, Donor Agency). The large amount of routine work appears to be also applicable to the MOH-affiliated implementing agencies with "…*considerable administrative burden on the PIU resulting from organization and implementation of training events for several hundred trainees under the project. The PIU should therefore consider contracting logistics services for travel and training events financed by the project*" (WB, 2007 p.10-11)

Many respondents reported their perception of the limited role of media in health policy processes. According to the respondents, this appears to be partly due to perceived threats of this interaction by the policy-makers:

> *"…maybe they [the MOH] haven't got anything to say? Maybe they are afraid to say something wrong and being punished for that?…"* (National Staff, National Agency).

Most respondents did not identify any direct implications of the degree of flexibility for the MOH capacity. Those who did referred to the similar capacity implications as identified in relation to the issue of power with suggestions that the limited flexibility may provide the MOH with an opportunity for capacity strengthening in engaging with more powerful actors.

Degree of knowledge

Different respondents reflected that the actors' knowledge affects the degree of their involvement in policy processes. The most commonly referred to areas included knowledge (and effective use) of funding and recruitment procedures and the degree of familiarity with the local context, as set out next.

The knowledge of procedures for internationally-available funding may enhance the role of some INGOs in policy processes. For example, project HOPE was the principal manager of funds from the Global Fund Against Aids, TB and Malaria (GFATM) grant, partly because of a

lack of MOH capacity to develop the application but also because of their knowledge of funding rules. However, one respondent reflected that this practice may prohibit MOH capacity strengthening in developing subsequent GFATM applications.

There was some criticism of the recruitment practices of the WB for HPAU, raising the question of the degree of MOH involvement in developing the job descriptions for the HPAU staff:

> *"They had criteria – not older than 35 years and knowledge of English. I'd say we need a person with large amount of experience and the knowledge of English is not essential. …I am a bit cynical, they also have number of other selection criteria but …they get young… green and they need time to ripen. And this causes delays…"* (Current MOH official).

The degree of international actors' knowledge of the local context was perceived as important by most national actors with the following statements being common: "… *if people do not have experience working in a particular …country what you end up getting is again not the very qualified work…[or not]… the proper consultants…"* (National Staff, International Agency). Related to this, the culture of not making mistakes (see Chapter 6) was perceived as increasingly applicable to the international actors with a MOH actor being of the opinion that *"…it's time to educate not only Tajiks but also donors who think that they are allowed to make mistakes…"* (Current MOH official).

One national respondent referred to the organisational priorities and financial accountability within international agencies as potential reasons for the perceived lack of knowledge and the resultant discrepancy of approaches with the national priorities. However, this view was not mentioned by other respondents or documents.

The most referred to implication for MOH capacity strengthening was the need for greater MOH engagement in different policy-related issues such as developing funding applications or commenting on job descriptions for internationally-funded policy experts. One respondent suggested that underlying all these is MOH capacity to maintain effective relationships with respective agencies applying for funding or recruiting specialists, to ensure sharing of roles and responsibilities.

7.2.3 Discussion

The consideration of policy actors is at the centre of many published studies (Buse et al., 2005; Gilson and Raphaely, 2008) and it is important to have a clear understanding of the concept of policy actors. The narrow fundholder-based definition of stakeholders raised by one respondent, although not shared by many, raises an important distinction between the powerful financiers of policy processes and the many other policy actors who may be excluded due to lack of control over funding.

Up to 14 broad groups of policy actors can be distinguished – a finding consistent with the internationally-identified trend of increasingly inclusive health policy processes (Buse et al., 2005; Walt et al., 2008). The descriptions of actors by most respondents referred to either the administrative or the political hierarchy (for example, the four-level taxonomy of international agencies or the explicit hierarchy of national actors). This suggests not only that the concept of policy actors is interrelated with the concepts of power-relationships and accountability but also links with the wider hierarchy within the society, described in Chapter 6 (for example, the need for manager's approval).

Each group of actors was perceived by respondents as heterogeneous, thus suggesting a large number of policy actors. This is also consistent with international literature which suggests that increasingly a greater number and diversity of actors are engaged in policy processes (Erasmus and Gilson, 2008). Different policy actors appear to have their own agendas, another finding confirming existing literature (Buse et al., 2005; Walt, 1994), influencing their involvement in policy processes and, ultimately, the MOH capacity to conduct health policy processes. The composition of health policy actors, particularly international organisations, is not static and is changing in line with the RT's transition from relief to development stage. This poses particular challenges in relation to MOH capacity to manage actors' involvement in health policy processes. Furthermore, the MOH itself needs to adapt from the relief (mostly money-seeking, short-term priorities) to the development stage (with the long-term vision, coordinated health systems development, rational use of limited resources).

The roles of individuals appear important in understanding of actors' power. The President and the Minister of Health were seen as the key people within the President's EA and the MOH respectively. This suggests that other policy actors are likely to be invited with less opportunity for them to 'claim' their spaces in policy processes as described in the concept of Power Cube (Gaventa, 2005).

The importance of individuals also helps to understand the contribution, and the complementary nature, of *individual* capacity within *organisational* capacity – for example, the technical knowledge of the MOH staff is complemented by the ability of the Minister of Health to establish dialogue with other ministries and the President's EA.

The concept of power is widely discussed in the literature (Erasmus and Gilson, 2008; Gaventa, 2005; Tantivess and Walt, 2008; Walt, 1994), which may have catalysed the recent interest in exploring the powers of ministries of health in various European countries (Greer, 2010; Mätzke, 2010). Respondents also identified power as the most important characteristic of policy actors and described the MOH as generally less powerful than President's EA and international community.

National policy actors particularly at *oblast* and *rayon* levels, were largely seen as less powerful than national-level actors, suggesting that the concept of street-level bureaucracy (Lipsky, 1980) is less applicable to the centralised context of the RT. Actors' power was found to be greater within the international actors. Power hierarchies also exist within both the national and the international agencies. The MOH may be left between the competing priorities of the international agencies and the President's EA, as was the case in the development of a SWAp. This is likely to negatively affect the MOH motivation though may contribute to the recognition of the need to further strengthen MOH capacity, for example, in order to establish effective dialogue with more powerful actors.

The ability of international policy actors to use existing structures and power relationships effectively may undermine the MOH authority and thus lead to low motivation of MOH staff. However, the MOH could build on the examples of its effective relationships with international community (for example, in the introduction of SWAp).

Guided by literature-based characteristics of power, such as control over resources or legal power (Greer, 2010), the RT's MOH may be interpreted as possessing very limited power. From the capacity perspective, the MOH needs to consider further means of increasing its power – for example, enhancing its role in internationally-funded projects or improving the dialogue with the rule-making element of government.

Actors' power may contradict the formal government decrees; for example, the MOH should ostensibly lead on health financing policy, but in practice the MOF has the final say. This may

negatively affect the MOH motivation to develop the skills to effectively lead health policy processes. On the other hand, this may represent an opportunity to enhance the MOH capacity to practice more inclusive policy processes, in order to secure the MOF agreements early in policy development.

It appears that the existence of power may also have negative effects on MOH capacity, as shown by the examples of the MOH abusing its power. The existence of a powerful and a more flexible international community, combined with the growing number of national actors such as civil society, can be seen as one way of establishing greater accountability and 'controlling' the MOH from abusing its power. However, the MOH may take advantage of a more complex arena in managing the competing agendas and interests (for example, by playing some actors off against each other).

The existing frameworks such as the Gaventa's Power Cube (Gaventa, 2005) are helpful in mapping out the relative powers, spaces and places of policy actors though one major disadvantage of this model is that it does not allow tracking changes in those areas. These are particularly important for the transitional countries such as RT where the composition of actors is changing fast, with implications for MOH capacity to accommodate 'new' agendas, values and practices.

The actors' power and the perceived degree of the MOH flexibility in policy processes provide examples where existing MOH *ability* may not be supported by the *willingness* (because of the perceived resistance or bureaucracy from other government institutions). As discussed in Chapter 2, the presence of both ability and willingness can be important in developing and applying capacity.

The increasing demand from the MOH for high-quality expertise amongst internationally-funded consultants suggests a shift in MOH priorities and practices from accepting <u>any</u> externally-available aid towards a more careful prioritisation of inputs. This may also indicate the improving capacity of the MOH itself in relation to policy processes.

The need for greater MOH engagement in different policy-related issues (such as funding applications and job descriptions for policy experts) is an important message for the MOH to consider. It is important, however, to avoid damaging the relationships between the MOH and the respective agencies in an attempt to re-distribute the relative influences within

policy processes. The latter is largely dependent on the actors' roles and practices, which are explored next.

7.3 Actors' roles and practices

This section summarises actors' roles and interrelationships in health policy processes with perceived implications for the MOH capacity. Three broad issues were raised by respondents in relation to actors' roles:

First, some respondents, especially those who are not directly involved in policy processes (for example, INGOs), suggested that actors' roles are often unclear in policy processes. However, this was not shared by all policy actors with, for example, *rayon*-level health authorities having much clearer views of policy processes than their international counterparts.

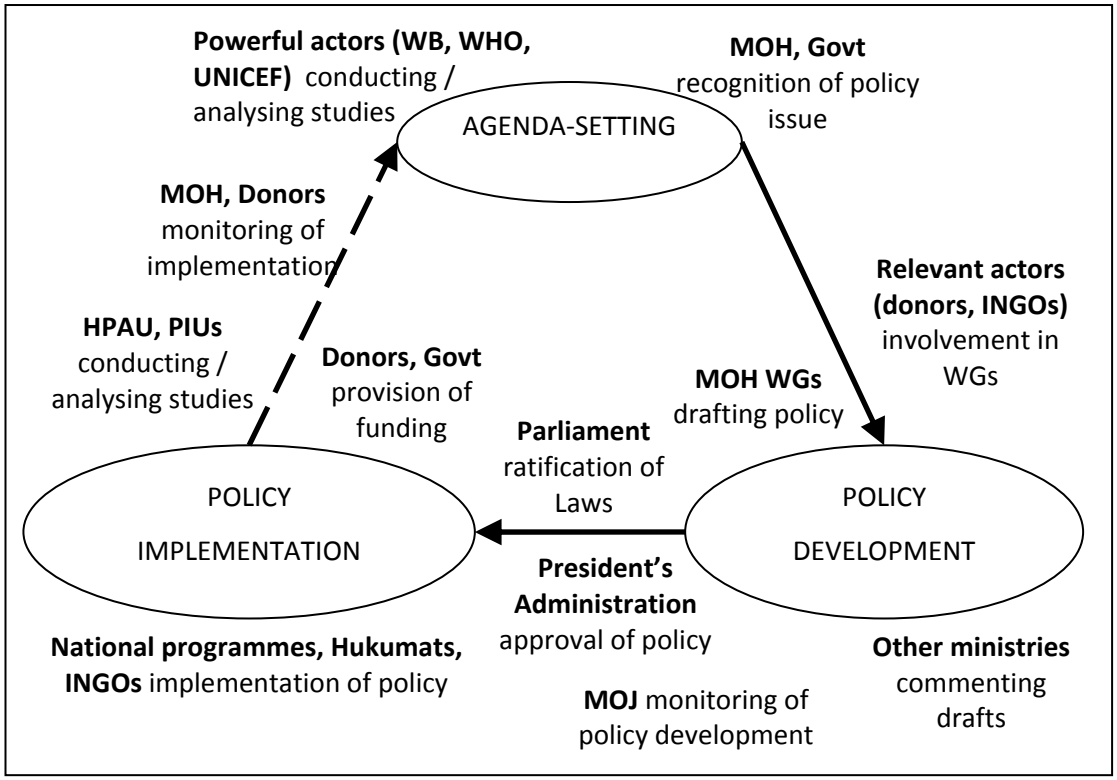
Second, the roles of some policy actors were sometimes interpreted differently. One example of this is related to the understanding of the HPAU role: at the time of the data collection their role was unclear to many policy actors whereas the WB stated in December 2007 that the *"…role of the HPAU is now well understood... [and] It is encouraging to see that the MOH now recognizes the major role that the HPAU has to play…"* (WB, 2007 p.1).

Last, some respondents from international organisations suggested that actors' roles and practices differ throughout the policy processes. For example, INGOs were described as advocates at the agenda-setting stage and sources of technical support/expertise during development and implementation. This is also applicable to the MOH itself, which was referred to as the policy developer during the development stage and the policy monitor during policy implementation (GOT, 2008).

7.3.1 Main actors' roles and practices

Most respondents felt that actors' involvement in policy processes is generally improving, particularly from the international community. When asked to describe specific actors' roles in policy processes, most respondents referred to different actors' roles throughout policy processes, as shown in Figure 15.

Figure 15: Summary of roles of key policy actors in RT



The situational analysis during the ***agenda-setting*** is usually conducted by powerful international policy actors such as the WHO or the UNICEF, who then raise MOH awareness of the policy issue. The MOH then formally recognises the issue through lodging to the Ministry of Justice (following the agreement from President's EA) its intention to develop a particular policy. There is no equivalent to the publicly-available UK White Paper and recognition of the issue is done within the government only.

The role of non-governmental actors is seemingly limited at this stage and includes mostly sub-contracts from WHO/UNICEF to conduct specific surveys. Some NGOs are involved in advocacy work though no evidence was found of the resultant agenda-setting of new policies. Some respondents reflected that the whole concept of civil society is not yet fully understood in the RT resulting in the "…*lack of interest from MOH … and probably* [the reason why] *MOH does not recognise the NGOs seriously …"* (National Staff, Development Agency).

Similarly, respondents felt the role of the media was limited during agenda-setting. In early 2008 the MOH established a press office to improve communication with the general public and the Minister of Health now conducts thematic press-conferences on regular basis.

Although visible effects of these initiatives were not identified in the interviews, all policy actors shared the view that these are positive steps in the MOH capacity strengthening.

Some donors, such as the WB or the ADB, commission their own situational analyses (for example, health sector reviews) and communicate the findings to the MOH as part of initial discussions of the planned projects. No evidence was found of the MOH commissioning situational analyses as part of the agenda-setting stage of policy processes, in contrast to the claims from national policy-makers.

It appears that agenda-setting can be an opportunity for powerful actors to promote their interests in particular policies, with implications for the MOH capacity to differentiate vested interest-driven policies from a genuine desire to improve the RT's health system. However, no evidence was found to support or otherwise this view.

The MOH initiates ***policy development*** through the organisation of thematic Working Groups (WGs), often with financial and technical support from ongoing projects. The main international actors working on policy development and health reform-related issues in RT are: WB, SDC, SIDA, WHO and USAID (Anonymous, 2008).

Once the draft policy is ready the MOH is required to consult other ministries. According to MOH officials, it is often a difficult process, due to lack of interest from other sectors in health policies and lack of MOH power to drive the process. The resultant lack of integration between sectoral policies may sometimes contribute to the existence of contradictory policies, as shown in case of educational policies (see 6.2.4).

After this consultation the draft is reviewed and approved by the President's EA. The EA may approve a draft policy either as a national programme or as Law – the latter is usually submitted for ratification by the National Parliament.

The monitoring of policy development is done at two levels. First, by the Ministry of Justice (MOJ) using the government-approved milestones as a framework (for example, a draft policy should be ready in two years for comments by the other ministries). The MOJ also identifies a list of relevant ministries to consult over the draft policy, before approval by the President's EA. Second, the monitoring is done by the MOH itself, through its regular collegiums. However, the observation of one MOH collegium raised doubts about the effectiveness of this monitoring mechanism – a view supported by many respondents who identified the MOH collegiums as the "*power screws*" and the "*ritual humiliation"*:

> *"The minister and his deputies are sat on a high upon a podium, all the representatives from the oblasts and rayons sit in the room, they hear the minister lambast on them, shout, scream on them; at particular points individuals have to stand up and justify themselves in a public…"* (Expatriate Staff, International Agency).

The MOH also usually consults international agencies with its draft policy though the number of international actors varies depending on the particular policy and the degree of involvement of the international community in the respective WGs.

Policy implementation is conducted either as part of national programmes or donor-funded projects. It is conducted mostly by sub-national health authorities, sometimes in collaboration with NGOs. The INGOs described themselves as working mostly with local communities, other INGOs, UN and - only after exploring opportunities with all above - they look for opportunities to collaborate with the public health sector.

There was evidence of willingness of some international actors (SIDA, SDC, WB) to involve the MOH in the project design (for example, in selection of staff and local NGOs for collaboration), as part of the capacity strengthening agenda. However, virtually all respondents shared the view that the MOH is involved as yet another actor in these processes and not leading these processes as it should.

The MOH is involved in the monitoring of implementation of national policies though it cannot influence the decisions made by the *Hukumats* or, often the international actors, as shown by the example of development of clinical guidelines for primary health care:

> *"I understand there is a need for methodology… You know, we have some political pressure, we need to approve this programme quickly… One year passed. The methodology development is still going on, a number of seminars are going on, at every event I was asking – we are developing the methodology for about a year, let's*

> *start the actual development. The second year passed…[and] we took our Tajik way – the minister says from the top "you got one month to put the clinical guidelines on my desk". This way isn't resulting in any good – the formats are slightly different… but the long delays…is another extreme..."* (Current MOH official).

International funders were also involved in the monitoring and evaluation of the individual projects. There were examples of joint efforts (for example, the inclusion of the MOH in project reviews by the WB and the SDC) though many powerful actors such as the WB conduct their own supervision missions largely independently and inform the MOH of their results.

The different policy actors have own policy agendas and values affecting their roles in health policy processes and exercised through their power in policy processes. Though not reflected in the interviews, this was particularly evident from the documentary reviews and the observations of policy events. One example of this is the WB dominance in the SWAp process through their supervision mission. Another example is the MOH attempts to repeatedly emphasise its role as a coordinator of all health reforms and projects at an observed monthly health coordination meeting.

Most respondents had difficulty in identifying the relationships between actors' roles and MOH capacity. Most respondents suggested that on-going reforms and available international funding provide opportunities for the MOH to develop capacity in various areas (such as interpreting results of studies and conducting stakeholder analysis). Virtually all respondents shared the view that many projects have limited flexibility to accommodate the emerging capacity needs of the MOH. Furthermore, one international respondent doubted the genuine interest of the MOH in capacity development and associated, for example, their willingness to participate in the international study tours with perceived material gains.

Some respondents reflected on the degree to which the existing MOH capacity can be applied in policy processes. For example, the MOH was referred to as being "squashed" between the agendas of the more powerful President's EA, other ministries and the international community thus limiting the application of its skills and expertise. There was no evidence, however, to confirm whether MOH capacity exists but cannot be applied or whether MOH capacity is lacking and there is no motivation to develop expertise within the prohibiting environment.

One area emerging from the above – though not supported by data – may be the need for the MOH to recognise and, where possible, manage the multiplicity of actors' roles and practices in policy processes. For example, the MOH may tap into actors' expertise in certain areas (such as the situational analysis) but it also needs to recognise the potential biases reflecting the values and agendas of those producing the situational analyses.

7.3.2 Actors' interrelationships

The respondents were asked to describe the interrelationships between the policy actors. Most respondents reflected on the *coordination* mechanisms and approaches as a reflection of formal interrelationships between the policy actors. One respondent mentioned the *advocacy efforts* by NGOs and *lobbying* by the WB as further mechanisms of actors' interrelationships in the RT though no examples were raised in support of these interrelationships. No evidence was found on informal interactions amongst the policy actors. Therefore, this section explores the different mechanisms for coordination and the perceived factors affecting the interrelationships between policy actors, which will be followed by discussion of perceived implications for MOH capacity.

The importance of coordination was emphasised in different documents (GOT, 2003, 2006c; MOH, 2008a) and is evidenced by formalisation of each of the 55 WGs in the MOH *prikaz* (Bandaev, 2008). The concept of *networking of policy actors* (either formal or informal) was not mentioned at all, though some networking practices were identified through the document reviews (for example, in combining the power of international actors).

Five levels of actors' coordination can be distinguished from the different descriptions and various documents, as shown in Box 6.

Box 6: Five levels of coordination in RT

1. *Donor Coordination Council* (DCC) comprising Embassies, International Financial Institutes and UN agencies. The DCC meets on quarterly basis and the chairing was rotated (in 2008 DFID chaired the DCC meetings). The agenda was not health-specific and the RT's Government is invited to these meetings as an observer.
2. *Quarterly coordination meetings* between the Minister of Health and main health-related donors. These are chaired by the MOH and were initiated since 2005, as a result of the Swiss-funded small project on policy dialogue (SDC, 2005).
3. *Monthly health coordination meetings* led by the MOH and the WHO, comprising INGOs and representatives of main projects. The agenda is coordination of operational issues though "*…the meetings are not always regular and there is a strong sense that the groups are for information sharing rather than fulfilling the clearly needed role of strategic oversight and technical support to the MOH…*" (Mahon and Tediosi, 2007 p.14)
4. *Intra-sectoral coordination* mechanisms through the MOH collegiums (monthly, quarterly, biannual and annual) where the progress within the national programmes is reviewed. The *oblasts* and *rayons* report on their achievements and needs and many decisions are prepared in advance by the MOH.
5. *Coordination within and between the different WGs* occurs with the support of the MOH secretariat. According to the international consultants, a total of 17 working groups exist, including 5 coordination councils; 1 interdepartmental WG and 9 current working groups (Mahon and Tediosi, 2007). However, the MOH accounts for a total of 55 working groups (Bandaev, 2008) though, as reported at an observed health coordination meeting that many WGs are non-functioning.

The following three factors were suggested as affecting the degree and effectiveness of interrelationships between the policy actors:

a. *Existence of a formal agreement.* The common view was that the interrelationships are the most effective when formalised in a document (such as a memorandum of understanding) outlining the roles and responsibilities of the parties.
b. *Effective communication.* This was described by all respondents as a prerequisite for effective coordination. This factor was perceived crucial for explaining a policy/reform change to the general public (as evidenced in the case of public's resistance to BBP introduction, see 5.3.3) as well as for ensuring the political and financial support from the *Hukumats*.
c. *Availability of resources.* This was particularly emphasised by national policy actors, including current and former MOH officials. For example, the MOH-level Aid Coordination Centre was described as a good idea with well-written statute but not implemented due to a lack of resources to sustain the change.

Coordination *between national and international actors* was referred to by many respondents as problematic though improving since independence. Specific coordination bodies have been established at different levels. For example, the Aid Coordination Unit (ACU) of the Executive Administration of the President of the RT in 2001, to "*…serve as a*

"One Stop" Service Centre … and to facilitate understanding of policies between Government and Development Partners." (President of RT, 2001 p.2). At the MOH level the Department for External Relationships played the main coordination role between the MOH and the international community though the effectiveness of coordination was questioned by many actors, who referred to late notices of meetings and the largely information-sharing (other than decision-making) nature of this interaction.

The coordination *between the MOH and different national actors* was reported to be good by most national actors. However, some documents suggest that limited coordination exists within the health sector (Euro Health Group, 2008) and the coordination is understood by the national respondents as 'ensuring compliance'. At the same time, coordination was thought to be poor between the different MOH departments:

> *"…we [MOH] are unable to develop a systematic schedule of meetings and things often happen on an ad hoc basis. … they [heads of MOH departments] can send me a message – tomorrow we will have a meeting tomorrow at 3pm but I will confirm if the meeting will still happen tomorrow morning so you could inform others."* (Current MOH official).

Coordination *amongst the international policy actors* appears at first sight to be generally good, as shown by the existence of DCC and by a case of networking amongst donors described in 'actors' power' in 7.2.2. However, many national policy actors did not share this view and raised the issues of limited accountability of the international community. All respondents shared the view that the MOH does not play a major role in coordination of international agencies.

As for the implications for MOH capacity, the MOH is generally well-represented at the different levels though the effectiveness of the MOH coordination practices was criticised. Many respondents suggested that developing better coordination ability is one area where MOH capacity strengthening should occur.

7.3.3 Discussion

The importance of wider participation of actors in health policy processes is recognised in many RT documents (GOT, 2003, 2006c). This finding is in line with the acknowledged trend towards wider involvement of actors in policy processes in the literature (Tantivess and Walt, 2008). Actors' participation in policy processes is generally improving though there are differences in the degrees of improvement perceived by national and international

respondents. These differences may also reflect the wider discrepancy between the views of the national and the international actors identified in earlier Chapters, with the former often seeing a more positive picture than the latter.

There was also a difference of opinion regarding the clarity of actors' roles in health policy processes. This may be related to the differing roles and practices at different stages of health policy processes – representing an important challenge for the MOH to identify, and ensure the involvement of, relevant actors in policy processes.

The relationships between the MOH and other policy actors are complex. Furthermore, the interrelationships amongst policy actors (such as the media and civil society) add a further element of complexity. One challenge for the MOH is to be able to manage the actors' interactions to ensure the participatory nature of health policy processes. However, possible disagreements between actors may provide an opportunity for the MOH to target the most influential ones, who are likely to secure agreements of others actors.

The MOH possesses less power than other parts of government and the international community and can be 'squashed' in the middle. This may result in limited flexibility in health policy and may cause low motivation to strengthen its capacity. Furthermore, the large burden of routine work referred to may negatively affect the availability of the MOH staff for capacity development.

Where the MOH staff <u>are</u> available for capacity development, they may be perceived as not genuinely interested in capacity strengthening but motivated by material gains. There is no evidence to support or otherwise this view but it is clear that the existence of such an opinion in international community may contribute to the lack of opportunities for MOH capacity development.

The literature-based concept of actors' networks distinguishes between looser policy networks and '*tight-knit*' issue networks (Exworthy, 2008; Walt et al., 2008). This concept was not evident in interviews, suggesting either that networks may exist but may not be recognised by respondents or that actors' networks may still be at a rudimentary stage in a state-controlled policy environment of RT. This represents a potential area for future research.

The actors' agendas and values affect their roles and practices in policy processes and are closely related to the characteristics of policy actors, which is also similar to the existing literature (see Gaventa, 2005; Grindle and Thomas, 1991; Walt, 1994). However, these may not easily be recognisable by the MOH and there are likely to be some hidden agendas. These pose challenges to the MOH ability to recognise the different agendas and practices of policy actors.

The MOH may also face a challenge of managing the competing priorities and agendas of different policy actors, including the MOH itself. For example, INGOs prefer to continue having greater flexibility in implementing their programmes whereas the tighter control of the internationally-funded projects appears to be high on the government agenda.

Although differences exist in relation to the effectiveness of different levels of coordination, the MOH is represented at four out of five coordination levels. This may reflect their growing ability to engage in dialogue at different levels. On the other hand, the multiple coordination levels, combined with the high routine burden, may cause a significant burden on the MOH to engage effectively at different coordination levels, including sharing information within the MOH itself.

One emerging area is the lack of visible interrelationships between the MOH and other national actors such as civil society or the media. The identified lack of involvement of CSOs and media suggest either a lack of MOH ability to see their true potential in health policy processes or a genuine lack of expertise of CSOs in the RT. This represents an area to explore in future research.

7.4 Conclusions

Up to 14 types of health policy actors can be distinguished in the RT. These are heterogeneous and include different views, agendas and practices. Some agendas might be hidden, with resultant challenges on MOH capacity to recognise these in policy processes. Differences exist between national and international actors in their characteristics and roles in health policy processes, most notably power. The MOH can be 'squashed' between the powerful President's EA and the international pressures leading to its limited flexibility. Furthermore, the large burden of routine work affects the MOH motivation in relation to capacity development.

The composition of policy actors is changing, with implications for MOH capacity to ensure their involvement in policy process. Similarly, actors' interrelationships are not static, posing a challenge for the MOH to engage effectively with, and manage, those interrelationships. There appears to be a trend towards the wider involvement of policy actors in key RT' policy documents. CSOs are increasingly involved in policy processes by international agencies though it is unclear whether this involvement can be sustained.

Two issues are important in understanding MOH capacity in relation to involvement of actors in policy processes: the need for both ability and willingness and the contribution of the individual towards the organisational levels of the MOH capacity.

The next Chapter explores the role of evidence in policy processes and its implications for MOH capacity.

8 ROLE OF EVIDENCE IN HEALTH POLICY PROCESSES AND ITS IMPLICATIONS ON MOH CAPACITY

8.1 Introduction

The use of evidence in health policy processes is one element of the MOH capacity component of the conceptual framework and is the focus of this Chapter. The Chapter starts with an overview of respondents' understanding of the concept of evidence, followed by identification of the key perceived characteristics of robust evidence in the RT. It concludes by exploring the evidence processes and their implications for MOH capacity.

8.2 Interpretation of evidence

In this study evidence is interpreted as information, formal or informal, which may inform, directly or indirectly, health policy processes. The term '*evidence'*, however, is understood as largely a legal term in Russian and Tajik and, therefore, the term *'information'* was mostly used in documents and by national actors. However, some international actors used the term evidence.

Evidence was perceived as important in key strategic documents, as shown by a separate Task of the Health Development Strategy devoted to the '*Scientific research and health-related information*' (GOT, 2003) or RT's Strategy for Science and Technology Development for 2007-2015 (Kurbanov, 2007).

Overall, many respondents felt that "*…evidence-based planning and the use of scientific research… [in] the health sector has always been weak [in RT]*" (Former MOH official, International Agency). However, some policy actors, particularly MOH officials, did not share this view and referred to MOH practices as evidence-informed.

The literature distinguishes different types of evidence, including *formal* (research, government documents) and *informal* (personal experiences, values) (Leeds HEPVIC team, 2009; Solesbury, 2001). Respondents were asked to distinguish different types of evidence which can inform health policy processes. Most study respondents referred to formal types of evidence, as set out next.

8.2.1 Formal types of evidence

When asked to define evidence, most respondents referred to formal types:

> *"…firstly, we need official statistical information which we receive from republican centre for health statistics and information. Secondly, it comes from assessments. The verbal information is not really good quality although you could take it into consideration. The official results of some assessments or our statistics should be in the basis of the documents."* (Current MOH official).

This view was also supported by key strategic documents. For example, the Health Development Strategy only referred to '*scientific research and health-related information*' as evidence to inform health policies (GOT, 2003). When probed further, most respondents identified three formal types of evidence, as set out next.

a) Outputs of research, normally from the WHO/UNICEF studies and as part of large projects. The RT's research system was described as having inadequate stewardship and a lack of effective utilisation of results (de Haan and Iskhakova, 2006). This is also exacerbated by a lack of perceived demand from policy-makers:

> *"…research as such is not really demanded and needed by any ministry. Research is something very theoretical, we don't need it, we know everything... We can live without it. Therefore, research as such is not really needed and everything is initiated by and paid for by the donor organisations. The public sector says to donors 'you need research so you need to pay but we won't'."* (National staff, National Agency).

Research outputs are usually available in the form of research reports and briefing papers. Two health scientific journals are published in the RT: *Avicenna Bulletin* (published by the Tajik State Medical University) and *Health of Tajikistan*. The MOH-affiliated *Health of Tajikistan* is mostly disseminating policy documents rather than reporting new knowledge per se with authors being mostly MOH officials (see Akhmedov and Mirzoeva, 2000; Akhmedov et al., 2003; Odinaev et al., 2003)

Academic evidence on health policy was limited. For example, the RT strategy for Science and Technology Development (2007-2015) did not mention *policy studies* as a priority research area, with most focus being on clinical areas such as cardiology, oncology, TB/HIV and mental health (Kurbanov, 2007). This view was also confirmed by respondents:

> *"The implementation of that health policy or health reforms has started really from 1999… During this period, at least I did not hear…[that] the health reform process itself could being the topic for many research…"* (Ex-MOH official, International Agency).

Only a few international respondents referred to literature reviews as a separate type of evidence. Reviews were mostly identified as part of wider research studies, rather than an output in itself.

b) HMIS-generated statistics and programme monitoring and evaluation. Some national actors, particularly sub-national health authorities, referred to HMIS-generated information and programme-specific monitoring and evaluation data as the '*official scientific proof*'. This suggests their trust in the official statistics though many recognised that often the HMIS-generated dataset is not comprehensive and programme-specific information is needed.

Many international respondents were openly critical of the limited use of the HMIS-generated information, because of the poor quality of data, a view also supported by documents (Gaibov et al., 2003; Mahon and Tediosi, 2007). Furthermore, many reflected on the slow availability of HMIS statistics as impeding its utilisation in policy processes – for example, the National Health Statistical Bulletin is published several months after the reporting year.

c) Official policy documents such as the PRSP, National Development Strategy and other policy documents. This view of evidence as documents was reported by national actors and was not typical of international respondents.

Actors' views also differed in relation to the use of formal documents in policy processes. International policy-makers interpreted official documents as evidence of government's intention and hence something to comment on and discuss. The sub-national health authorities perceived official documents as a guidance for action/implementation, rather than as an opportunity to challenge, and comment on.

8.2.2 Informal types of evidence

As mentioned earlier, informal types of evidence did not feature frequently in the responses though some respondents referred to informal evidence as a backup option in the absence of formal types, for example in the pharmaceutical field. The following three broad forms of informal evidence can be identified.

a) Information in the media. Some international actors raised examples of extreme cases of saved lives of bleeding women as a powerful tool to inform policy in relation to the traditional birth attendance. Another example was the negative reaction from civil society,

reported by the media, on the introduction of the Basic Benefit Package which led to the President's decision to stop implementation of BBP in 2005.

b) Experiences of policy-makers following their participation in the study tours or relevant meetings. Many international actors raised the need to adapt such international experiences:

> *"I think what officials look at is international experience. They may go to some countries to look at different structures and different kind of reforms. Sometimes they get excited about those features and try to replicate it here whereas it's not always applicable in the context of Tajikistan.."* (Expatriate staff, Donor Agency).

c) Information from the Internet resulting from the use of generic search engines such as Google, Yahoo or Yandex[15]. This was interpreted as being similar to literature reviews but not systematic and without the element of peer-review/critical appraisal.

Some respondents initially referred to the results of meetings and round tables as a separate type of evidence. However, after further probing they interpreted these as rather mechanisms for sharing and dissemination of other forms of evidence, for example, documents and personal experiences.

Other forms of informal types of evidence such as preconceptions, shared norms and values did not feature at all in the responses.

8.2.3 Discussion

The reviewed literature and the current study interpret evidence widely, including formal and informal types (Leeds HEPVIC team, 2009; Rychetnik et al., 2004) – a view shared by some international actors. There is, however, a clear dominance of formal types of evidence in the perceptions of the national policy actors, reinforcing a heavy reliance on guidance documents and instructions. This may also be linked to some of the contextual factors, for example, the culture of not questioning management. One of the resultant challenges on the MOH capacity is the potential inability (or lack of willingness) of peripheral levels to critically appraise centrally-available evidence. For example, the case of resistance to the BBP from the general public could have been prevented if the sub-national health authorities had warned national-level colleagues.

[15] The Russian-language search engine

Formal documents such as the PRSP and the National Development Strategy, although referred to be many as 'evidence', can be interpreted as outcomes of other types of evidence. These documents provide guidance or broad policy framework for developing more specific policies (for example, on health financing or family medicine) and most respondents interpreted this use of policy documents as 'evidence'. From another perspective formal documents, as with round tables and meetings, can also be interpreted as mechanisms for sharing and disseminating evidence. The MOH needs to recognise official documents as both an outcome of 'previous' applications of evidence as well as a normative input towards further policies.

The legal interpretation of the word 'evidence' is similar to what '..*detectives looked for in making up their minds*' in Britain (Solesbury, 2001 p.4). Although this might be regarded as a minor language-related issue, it suggests the implications about the degree of understanding of translated literature by the MOH and other actors. This also raises the need to invent and consistently use a Tajik/Russian term for evidence, different to its legal interpretation.

The limited coverage of different forms of evidence in the responses suggests that only 1-2 different forms of evidence are actually used in policy processes, depending on the actors' views and practices – a view shared in the literature (Campbell et al., 2009). This has two potential implications for MOH capacity. First, it suggests the need to enhance the MOH capacity to use more types of evidence. Second, it suggests that involvement of a combination of actors should be sought, as one way of using different types of evidence.

The lack of academic evidence in relation to RT's health system and policy may reflect the government research priorities, as reflected in the RT's Strategy for Science and Technology Development. It reflects the perceived low profile of policy research, compared to clinical studies and does not provide a favourable framework for the MOH capacity strengthening in relation to policy analysis.

The use of information from the Internet suggests that policy actors have limited access to rigorous evidence on the Internet, possibly doe to the limited availability of scientific evidence in Russian/Tajik. Although there is insufficient data to support this view, it appears that there is a stereotype of evidence being a 'formal document' - often in hard copy - with less importance of other forms, including electronic copies.

Different interpretations of evidence raise challenges for the MOH capacity to conduct policy processes, particularly in relation to ensuring evidence-informed policy processes. The MOH is faced with a challenge to recognise the different interpretations of the concept of evidence, including that of the MOH itself. This is important in ensuring the availability of 'preferred' types of evidence. The MOH needs to establish an effective dialogue with other policy actors, for example with donors or other parts of government, in order to identify their evidence preferences and attitudes and to identify the best ways of addressing these in policy processes.

The different interpretations of the concept of evidence contribute to the different evidence preferences by the policy actors, as exemplified by the MOH's preference for formal evidence. Evidence preferences are also affected by the perceived characteristics of robust evidence, as set out next.

8.3 Perceived characteristics of robust evidence

As explored in section 2.4.2, the different literature-based taxonomies of robust evidence range from the simple three-characteristic models (Solesbury, 2001) to the more complex ones comprising five or more characteristics (Court et al., 2005; Shaxson, 2005). This section explores the perceptions of characteristics of robust evidence, followed by discussion of implications for MOH capacity.

Although different documents identified various weaknesses in evidence-generation systems (de Haan and Iskhakova, 2006; Gaibov, 2004; Gaibov et al., 2003), no documents were found from the RT referring to the perceived characteristics of robust evidence. One MOH official suggested a three-tier evidence classification in relation to the pharmaceutical field:

> *"…[the] information…can be primary, secondary and tertiary. The primary information is non-objective and often comes from manufacturers... The secondary type of evidence is coming from the experience of use …[of products]… in the various contexts. The tertiary is the most reliable such as Martadel, British Formulary and the Cochrane Library – these... reflect the independent reviews and assessments... This evidence is mainly used in our decisions…"* (Current MOH official).

The respondents were asked to reflect on the characteristics of robust evidence. Most respondents referred to the evidence guiding the *contents* of policies, such as the identification of priority thematic policy areas. The responses from those that did focus on

policy *processes* included the various combinations of the five interrelated characteristics, as set out next.

8.3.1 Methodological rigour

The importance of methodological rigour was shared by all respondents. This characteristic was interpreted as a reflection of degree of rigour in the approaches to the data collection and processing, the existence and appropriateness of quality control mechanisms, the degree of error in data transmission and the appropriate skills and expertise of staff involved in data analysis.

None of the respondents referred to the degree of methodological rigour in official documents such as thematic policies (for example, in relation to the framework guiding the choice of policy options).

Many respondents raised the poor quality of the HMIS-generated evidence. Similarly, various documents criticised the ineffective manual systems of data processing and the lack of quality control mechanisms (Gaibov et al., 2003; WB, 2007). The contents of health statistics was thought to be also influenced by the pressure to present positive results:

> *"What is the problem in our health sector, we still have some culture of reporting figures, you know, every single proper condition, percentages, trends. I mean there is a pressure to present good outcomes."* (National Staff, Donor Agency).

Many respondents suggested the need to develop a culture of using evidence in the RT:

> *"…big banks come with what they call 'turn key' systems to meet the information requirements of sophisticated health service systems – it's not needed here… The philosophy for collecting information, what you do with that is important. Part of the review that we had recently just shows that people just put the data in because they are told to. So, they all put any data really and all you are doing is just feeding a system which is itself generated a rubbish. There is no use of it."* (Expatriate Staff, International Agency).

Some respondents raised doubts regarding the methodological rigour of some indicators used in different surveys, as illustrated by the example of interpretation of an indicator used in the Tajikistan Living Standard Survey conducted by the State Statistical Agency with the support by the international community:

> *"They gave an indicator for urban area that 93% have access to improved water but … there is a big difference between safe water and improved water…"* (National staff, Donor Agency).

There was recognition, by the MOH and other policy actors, of the value of second opinions in ensuring methodological rigour. For example, peer-reviewed academic publications and commented reports were perceived by the MOH officials as better quality than non-reviewed evidence, for example, from the pharmaceutical industry.

Most policy actors shared the view that rumours and personal experiences are not reliable, unless supported by more formal types of evidence.

The interpretation of methodological rigour also comprised the skills and expertise of staff associated with evidence generation and interpretation. Many respondents reflected that actors' reputation is also important, as explored next.

8.3.2 Reputation of actors

Though not related to the characteristics of evidence itself, the reputation of policy actors associated with evidence was raised by many respondents. For example, the involvement of reputable international agencies such as WHO or UNICEF was perceived as adding quality to the methodological rigour of evidence. One example of the use of results from the WHO-supported study in policy development was raised:

> *"…with the support from WHO in 2001 there was a several-year assessment or monitoring of prices of essential drugs …in Dushanbe and surrounding rayons. …we tracked the prices on quarterly basis and after this we also tracked the availability at different times and places. … we used those in developing the normative documentation. Also, we had the drug procurement strategy approved and we also used that information there…"* (Current MOH official).

Many respondents also reflected that actors' power may be a reason for the perceived lack of critical appraisal of evidence from President's Administration by the MOH, as with MOH-disseminated evidence to sub-national health authorities. The reputation of actors driving the perception of quality of evidence also applied to the internationally-recognised individuals, as shown by the case of MDG assessment (see 6.2.5).

Lastly, research-related skills and expertise were increasingly recognised in RT, as illustrated by a growing number of commissioned studies by the WB, WHO and UNICEF to two private research companies: Panorama and Zerkalo. No link was identified between these two companies and academic institutions such as Tajik State Medical University, Post-Graduate Institute or Medical Colleges.

8.3.3 Accessibility of evidence

Accessibility was interpreted as the degree of ease of access to available evidence. A few international respondents suggested that robust evidence is normally easily accessible, as exemplified by survey reports. Many national actors regarded the degree of access as a reflection of formal government protocol or institutional procedures and did not identify the link between accessibility and methodological rigour.

In relation to government documents, accessibility was interpreted as ease of acquisition of a copy and the protocol to be complied with (for example, the need for a formal letter, whether only a certified copy is available and the waiting period involved). Many international respondents, in contrast with sub-national health authorities, suggested that most government documents are not easily accessible.

A few respondents expressed an opinion that access to evidence is related to actors' roles and practices in policy processes. For example, one respondent reflected that *"…if [I] was an ordinary citizen I am not sure if I'd hear that… [evidence]…it's because of my position and profession…"* (National staff, Donor Agency). Another actor referred to the potentially detrimental effects of the MOH working practices on access to evidence:

> *"…a person from rural place, she was disabled because of failure of the doctor…- came directly to see minister of health and asked for help... Maybe she was promised something and this made her go away but …[as a] result, the security and guard system in the MOH building was strengthened… not to allow any further strangers to come in without the prior appointment..."* (National Staff, International Agency).

Lastly, issues affecting accessibility of academic evidence included resource constraints to maintain subscriptions and the lack of electronic copies of academic papers. Many respondents, including MOH officials, reflected that policy research in Russian is limited. The language barrier was also applicable to information on the Internet, including information available from the international community (UNCU, 2006).

8.3.4 Timeliness of evidence

The time when evidence is available for use in policy processes was perceived as important. This characteristic was raised in recognition that there may be a gap between the data collection and its use in policy decisions, for example in relation to large-scale surveys. Similarly, respondents reflected that academic evidence becomes available only after dissertations/theses for Candidate and Doctor of Medical Sciences[16] are defended.

A case was identified in which what was described by some as a capacity development initiative caused some frustration from MOH officials:

> *"We asked for support the development of clinical guidelines on main diseases… We were told to develop methodology. …a number of seminars are going on, at every event I was asking… let's start the actual development… the methodology has finally been approved in the third year. Obviously, we are delaying the development of clinical guidelines by three years. [It] is not doing any good…"* (Current MOH official).

Many respondents suggested that time is related to the quality of evidence – for example, robust methodologies require time to develop/adapt. However, most policy-makers reflected that there is no reason to produce good-quality evidence late.

8.3.5 Practical applicability of evidence

The importance of practical applicability was raised by many national respondents (especially the MOH). This refers to the existence, and feasibility, of recommendations or options explored; for example in research studies.

Virtually all respondents reflected that the MOH cannot afford wasting money for 'non-useful studies'. The issue of practical applicability was also recognised in the reviewed documents, as illustrated by a reference to the President urging scientific institutions to focus on evidence of practical relevance and importance to the government (Gaibov, 2004).

Some respondents felt that most evidence usually explores a single policy option. However, review of documents revealed that evidence exploring different policy alternatives is also available in the RT, as shown by two policy options suggested in relation to the training of family doctors (Kadirova, 2006).

[16] MA and PhD equivalents in the FSU academic system

Many respondents reflected that evidence from different government ministries is often contradictory. One example was contradiction of two policies related to medical education (see 6.2.4). Another example is related to contradictions in relation to cotton collection during the academic year:

> *"We have a policy which states that schoolchildren must not be involved in cotton collection but at the same time the government… make[s] the school principal responsible [for collection] during the cotton season in that village and how can this person… [alone] gather this cotton? So it makes him to push all children to collect cotton..."* (National staff, International Agency).

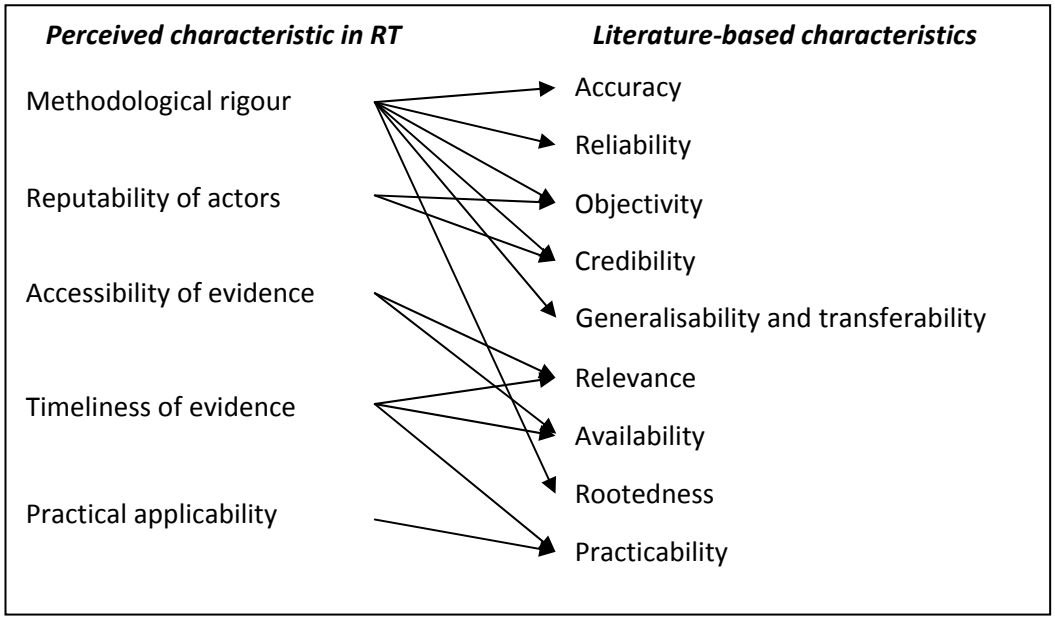
Lastly, most respondents, when discussing the practical applicability of evidence, explicitly referred to both formal and informal types of evidence.

8.3.6 Discussion

Five perceived characteristics of robust evidence in RT broadly correspond to the nine characteristics identified earlier from the literature (see Figure 16). Two issues emerge from the above. First, the different characteristics of robust evidence overlap with literature-based characteristics as shown by the multiple arrows. For example, the methodological rigour and the reputation of actors contribute to the credibility of evidence. Secondly, different characteristics are related. For example, actors' reputation contributes towards perceived methodological rigour; timeliness affects accessibility and the practical applicability of evidence. The obvious implication of this for MOH capacity is the need to recognise the above overlaps and interrelationships and, where applicable, manage actors' views and practices in relation to evidence (including those of the MOH).

Figure 16: Perceived and literature-based characteristics of robust evidence

Based on: (Court et al., 2005; Shaxson, 2005; Solesbury, 2001; Spencer et al., 2003; Sutcliffe and Court, 2006)



Limited evidence, if any, exists in relation to policy *processes* though this may be true in most health systems. Similarly, evidence was perceived to focus on mostly a single policy option, despite the availability of different policy alternatives in the academic literature. This suggests the limited access of key policy actors to scientific publications (possibly related to the limited power of academic institutions) but may also suggest the MOH practice of looking for confirmation of pre-formed views in policy processes (as a reflection of their values and agendas). Two implications can be derived in relation to MOH capacity. First, the above findings, being an important reflection of MOH capacity, suggest areas for capacity strengthening. Second, this once again reaffirms the need for both ability and willingness in understanding MOH capacity (for example, the willingness to explore the different alternatives may be balanced by the ability to recognise and assess different policy options).

Interpretations of robust evidence vary, reflecting values, agendas and roles of different actors in policy processes. For example, policy-makers prefer something 'practical' whereas international actors frequently referred to scientific rigour. The time-consuming nature of producing evidence suggests that 'quick and clean enough' evidence may be used in health policy processes (Lavis et al., 2008b) – the view contradicting some perceptions that methodologically-rigorous evidence often needs inordinate amounts of time.

Differences were also found in the perceptions of some characteristics of robust evidence. For example, the accessibility of formal documents was perceived by national actors - in contrast with their international counterparts - as a reflection of government rules, rather than a reflection of the degree of robustness of evidence. The literature makes a similar distinction between the practices and views of researchers and policy-makers (Campbell et al., 2009) and managing these differences appears to represent one particular area for MOH capacity strengthening.

The study findings suggest different interrelationships between the context and perceived quality of evidence – as reflected in the literature (Dobrow et al., 2004). For example, the quality of evidence is affected by the pressure to present good results, for example from pilot projects. This may relate to the culture of not making mistakes (see Chapter 6) and, having implications for the quality of evidence (for example HMIS data), represents an important area for MOH to recognise and manage.

The case of cotton policy (see 8.3.5) suggests that where contradictory policies exist, the actors' values and agendas may influence interpretation of available evidence – for example, the perceived economic benefits from the schoolchildren's involvement appear to prevail over the social gains from their education time. Although there is no sufficient evidence to support (or otherwise) this view, the issue of practical applicability in the President's speech could also be interpreted as being biased towards the country's economic development. This raises again the issue of social sectors, including health, being less powerful than other ministries. Following from this, the MOH needs to have unequivocal evidence in such dialogue with more powerful local authorities or other ministries.

The President's speech may also be interpreted as a reflection of willingness to use evidence if its practical applicability is understood. The potential implication on MOH capacity is the need to develop capacity, within the MOH and wider, to understand the potential practical applicability of different types of evidence, for example produced by academia.

The view that the HMIS-generated evidence is not reliable was common. Project-based monitoring and evaluation systems were ostensibly producing better quality information but are clearly not sustainable. At the same time, the lack of reliance on mainstream HMIS diverts potential funding for HMIS strengthening and further weakens the government system, thus contributing to a vicious cycle. As suggested by some respondents, the international community may also further weaken HMIS by introducing sophisticated

elements without addressing the fundamental issues such as fostering a culture of evidence use. Therefore, the MOH needs to ensure an adequate balance between project-based information systems and mainstream HMIS in the short-medium and long-term as well as to focus on developing a culture of evidence use in the RT's health sector and beyond.

In summary, the perceived characteristics of robust evidence have different implications for MOH capacity. The perceived characteristics differ amongst policy actors (including within the MOH) with resultant implications on the need for the MOH to reconcile its views with the more powerful government departments and international community. The culture shift towards evidence use needs to be managed alongside the efforts to increase quality of information itself. The MOH needs to further develop expertise in critical appraisal of the available evidence – for example, to be able to distinguish whether an unsuccessful intervention is a reflection of the poor design or the poor delivery (Rychetnik et al., 2002). The importance of actors' reputations suggests the opportunities for the MOH to enhance the involvement of reputable actors with expertise in the production of evidence such as WHO/UNICEF. It is important, however, for the MOH to also recognise the value of less reputable academic institutions in the longer-term. Lastly, the MOH needs to recognise that methodological rigour may sometimes counter-balance the pressure to present a positive picture and the need to ensure the timeliness of evidence for policy decisions.

The next section explores the evidence processes and their effects on MOH capacity.

8.4 Perceived evidence processes and their implications for MOH capacity

The different literature-based models of evidence processes range from simple three-stage models comprising introduction, application and use of evidence (Dobrow et al., 2004) or sourcing, using and implementing evidence (Bowen and Zwi, 2005) to more complex models comprising identification of research priorities, knowledge generation and dissemination, evidence filtration and amplification and its application in policy processes (Green and Gadsby, 2007). This section explores the main perceived stages of evidence process and their implications on the MOH capacity.

Despite the recognised importance of evidence in numerous documents (GOT, 2003; Kurbanov, 2007), no documents were found from the RT referring to evidence processes. Furthermore, the evidence processes within the public health sector appear to be unclear to many international actors, including those closely working with the MOH. Similarly, although

the MOH is aware of the processes used within large projects and by the key actors (WHO, UNICEF), the MOH is unclear of evidence processes used by the INGOs.

Most respondents shared the view that evidence processes are complex and involve different stages. Some respondents, when asked to describe the stages of evidence processes referred to the standard research cycle: methodology development, data collection, analysis, report writing/recommendations. However, after probing, most respondents identified three stages of evidence processes: evidence generation, dissemination and use/utilisation. The identification of information needs, though recognised by a few academic respondents as a separate stage, was largely missing from the responses of other policy actors.

8.4.1 Identification of information needs

An opinion shared by many was that information needs are mostly driven by internationally-funded projects. Most respondents, in contradiction with the earlier-referred country's strategic documents and in contrast to the MOH, also reflected that there is no continuous demand for evidence from the government, due to a lack of political support:

> *"In the recent speech of the President he highlighted ok we have had all those assessments and studies and we don't want any more assessments and studies. I talked with the minister... [and] it was very difficult…"* (National Staff, Development Partner).

Similarly, different respondents also mentioned that "…*there is no demand [for evidence] from the civil society…"* (Expatriate staff, Donor Agency). However, this opinion was not shared by the CSO representatives, who referred to the lack of political support and the bureaucratic processes for approval of research agenda as the main barriers.

According to some respondents, the MOH-based Medical Research Council (MRC) normally approves topics for post-graduate research, based on their relevance and practical applicability. However, their approval is only required for MOH-funded studies (mostly clinical studies and no policy research was identified); research funded by other agencies is not reviewed. The MRC's ethical review board meets on a quarterly basis, consists of chief MOH specialists (based mostly on tertiary health facilities) and is chaired by the part-time Head of the MOH Science Department. However, no evidence of functioning of that board was found during the data collection and, for example, approval for the data collection for this study was obtained from the Minister of Health. Furthermore, no evidence was found of the subsequent *use* of results of MOH-approved studies.

The MOH-affiliated HPAU has an annual plan for studies, developed by the WB-funded Community and Basic Health Project (CBHP) in consultation with the MOH. The HPAU also conducts ad-hoc studies in response to the emerging needs within CBHP. For example the BBP survey was conducted following the President's decision to stop the implementation (see 5.3.3).

Most international agencies have a pre-determined evidence agenda set out in a Memorandum of Understanding or the project documents. However, in contrast with the HPAU, most INGOs do not have much flexibility to respond to emerging information needs and only development agencies (WHO, UNICEF) are able to get MOH approvals for research on an ad-hoc basis.

Lastly, a few international respondents suggested that media is not entirely independent in the RT. Many shared the view that media is often looking for sensation stories.

8.4.2 Evidence generation

The respondents were asked to describe the processes for generation of different types of evidence. These were described in detail in relation to the research-related evidence only:

> *"…the first is preparation when methodology is developed, all technical issues are thought through. Second is field work, third is data processing and four is analysis including presentation of findings. The four usual stages."* (National Staff, National Agency).

Formal government documents and the HMIS were only mentioned by a few respondents when exploring the evidence generation stage. The mainstream HMIS was identified as inflexible to accommodate emerging information needs. The lack of hardware and data collection and processing skills at the grassroots level were mentioned as factors resulting in low-quality health statistics.

The MOH was described as having limited capacity and resources to commission research and most respondents suggested that the MOH itself was typically not involved in evidence-generation. Instead, the MOH was reliant on the involvement of the international community, though many international respondents did not share the view below and reflected on the lack of initiative from the MOH:

> *"…we have both examples of the MOH commissioning those where we ask international organisations to conduct a survey with their own methodology…. Obviously, they agree the tools with us and we can comment and revise the tools. Another option is when we have methodology and we just need implementers so we also ask other partners. When they are donors for those surveys they then look at our indicators, agree them with us and then they carry out the research…"* (Current MOH official).

According to respondents, research is mostly done by for-profit companies such as Zerkalo or Panorama, under the supervision, and with the support of, their clients. For example, the baseline and intermediate BBP surveys (August and November 2007) were conducted by Panorama with technical support from WHO-EURO and financial support from CBHP (Jakab et al., 2008). Sometimes the analysis and interpretation of study results is done by the clients, for example by the HPAU.

CSOs were sometimes involved in conducting surveys (for example, commissioned by UNICEF). WHO and UNICEF are contributing technically and financially to the generation of evidence and are often consulted by the MOH. For example, UNICEF is involved in regular large-scale surveys in RT and WHO has recently initiated regular reviews of externally-funded projects in the RT (see WHO, 2007b).

8.4.3 Evidence dissemination

Most policy actors referred to the importance of adequate evidence dissemination. Examples of evidence amplification can be identified – for example, the amplification of public opinion by the media contributing to the President's decision to stop the BBP implementation.

An opinion was shared by some respondents that the media's involvement in evidence dissemination is limited, partly because of its perceived role throughout policy processes:

> *"…they [media] don't play role in policy development because media are normally for disseminating messages for population. They are used for delivering messages to the people and normally not from population to us…"* (Current MOH official).

Some respondents suggested further reasons for limited media involvement, which were more critical of the MOH capacity:

"…maybe they [MOH] haven't got anything to say? Maybe they are afraid to say something wrong and being punished for that? I think both. We have also got another aspect – people are not used to express their opinion publicly, especially when we would like it to be in Tajik. They are lost, they don't want to be shown as funny and think that it's very important not to lose the face…" (National staff, National Agency).

Most respondents shared the view that different events (such as presentations, workshops and seminars) were used for disseminating evidence. Other mechanisms included official letters used to disseminate government documents, various project-specific information and education campaigns (IEC), and project reports. Many international actors shared the view that many project reports are left unread by MOH officials, due to the large amount of routine work.

The MOH introduced additional dissemination mechanisms – for example, the recently-established MOH press-centre. Although it was too early at the time of the data collection to gauge its effectiveness, respondents shared the view that it can potentially become an effective MOH channel for evidence dissemination.

8.4.4 Evidence utilisation

Respondents shared the view that evidence is of no value unless it is used in policy processes. International actors, in contrast with national policy-makers, were critical of the degree of evidence-informed nature of policy processes.

Most respondents felt that HMIS-generated statistics are unreliable. Some respondents reflected that, because of the perceived low quality of the HMIS, the MOH is increasingly including other types of evidence in their decisions. The UNICEF surveys were raised as an example. However, MOH officials reflected that the reliance on more expensive surveys does not represent a sustainable solution.

Different factors affecting the use of evidence in policy processes can be identified from the different responses. The most commonly referred to factors were:

- the perceived quality of evidence (related to the perceived characteristics of robust evidence explored earlier in this Chapter),
- the origin of evidence (the MOH officials reflected that they are more likely to use locally-generated evidence in policy processes, because of context-specificity) and,

- the existence of a favourable wider context (for example, the WB missions were described by many international agencies as opportunities for evidence dissemination; the MOH does not often have money to implement the research recommendations).

Some international respondents also referred to the perceived lack of MOH skills in interpreting evidence, which, as a reflection of MOH capacity, suggests the need for greater engagement of other actors in assisting the MOH in analysing and interpreting evidence.

Many policy actors reflected that evidence can be misinterpreted and misused by both national and the international actors. For example, the pressure to present good results was raised in relation to HMIS data. Another example is related to the sanctions implemented in response to the fire in a disabled school (see culture of not making mistakes in 6.2.5).

Similarly, the MOH was described by many international respondents as lacking the skills to fully understand and implement results of studies. At the same time, the MOH reflected that many international agencies use surveys to monitor and evaluate their projects and to '*justify expenses to their funders'* (current MOH official) and only to work of a few agencies such as UNICEF was referred to as informing policy processes.

8.4.5 Discussion

The four-stage classification of evidence processes (identification of information needs, evidence generation, dissemination and use) in the conceptual framework derived from the literature (see Bowen and Zwi, 2005; Dobrow et al., 2004; Green and Bennett, 2007) is applicable to the RT. The identification of information needs, mostly by academics, suggests the lack of recognition of this stage of the process by many actors and represents one area for MOH capacity strengthening.

The lack of clear evidence processes in the reviewed documents, combined with similar finding from interviews, may be interpreted as an indication that adequate evidence processes were not a priority by the MOH. In fact, this appears to be similar to the general lack of explicit recognition of policy *processes* identified in Chapter 5 and is a potential area for improving the MOH knowledge.

Many strategic documents are driven by internationally-funded projects and hence their contents may not always reflect the views of the country's leadership. This might be one of

the reasons for the contradictions identified between the President's verbal statements and the key RT's strategic documents identifying research as a priority. In a hierarchical society, such as the RT, more emphasis is likely to be given to the former and the lack of political support for research is likely to translate into a lack of financial commitment and a lack of implementation. This represents an important challenge for the MOH to overcome in ensuring evidence-informed policy processes.

Some internal challenges also appear to hinder MOH capacity in relation to the use of evidence. For example, the lack of a mandate to review the internationally-funded research agenda and the centralised MRC functions raise questions with regards to the technical ability and availability of MOH staff to review research proposals. Furthermore, the minister's approval of research projects may reinforce the hierarchy within the MOH and thus make the work of the MRC redundant. One possible option for the MOH to consider is to decentralise the MRC functions to academia.

Many international respondents, in contrast with their national counterparts, suggested the lack of evidence use in policy processes. This may reflect a general difference between the views of policy-makers and other policy actors described in the literature (see Campbell et al., 2009), but also raises the issues of transparency of the evidence processes, within the MOH and the other actors. The difference between the opinions of national and international respondents is similar to the same finding in earlier Chapters.

The MOH has different evidence dissemination mechanisms such as events and official letters. The introduction of additional information dissemination channels raises questions as to whether proper attention is paid to assessing, and seeking possible ways of enhancing effectiveness of existing channels – for example, the balance between official letters and e-mail communication (also see Chapter 7). Therefore, the MOH needs to recognise, in its capacity strengthening, the balance between introducing additional mechanisms and improving the effectiveness of existing dissemination channels.

No respondents referred to knowledge brokering, distillation, or amplification and filtration, concepts increasingly mentioned in the literature (see Delany-Moretlwe, 2009; Green and Gadsby, 2007; Ward et al., 2009a, b). However, some practices were identified suggesting the applicability of some of these issues to the RT. Key policy actors may lack understanding of key theoretical concepts. This may be a reflection of a lack of access by key policy actors to available literature, possibly due to a language barrier. The implications of this on the

MOH capacity include its ability to further develop language skills of its staff and/or effectively use available resources of other policy actors to obtain, translate and interpret evidence.

The lack of government's demand for research may contribute towards weak links between academia and policy and practice. International respondents suggested that more systematic surveys should be commissioned though the MOH did not see the need for these. This is clearly one area for the MOH capacity to identify, and where possible manage, the information needs of the different actors.

The MOH approves methodologies for surveys though many respondents raised doubts as to whether the MOH itself has an adequate capacity to provide comments on scientific methodologies. This issue, combined with what appears to be an ineffective MRC, exemplifies the lack of a systematic approach for reviewing and approving the research agenda and may eventually be an important contributor towards the fragmented identification of information needs and the lack of evidence in policy processes. Examples of the potential implications of this for the MOH capacity include the need to align the decision structures and processes (see Chapter 9) and to establish dialogue with, and effectively use the expertise of, the key institutions involved in evidence processes.

Last, but not least, following international funding, research is done by private agencies (Zerkalo, Panorama) who are not academic institutions and mostly for-profit private organisations, resulting in competition with academia for funding and recognition. Some may argue that the development of private institutions, through competition, may contribute towards the development of academia. On the other hand, in the RT the state-funded not-for-profit academia is faced with severe resource shortages resulting in migration of staff (to the private sector and from the RT generally). Therefore, the current practices of the international community may jeopardise the capacity development of local academic institutions and may inhibit the establishing of stronger relationships between academia and the MOH policy and practice.

8.5 Conclusions

The use of evidence in health policy processes was perceived to be limited by international actors, in contrast with the views of national policy-makers. Different formal and informal types of evidence were identified though the overwhelming emphasis was on the former.

The MOH is faced with a challenge to recognise, and respond to, the different perceptions of evidence, including that of the MOH itself.

The different characteristics of robust evidence identified by policy actors broadly correspond to existing literature. There are overlaps and interrelationships between different characteristics. The implications of the perceived characteristics of robust evidence on the MOH capacity include the need to use the expertise of reputable actors in evidence generation and manage the perceptions of the characteristics of robust evidence, including those of the MOH itself. The wider context, for example, the pressure to present positive results, raises additional challenges to overcome in ensuring the quality of evidence.

The absence of clear and adequate evidence processes in the reviewed documents and from the interviews suggest that evidence processes are not seen as a priority. The HMIS was thought to generate unreliable information and the MOH needs to ensure a culture shift towards the use of evidence in policy processes. The project-based monitoring and evaluation systems are not sustainable in the longer-term and the MOH needs to ensure an adequate balance between project-based systems and the mainstream HMIS. Furthermore, the commissioning of research from international agencies to for-profit organisations may jeopardise the capacity development of national academia.

The next Chapter explores the perceived governance and leadership arrangements and their implications for the MOH capacity to conduct health policy processes.

9 LEADERSHIP AND GOVERNANCE AND ITS IMPLICATIONS ON MOH CAPACITY TO CONDUCT HEALTH POLICY PROCESSES

9.1 Introduction

The Chapter 8 identified implications of actors' roles on the MOH capacity. Implicit in the MOH capacity to conduct health policy processes, particularly in managing actors' involvement, is the need for appropriate leadership and governance arrangements, one element of MOH capacity in the conceptual framework (see 2.4.7). This Chapter sets out the key issues around leadership and governance of policy processes and explores their implications for MOH capacity. It is structured as follows. First, an understanding of leadership and governance in the RT is explored, including their perceived elements and associated features. This is followed by discussion of perceived changes in leadership and governance and their implications for the MOH capacity to conduct health policy processes.

9.2 Understanding of MOH leadership and governance

In this study governance in relation to health policy processes is understood as a way in which policy decisions are made and implemented. Leadership is government's oversight function with a distinction between transational and transformational leadership being particularly relevant to this study.

Many RT documents emphasised the importance of appropriate leadership and governance arrangements. For example, the MOH leadership role was a key priority in the Health Reform Conception (MOH, 2002) and a separate working group (WG) includes governance as an explicit part of its activities described as "*Devolution of Authority/Autonomy and Governance*" (Euro Health Group, 2008 p.15). Similarly, most policy actors recognised the importance of these two concepts in policy processes.

Respondents were asked to define the concepts of leadership and governance. Leadership of health policy processes was interpreted by most as the MOH "*driving the process with own examples*" (National Staff, National Agency). Most respondents did not provide definitions of governance though referred to its different characteristics, similar to the statement below:

> *"It means transparency, openness, accountability, participation… and the question is how to measure their extent of willingness of the ministry of health – whether it was a will of the ministry of health or whether it was imposed by donors, whether it was a consciously taken decision in the first place or whether it was a necessity to align everything."* (National Staff, Donor Agency).

In contrast, some documents from the RT did define governance as "…*the ability to scrutinise that decisions are being taken in line with public policy, and appropriately*" (Euro Health Group, 2008 p.15). However, no definitions of leadership were found in the documents though the importance of national leadership of reform processes was emphasised in various strategic documents (GOT, 2003, 2006a, b, c; GOT and UNDP, 2003).

One overarching issue emerging from the interpretation of leadership and governance was the need for appropriate MOH policy decisions as well as a MOH role in policy decisions by other actors. Within this, two themes can be distinguished:

1. *MOH decision-making style* within the wider culture of decision-making
2. *Decision structures* as a reflection of organisational structures.

The next sub-sections set out the above two groups, including the perceived associated features in the RT, followed by a discussion of their implications for the MOH capacity.

9.2.1 MOH decision-making style

Three broad themes can be distinguished from respondents' views and reviewed documents: a) the degree of rational decision-making within MOH, b) the degree of MOH initiative as a reflection of its leadership of policy processes and c) the balance between centralised and decentralised decision-making. These are set out below including the perceived implications for the MOH capacity.

Degree of rational decision-making

As discussed in Chapters 5-8, the most national respondents, in contrast to their international counterparts, referred to policy processes as being participatory and evidence-informed.

Most national policy actors, particularly the MOH officials, referred to the systematic priority-setting as a reflection of rational decision-making by the MOH:

> *"…we start with strategic document where we define our priorities and then these projects are attached to our priority areas. In other words, the MOH vision is then backed up by the available support from donors."* (Current MOH official).

However, many international agencies did not share the above view and suggested that the MOH policy priorities are driven mostly by the availability of funding rather than by a genuine

perception of health sector needs. For example, reference was made to the policy priorities being driven by requirements and conditionality within individual initiatives such as the WB or ADB-funded health reform projects. According to most respondents, one implication of the above approach is the significance of personal relationships of different policy actors with the MOH in general and the Minister of Health in particular.

Many respondents referred to the wider issue of corruption within the health sector as prohibiting greater participation of the international community in policy processes:

> *"Here what I see in Tajikistan a big concern a big talking about corruption… Of course when a government is facing situation of poverty this is a little bit more offending ..[but] sometimes here in Tajikistan international community tend to label government of not capable or lack of capacity or corrupt to justify not to work together and according to me this is a big mistake.."* (Expatriate Staff, Development Agency).

Many respondents were of the opinion that "*…most weight* [in policy decisions] *is put on opinions of some individuals"* (National Staff, International Agency). Different respondents emphasised the importance of formalisation of policy decisions, as reflected in most MOH decisions needing a formal order (*prikaz*). The involvement of individuals in policy decisions was interpreted by a few international respondents as opportunities for material gain.

A few national respondents suggested that the practice of formalisation of policy decisions may provide a favourable environment for monitoring of implementation of policy decisions – for example, the MOH *prikazes* determine the nature and timing of planned outputs from WGs (MOH, 2008a, c, d, e). On the other hand, many international respondents suggested that the resultant bureaucracy may contribute to the high volume of MOH routine work and thus may cause delays in policy processes.

MOH initiative in policy processes

Important in understanding of leadership in policy processes is the extent of MOH initiative, which can be interpreted as the degree of MOH proactive engagement in policy process. Such initiative was perceived as important by all respondents.

Though not shared by MOH actor, some respondents felt that the MOH staff are often "*… very scared about taking any decision or start talking or to initiate something.*" (National Staff, Development Agency) and many policy processes are driven by externally-funded projects. This was perceived partly due to the lack of power, knowledge and expertise in

thematic areas, for example family medicine. One respondent provided a typical view of the MOH relationships with the more powerful other government departments and the international community:

> *"…it's not a secret the international organisations have…[projects] for their convenience…, they have some certain… thematic topics which may not be too desirable for the ministry of health… and from the other side there is also pressure coming from Presidential Administration"* (National Staff, Donor Agency).

However, some examples of MOH initiatives in policy processes were also raised. For example the MOH seeking technical and financial support from the international community in developing the health financing strategy. A few international respondents referred to the perceived lack of MOH skills to systematically plan and maintain effective communication and coordination with other actors as potentially contributing to the rather fragmented MOH practices:

> *"The [MOH] were so unpredictable, they could come to our office and say we need one thousand dollars for implementing this kind of training. They were going round and asking for money without any previous planning. That's why we kept a certain amount of money for these unpredictable requests and situations"* (National Staff, International Agency).

One respondent suggested that interest in internationally-funded courses and hence the MOH initiative in some policy processes may be driven by perceived material gains. However, there is insufficient evidence to support or negate this view.

Balance between centralised and decentralised approaches

Most respondents shared the view that the dominant decision style in the public sector, including the MOH, is authoritarian. This is reflected in the organisation of the RT's public health system (see Appendix 7). Different respondents labelled this style of decision making in RT as a '*system of command and control*', '*paternalistic*' or '*hierarchical*'; all referring to the centralised decision-making style where oblasts and rayons "…*might provide inputs but major decisions of course are made by the ministry staff"* (Expatriate Staff, Donor Agency). A similar phenomenon was also identified by many in relation to the interaction between the MOH and President's EA where "*…the ministry of health is subordinated too much, they have not been provided with real flexibility, with the real freedom to take decisions…."* (National Staff, Donor Agency).

Some international respondents suggested that this centralisation of policy decisions within the government may reinforce the lack of MOH ownership of the policy agenda:

> *"The origin, the genesis of the policy needs or reform needs are …completely outside of the ministry of health and the policy formulation comes from the Executive Administration, from the President and not from the MOH and they are almost not involved…"* (Expatriate Staff, Development Partner).

Most actors suggested that centralised decision-making also exists at the local level – a phenomenon described as '*decentralised authoritarianism*' (Engvall, 2006). Many international respondents raised the potential for a lack of transparency and consultation in centralised policy decisions. This view was not shared by policy-makers, who claimed that policy decisions are made in consultation with relevant policy actors, for example at round-table discussions as part of individual projects (World Bank, 2006).

A few respondents raised the lack of accountability of decision-makers as one negative implication of centralised decision-making:

> *"You know the overall system is that those who are in power they are favouring from the situation of unaccountability, from those things which relate to poor governance"* (National Staff, Donor Agency).

Most respondents shared the view that low delegation of duties (within the MOH and beyond) is closely related to centralised policy decisions. One international respondent suggested that this may prevent capacity strengthening of different actors, including the MOH itself. The structures for MOH policy decisions are explored next.

9.2.2 Structures for MOH health policy decisions

Respondents were asked about the health policy decision structures. The majority shared the view that there is a delicate balance between formal roles, structures and powerful individuals, with implications for the degree of effectiveness of formal decision structures:

> *"I think there are formal officials who are responsible for various decisions and informal people with significant power and influence over the certain decisions. It is not always the formal people are actually able to do so without the second group. I think the existing advisors can play significant role in decision-making as long as those advisors have sufficient experience and understanding of the on-going changes and reforms."* (Ex-MOH Staff, International Agency).

Two types of structures can be distinguished: *decision structures* established for making policy decisions and *advisory structures*. These are set out next.

Decision structures

The MOH comprises seven departments and six units, managed by the minister and his three deputies (see Appendix 8) and its current structure does not allow systematic support for policy decisions. At the time of data collection the MOH did not have a policy or overall health planning unit in its new statute (GOT, 2006a, 2008) and these functions were performed in a rather fragmented way by different departments. Furthermore, according to international respondents, some MOH work could be delegated to other national actors.

The MOH secretariat (established to support the MOH coordination role) and the Health Policy Analysis Unit are funded by the WB-funded Community and Basic Health Project (CHBP). Although both the secretariat and the HPAU are located within the MOH premises neither is regarded as a department/unit in the MOH statute (GOT, 2008).

The MOH collegiums were identified by the key documents (GOT, 2005, 2006a) and most national actors as the primary structure for making policy decisions. According to the MOH statute, membership of collegiums requires approval by the President's EA (GOT, 2006a). Many international respondents referred to MOH collegiums as forums for disseminating policy decisions made earlier by the Minister of Health. Some international respondents viewed MOH collegiums as authoritarian and an opportunity for the Minister to '*exercise his power*', raising the need for other policy actors to '*justify themselves*' with the resultant limited participation in the actual decision-making (see Chapter 7).

The Minister gathers all his deputies and heads of departments every Monday morning for a regular meeting though it was difficult to ascertain whether these are policy decision-making forums or opportunities for information-sharing. Some respondents also referred to monthly coordination meetings as supporting policy decisions at the operational level. However, this view was not widely shared and some viewed these meetings as advisory structures only.

Many respondents shared the view that clarity and appropriateness of organisational structures are important for supporting policy decisions. According to the MOH statute, the Minister is personally responsible for MOH activities (GOT, 2006a), which may contribute to the authoritarian decision-making discussed earlier. Furthermore, document reviews revealed that, although the functions of President's EA, Parliament and the MOH as a whole

are identified in various documents (GOT, 2005, 2006a), there are no detailed terms of references for individual MOH departments other than reference to the "…*development and implementation of health policy, development of standards, regulations and norms within the health system*" (GOT, 2006a paragraph 13 p.5).

Some respondents referred to the MOH support structures which, through taking on the burden of MOH routine work, may free up core staff for policy issues. For example, some respondents referred to the recently established MOH secretariat and the HPAU – both under the MOH health reforms department – as increasingly taking on the MOH routine burden. However, some respondents suggested that this 'diversion' of HPAU may not help with strengthening of the health policy analysis function within the MOH and, therefore, their involvement in the MOH routine should be avoided.

Many respondents reported that current health financing structures may constrain the MOH capacity. The MOH controls the so called *republican budget* covering only tertiary-level hospitals and the MOH activities, whereas all other facilities (PHC, *rayon* and *oblast* hospitals) are funded through *local health budgets* managed by the *Hukumats* (Cashin, 2004). Although the bottom-up budgeting process is, in theory, a good approach to ensure implementation, the MOF often funds parts of locally-projected health budgets, thus undermining the MOH ability to match policy targets with available resources:

> *"…we had instructions for budgeting for the period 2009-2011. I developed my budget projections … [and] MOH accepted this but MOF rejected."* (Sub-national Health Authority).

Advisory structures

The two main advisory structures referred to by many respondents included the recently-established HPAU and thematic policy working groups, as set out below.

The recently-established HPAU was not part of the formal MOH statute (GOT, 2008) although the statute was revised approximately at the same time as the HPAU was established. Many respondents shared the view that the perceived rivalry between the main MOH staff and higher-paid HPAU experts may prohibit better utilisation of this unit in health policy decisions.

The following view of the roles of WGs in policy processes was shared by most respondents:

> *"…working groups are usually not a decision-making body. They usually work on some concept or on some idea, they work out… a document.. But, usually decision-makers are ministers, government whatever, they just do technical work and…[present for review by decision-makers]"* (National Staff, Donor Agency).

Most respondents shared the view that advisory structures use more inclusive, participatory and transparent approaches, than decision structures. A WG is usually chaired by, or includes, a head of MOH department and these are often people who, according to many, do not have time to fully engage in these activities, as illustrated in the statement below.

> *"…this WG is a very difficult issue for me because …[our organisation] has supported twelve working groups …. The problem is that we supported them and they haven't done their job well and we hold on to the last part of the payment and we agreed to pay on deliverables…"* (National Staff, Donor Agency).

Some respondents also raised doubts as to whether the membership in the different WGs is largely driven by perceived material gains.

Most respondents interpreted advisory structures as improving the MOH capacity, as long as these are utilised effectively. For example, a few respondents suggested that the HPAU can be seen as an opportunity to engage highly-paid and ostensibly better qualified staff in MOH work. However different respondents suggested that the MOH does not utilise the advisory structures to their full potential, mainly due to a) the overwhelming amount of MOH routine, b) the increasing involvement of externally-funded structures such as HPAU in this routine, c) the existing bureaucracy within the RT's health system as reflected in the need for MOH *prikazes* for WGs and d) the increasing number of non-functioning WGs.

9.2.3 Discussion

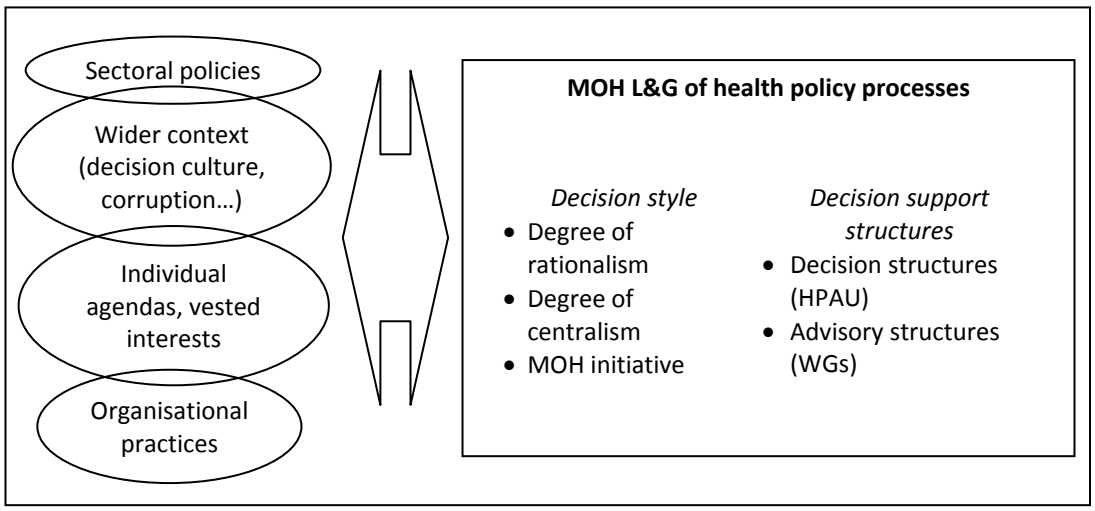
The three groups of issues (degree of rationalism, MOH initiative and degree of centralism) and their resultant implications for accountability, transparency, inclusiveness, ownership and evidence-informed nature of policy decisions are similar to the literature-based principles of good governance (see Boffin, 2002; Siddiqi et al., 2009; Travis et al., 2002; UNDP, 1997). The challenge for the MOH is to recognise the relative importance of these three groups and address them as part of its capacity strengthening.

Although reflected in some documents, the concepts of leadership and governance appear to be little understood in the RT. Those with clearer views included mostly international

organisations and national actors who have been exposed to some international training. In addition, the governance arrangements are complex and different decision-making styles exist at different levels in the decision structures. The examples of good working practices within the HPAU and WGs (wider participation, evidence-informed decisions) are something for the MOH to learn from. However, the HPAU and WGs are not seen as policy decision-making bodies, hence their significance for decision structures can be undermined in a hierarchical society – an area for consideration by the MOH and other key policy actors.

Certain governance issues, such as corruption, were widely recognised, possibly following pressure from the international community. For example, the delicate balance between personal gains and the promotion of the wider agenda was explicitly recognised in relation to the membership of thematic WGs. None of the respondents explicitly reflected on the potential relationship between the perceived corruption and the leadership and governance arrangements. It can be assumed that leadership and governance is a result of a balance between individual vested interests, perceived personal gains, organisational practices, sectoral policies and wider context, as shown in Figure 17.

Figure 17: Perceived effects on MOH leadership and governance of policy processes



In addition, sectoral policies are influenced by the international community though the relatively large number of ongoing and un-coordinated policy experiments and the perceived lack of inter-sectoral collaboration may result in 'governance gridlocks' as reported from Russia, where incentives from medical insurance to reduce beds were counter-balanced by a bed-based approach to funding hospitals (Sheaff, 2005).

There seems to be pressure from the international community and a willingness of the RT's Government, to move from the centralised system of command and control to a more incentive-based governance system (MOH, 2000). However, there is still a limited number of actors involved in developing and implementing health policies (Mirzoev et al., 2007) and authoritarianism is still dominant. Furthermore, the gradual shift of the MOH towards a more strategic role requires significant capacity building at lower levels of the system (Mira, 2002) which may not be feasible in the short-term.

The MOH leadership style can be described as being mainly transactional i.e. based more on reinforcement and exchanges, than on incentives. This may be regarded as a reflection of the centralised decision style with little involvement of other actors and limited use of evidence in the process. The different strengths and weaknesses of both transformational and transactional leadership styles are explored in the literature (Aarons, 2006; Hater and Bass, 1988; Stordeur et al., 2000) and the MOH should be aware of these.

Many international agencies seem to be critical of the existing style which might be a reflection of a generally negative attitude towards centralised decision-making and resultant authoritarianism. This represents an area of MOH capacity in need of further exploration. In particular it may be an opportunity for the MOH to review and clarify, jointly with other actors, the strengths and weaknesses of centralised and decentralised decision-making and subsequently address the balance between these two approaches as part of MOH capacity strengthening.

The literature suggests that effective leadership requires "*knowledge, power, and will*" (White, 2003 p.217), often reflected in dedicated structures such as the National Leadership Council created in UK's Department of Health 2009 (Jarman and Greer, 2010). Although knowledge and power were not raised explicitly in relation to leadership, these were explored in Chapter 7. The degree of initiative can be regarded as a reflection of its will and one area of capacity strengthening for the MOH is to consider demonstrating its leadership through the various organisational structures and forums identified earlier. It is important, however, to distinguish leadership from centralised decision-making and to recognise that inclusive decision-making is one of the prerequisites for effective transactional leadership.

It appears that the MOH decision style is related to the existing working culture as a reflection of various contextual influences (see 6.2.5). For example, the authoritarian decision style may reinforce the culture of a lack of critical appraisal and continuous need for

manager's approval and the degree of MOH initiative may be negatively affected by the authoritarianism which is prevalent within the wider public sector.

Most examples of the MOH leadership provided by respondents (such as use of initiative), are related to policy implementation and no references were made to MOH leadership of policy-setting. On the contrary, various respondents identified that policies are often set as a result of individual projects or conditionality by the powerful international community. A widening of MOH leadership from policy implementation to agenda-setting and policy development is an important next step in MOH capacity strengthening.

The characteristics of rational policy-making in the literature are: clear and transparent policy processes, adequate use of evidence, widest possible participation of actors and integrated nature of health policies (Peabody, 1996; Walt, 1994). Different aspects are explored in Chapters 5, 7 and 8). It is difficult to conclude in simple terms whether the MOH decision-making is rational or not, not least because no clear framework was found in the literature for relative importance of its different characteristics. In other words, if the use of evidence is generally adequate but actors' participation is low would this decision style be rational? The difference between the views of national and international policy actors in relation to rational decision-making raises the need for the MOH to understand and address the perceived weaknesses in relation to its capacity to ensure this in policy processes.

The perceived strong role of individuals in health policy processes raises the importance of personal relations. This, combined with the lack of transparency and the perceived culture of unaccountability amongst high-level officials, may provide a favourable environment for the different manifestations of poor governance such as corruption. This, in turn, may deter some international agencies from expanding the scope of their work in the RT's health sector, thus contributing to a potentially vicious cycle of the above factors. MOH staff should recognise these dangers, including the interests and agendas within the MOH itself.

The centralised decision-making and lack of delegation of duties by the MOH also suggests a lack of trust of other levels of the health system. This may be related to a perception of low capacity at the local levels, and may contribute towards a high burden of routine work for the MOH and may negatively affect the development of the MOH capacity.

The existing form of decentralisation (functional deconcentration) prohibits effective dialogue between the MOH and the *oblast* and *rayon Hukumats*. However, it may provide an

opportunity for the MOH to delegate functions to the *oblast* and *rayon* health departments, who, as part of the respective *Hukumats*, are much closer to the decision-making at those levels. However, there is a need to recognise the potential constraints resulting from the pubic-sector authoritarianism, which may prohibit local health departments from influencing decisions by the *Hukumats*.

It appears that the exclusion of the MOH from some policy decisions by the President's EA was recognised by the international community as an opportunity to bypass the MOH in their interaction with the public sector. This may negatively affect MOH esteem and its willingness to strengthen its capacity.

Not all findings represent barriers for MOH capacity strengthening in relation to health policy processes. For example, the HPAU can be viewed as a mechanism to attract otherwise unaffordable expertise to the MOH. However even here, there is a need to focus these experts on key priority areas and avoid them being 'swallowed' by MOH routine work.

The national policy actors generally had a more positive opinion of leadership and governance of policy processes, compared to their international counterparts. For example, the MOH decision-making was described by national respondents as transparent, inclusive and evidence-informed. This may be linked to the different elements of working culture explored earlier (see 6.2.5). At the same time, it may also reflect a more general difference in opinion identified earlier between national and international respondents.

Lastly, all policy actors were willing to discuss the MOH approaches to, and principles of, leadership and governance. However, when probed about their own, many policy actors (including international respondents) were not particularly keen to discuss the principles behind their own decisions and their implications for the MOH decision-making styles. This may reflect their status within their organisations (field offices may not be involved in centrally-made decisions) but may also reflect the degree of transparency and clarity of governance principles within their organisations. There is, however, insufficient evidence to support or negate this view.

The next section explores the perceived changes since independence in leadership and governance and their effects on MOH capacity.

9.3 Perceived changes in leadership and governance and their effects on MOH capacity

The respondents were asked to reflect on any perceived changes since independence in leadership and governance and their effects on the MOH capacity. Most respondents did not explicitly identify a relationship between leadership and governance and MOH capacity. Therefore, this section summarises two groups of issues: perceived changes in, and the key factors affecting, leadership and governance, which is followed by a discussion of the potential implications for MOH capacity.

9.3.1 Perceived changes in leadership and governance

The majority of respondents shared a view that the MOH is gradually becoming more 'visible' in its relationships with the international community. For example, the newly-appointed minister openly criticised the internationally-funded initiatives (though some respondents suggested that this approach may be interpreted as the usual practice of 'establishing himself'):

> *"The current minister is I think is quite clear as to what he wants to try and achieve, he does not necessarily want to follow advice from the international community. As soon as he came into place we all went to a collegium where he said all that stuff that had happened, being delivered by the international community before his appointment was rubbish, it all had to be reviewed let's start afresh…"* (Expatriate Staff, International Agency).

The MOH was described by different international respondents as increasingly becoming a 'fault-finder' rather than a leader per se. Different case studies were raised by various respondents in support of this view. These ranged from the general statements that "…*international consultants [are] not always knowledgeable of the context*" (ex-MOH official, International Agency) through to the MOH 'succeeding' in dismissing a consultant from an ADB-funded health reform project who "…*did not have appropriate qualification and skills*" (current MOH official).

The majority of respondents, however, shared the view that MOH practices in relation to leadership and governance are improving. This view was also supported by documents (Euro Health Group, 2008; WB, 2007). Different examples, raised by respondents in support of this view, included references to MOH initiatives (for example, the MOH chairing the SWAp

workshop in May 2008) and to improved consultation practices in the revision of the RT's Essential Drug List:

> *"…we already have several letters which are suggesting some changes to the list as recommended by WHO... We consider their suggestions, we will again conduct series of WG meetings, discuss the advantages of the new drugs and decide if those need to replace the current names…"* (Current MOH official).

Most respondents reflected on the changes in overall approach by the MOH reflecting mostly their diplomacy skills and no references were made to other technical skills of relevance to leadership and governance of policy processes (for example, in relation to policy analysis, assessment of power and interrelationships between main policy actors). Respondents suggested that there are different factors affecting changes in leadership and governance and their implications on MOH capacity, as set out next.

9.3.2 Factors affecting changes in leadership and governance

No documents were found referring to factors affecting changes in leadership and governance. Three broad factors can be distinguished from interview responses.

Firstly, many respondents, both national and international, shared the view that the powerful international community were increasingly providing the MOH with 'space to lead'. The example of the SWAp workshop in May 2008 was referred to on numerous occasions where donors agreed that the MOH should chair various sessions. Some respondents, however, reflected that the space to lead may have become available as a result of disagreements amongst the donors (the SWAp process was initiated by the SDC but eventually was taken over by the WB causing a negative reaction from the SDC).

Secondly, different respondents, especially national policy-makers, reflected that the pace of change in relation to wider consultation within the public sector is affected by the changes in capacity of the MOH and other actors. For example, many respondents shared a view that local health authorities, apart from facing the cultural barriers discussed in Chapter 6, may lack skills to understand and comment on policy documents:

> *"…the weaknesses include...[that] the local level don't always have capacity to comment. They think that if central MOH developed something they take it as granted and don't really provide many comments. They don't really express their opinions in the comments…"* (National Staff, International Agency).

Lastly, most respondents reflected upon the importance of expertise as a determinant for recognition. For example, many international policy actors reflected that the HPAU was recognised within the MOH as a useful unit only after the arrival of expatriate staff, recruited by the WHO, with extensive experience of policy analysis in various countries.

9.3.3 Discussion

No respondents explicitly identified a relationship between leadership and governance and the MOH capacity. Furthermore, none of the respondents referred to technical skills in relation to leadership and governance, which could have bridged the concepts of leadership and governance and MOH capacity. This may partly be due to the complexity of the concept of leadership and governance but may also relate to the lack of understanding of capacity.

Overall, leadership and governance arrangements were thought to be improving. However, disagreements were identified amongst the respondents in relation to the degree and pace of improvements. This may reflect actors' involvement and experiences but may also reflect a more general difference in opinions between the national and the international respondents identified earlier.

The perceived fault-finding nature of MOH approaches appears to be related to the contextual influences on health policy processes and, more specifically, the working culture. One area for MOH consideration is the best time to introduce changes in the MOH-donor relationships, for example as part of the RT's transition to the development stage.

The practices of international agencies appear important in ensuring the availability of space for the MOH capacity development. More specifically, attracting more externally-funded individuals within the MOH structures may be considered in strengthening the MOH capacity. It is important, however, to recognise the potential resultant rivalry and the possibility of greater divide and hence the possible risks of decreasing MOH capacity.

Lastly, it appears that the MOH has now greater influence in governance of internationally-funded projects. However, with greater influence comes potential application of current MOH practices and values including those which were openly criticised by many policy actors (for example, the culture of not making mistakes resulted in dismissal of some consultants). One specific area for consideration by the MOH is an obvious need for changes in MOH practices (and possibly wider), to ensure effective relationships with the international community.

9.4 Conclusions

Two key aspects of leadership and governance can be distinguished: decision style and decision structures. The current decision style is mostly centralised and authoritarian though there are indications of a willingness to shift towards more decentralised and inclusive decision-making. Two types of structures were distinguished by respondents in support of policy decisions: decision structures and advisory structures and a difference was found in the perceived effectiveness of each of these between the national policy-makers and other policy actors.

Overall, most respondents reported improvements in MOH capacity since independence though opinions differed with regards to scale and pace of improvements. Particular areas emphasised by different respondents included a more prominent role for the MOH and perceived improvements in leadership and governance. None of the respondents referred to MOH technical skills, possibly reflecting a difficulty in relating together the concepts of leadership and governance and MOH capacity. One specific area for consideration by the MOH is the need to change its practices in order to ensure more effective engagement with the international community.

The next Chapter explores the MOH capacity to establish and effectively use resources in support of health policy processes

10 MOH CAPACITY TO ESTABLISH AND USE RESOURCES IN SUPPORT OF HEALTH POLICY PROCESSES

10.1 Introduction

The ability to establish and effectively use available resources in support of health policy processes is an element of the MOH capacity component of the conceptual framework. This Chapter summarises the key findings in this area and is structured as follows. It starts with an overview of understanding of resources in support of health policy processes in the RT. This is followed by a description of, and the main perceived factors affecting, MOH capacity to establish and use available resources.

10.2 Interpretation of resources in support of health policy processes in RT

Respondents were asked to identify the different types of resources in support of health policy processes. The resources were interpreted as "…*tools to ensure that other elements/components work…*" (National staff, International Agency). Most respondents had difficulty in relating resources to health policy processes and often referred to resources in relation to service delivery, with a statement below being a typical response:

> *"Resources can be human, in terms of money, equipment... but most important is to have sustainable inflow of funds and [their] predictability…"* (National Staff, Donor Agency).

Similarly, the documents reviewed focused on generic resources, for example the numbers of health professionals (Hemming, 1999; McKee et al., 2002; Mirzoev et al., 2007), the health facilities' network (Gedik et al., 2002; McKee et al., 2002; Mira, 2002), the levels of financing and the related degree of the RT's dependency on external aid (Cashin, 2004; Mirzoev, 2004; Vargas and Clary, 2002) and the resources required to address the needs of vulnerable groups (Falkingham, 2003; Hemming, 1999; Keshavjee and Becerra, 2000). Some MOH *prikazes* focused on resources in support of health policy processes (such as working groups) though those were not explicitly identified in the documents.

The responses from those who were able to focus on resources in support of policy processes can be categorised in three broad groups: a) staff numbers, skills and expertise, b) finance and c) evidence. None of the respondents provided a comprehensive overview of all three groups though most respondents suggested that there is no one 'central' resource and a combination of, for example, staff and money is needed.

A few respondents referred to time, political support and appropriate management. However, when probed, the respondents regarded these as either part of the context (time and political support) or leadership and governance (management). The role of evidence in policy processes was explored in Chapter 8. Therefore, the next two subsections focus on the staff expertise and skills and the finance, as a background for exploring MOH capacity to establish and effectively use resources.

10.2.1 Staff numbers, expertise and skills

Many respondents reflected on the limited numbers of staff within the MOH as an important factor affecting its capacity. Although the MOH statute does not provide explicit guidance on required staff numbers (GOT, 2006a, 2008), any changes to MOH staff numbers require approval by the President's EA.

In 2008 the MOH had a total of about 60 staff with half being non-technical staff, hence with no role in health policy processes. The Minister was lobbying the President's EA for an increase in staff numbers, demonstrating his concern about this issue.

Many respondents emphasised the importance of expertise and technical skills in specific subject areas, for example policy analysis. Some respondents, also referred to generic management skills such as the *"basic etiquette about how to run a meeting"* (Expatriate Staff, International Agency) as being important. All respondents shared the view that the amount of expertise and skills in the MOH was limited, resulting from the lack of incentives to attract the knowledgeable and skilled staff:

> *"What do we have now – everyone is working in international organisations because they pay more…. As for the MOH, we have a lot of empty positions, the salaries are low and the good specialists don't come to work here… Only those who don't know the language and who can't get the job with external agencies come and work here..."* (Current MOH official).

Since late 1990s various MOH staff participated in study tours, training and workshops though the high turnover of staff was identified by many as preventing the application of those skills and expertise (see 4.2.2). Furthermore, many international respondents recognised the need to change in the MOH role from routine issues (see 4.3.1); otherwise any additional staff will be 'swallowed' by ever increasing amount of routine duties and will not help to strengthen the MOH capacity. Many national and international respondents

suggested that the current MOH staff numbers may be reasonable and that adequate incentives are needed to attract qualified and skilled staff from international organisations.

10.2.2 Financial resources

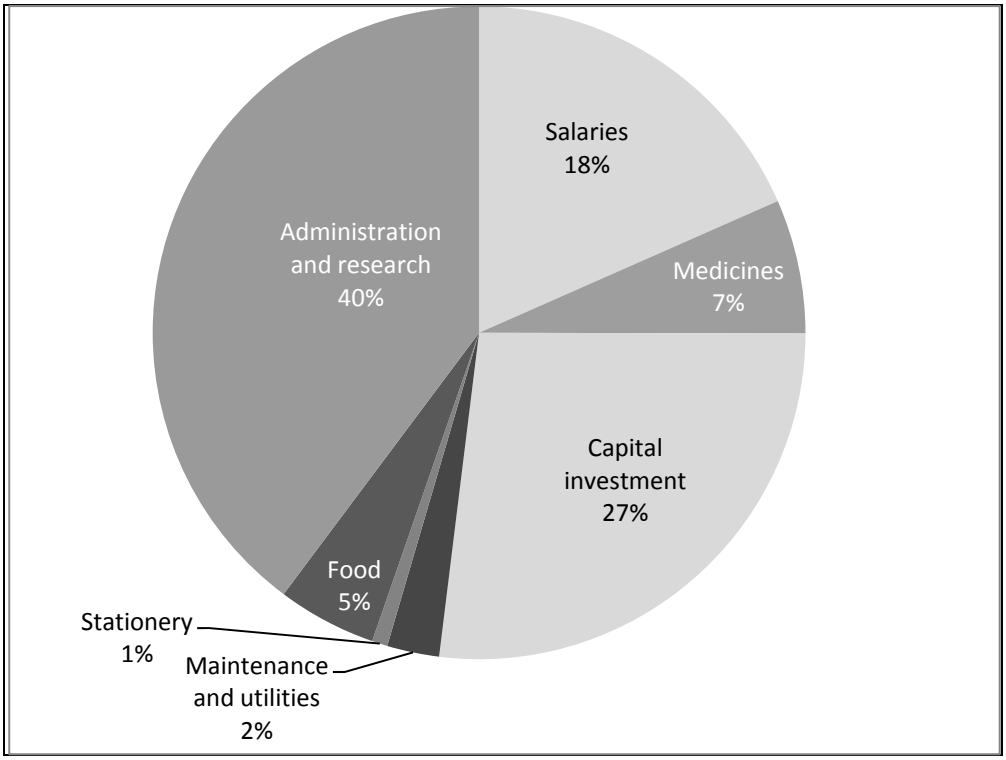
Financial resources were mentioned by all respondents as important though many could not elaborate on the specific applications of finance as a resource in support of health policy *processes*. Since the soviet era access to financial data is restricted in the RT and, therefore, most financial information was obtained from internationally-available sources.

The MOH is in control of only *republican* budget (see 9.2.2), which in 2006 was 24% of total government health spending (World Bank, 2008). In 2003 the share of 'administration and research' category (which among other issues includes the budget for establishing working groups and the provision of other direct financial support to health policy processes) was just over 50% of the *republican* budget – a figure down by 10% from 1999 (Cashin, 2004; Vargas and Clary, 2002) and further decreased down to 40% in 2006, as shown in Figure 18.

With the total amount of *republican* budget being about USD 8million (World Bank, 2008), the absolute amount of the MOH funding in support health policy processes is limited, not least because there is no separate budget line for health policy processes. The *local* budgets are managed by the *oblast/rayon Hukumats* and, according to most respondents, there is usually no funding in support of health policy processes at those levels.

Figure 18: MOH budget breakdown in 2006

Source: (based on data from World Bank, 2008)



Many international respondents reflected that most financial support to health policy processes (for example, funding for the working groups and organisation of workshops) is done within externally-funded projects, as explored in Chapter 7.

10.2.3 Discussion

The three groups of resources distinguished earlier (staff numbers, expertise and skills, finance and evidence) broadly correspond to the understanding of resources in the health sector (Green and Collins, 2006) as well as those related to health policy-making (Mätzke, 2010). Most respondents and documents identified resources in support of service delivery (corresponding to *generic resources* in the conceptual framework) with only a few respondents being able to identify the resources in support of health policy *processes*. This may suggest a lack of conceptual understanding among the policy actors, including the MOH itself, of resources in support of health policy processes.

None of respondents provided a comprehensive overview of resources covering the above three groups. These different views of resources may reflect actors' roles and practices within health policy processes – for example, skills and expertise were raised by the institutions involved in policy analysis only (academia or the HPAU). One of the challenges

for the MOH, from the perspective of capacity, is to recognise the different views of policy actors (including their own), within health policy processes.

Most policy actors reflected that there is no one 'central' resource and suggested a need to ensure an appropriate balance between the different resources in supporting health policy processes. The lack of conceptual understanding may have resulted in many respondents using the concepts of resources required to ensure service delivery and resources in support of health policy processes interchangeably.

If guided by the numeric measures of capacity such as the staff numbers and the amount of funding, MOH capacity would be very limited. There are, however, important implications of the current levels of staff and funding on the MOH capacity. The perception of limited numbers of staff is related to the MOH ability to shift from time-consuming routine issues. Furthermore, the limited funding, skills and expertise may provide opportunities for the MOH to engage with resource-rich internationally-funded projects. It is important, however, to recognise the need for both ability and willingness (from both the MOH and those projects) to make this engagement possible and to sustain any improvements in MOH capacity, for example, through developing ways of retaining staff.

The financial support from internationally-funded projects may not always be easy to obtain, not least given the lack of flexibility in donor-funded projects. The identification of a separate budget line in support of health policy processes may demonstrate recognition of the importance of health policy processes by the MOH and may ultimately help to secure continuous international funding in support of policy processes.

The next section explores the perceived MOH capacity to establish and effectively use resources in support of health policy processes.

10.3 MOH capacity to establish and use available resources

Respondents were asked to reflect on the MOH capacity to establish and effectively use available resources in support of health policy processes. Most respondents shared the view that the MOH capacity is improving. However, when probed further, it was difficult to ascertain the specific case studies in support of the above view.

Differences were found in actors' perceptions of degree and pace of improvement. Most national respondents, in contrast with their international counterparts, reported a more positive picture, similar to the statement below:

> *"I think the amount of financial resources is increasing… the HR capacity is improving every year and the change to the structure is getting better in order to carry out the tasks which the MOH is responsible for."* (Current MOH official).

When probed, none of the respondents reflected on the changes in the MOH practices of establishing resources. Some national respondents did refer to improvements in the MOH expertise in forward planning as leading to better utilisation of resources by the MOH.

Two issues can be distinguished from the different responses in relation to the MOH capacity: the mechanisms for resource utilisation and the factors affecting the degree of effective resource utilisation, as set out next.

10.3.1 Mechanisms for resource utilisation

Three specific structures were identified by different respondents as mechanisms for utilising resources in support of policy processes.

Thematic Working Groups (WGs), as reflected in earlier Chapter on leadership and governance, were perceived as advisory or technical support structures. Many respondents, including the MOH officials reflected that there is a large number of WGs with many non-functioning (Bandaev, 2008; Khadjieva, 2008). Each WG is formalised by the MOH *prikaz* (MOH, 2006, 2007, 2008b, c, d, e), with the progress being monitored at MOH collegiums (MOH, 2008g). Most WGs are established as a result of individual projects with only a few being initiated by the MOH. Many respondents raised doubts in relation to the effectiveness of various WGs and the MOH ability to effectively utilise the available WGs.

The *Health Policy Analysis Unit* (HPAU) was established within the MOH as part of the WB-funded CBHP and is another advisory structure. Established in 2008 under the MOH Health Reforms Department, the HPAU is not formally recognised in the MOH organisational structure in the MOH statute (GOT, 2008). The HPAU was staffed by one expatriate staff and five national experts, all funded by the CBHP project though the expatriate staff was selected and is contracted by the WHO country office in the RT. Many respondents, particularly the international organisations, reflected on the perceived rivalry between the core MOH staff

and the HPAU as contributing to underutilisation of HPAU (see section 'culture of protecting own area' in 6.2.5).

The *Secretariat* was established in the Health Reforms Department and comprised three national staff, all funded by CBHP. The general objective of the secretariat was to support the process of coordination of health reforms at a technical level (WB, 2007). The secretariat developed a database of the internationally-funded health projects, which informed a WHO review of externally0funded projects (see WHO, 2007b) and was involved in organising and servicing meetings, and in monitoring of performance of, various thematic WGs. Some respondents expressed concerns that the secretariat (and occasionally the HPAU) is increasingly involved in MOH routine work outside their job descriptions which affects their effectiveness.

10.3.2 Factors affecting use of resources

Different factors were raised by different respondents as affecting the MOH capacity to establish and effectively utilise available resources. Some respondents identified the explicit relationships between the degree of effective use of available resources and the wider contextual environment. For example, one respondent referred to the limited use of evidence in the area of maternal mortality as being closely related to the working culture:

> *"The evidence we talked about, sometimes they are just disregarded by the MOH, some sources they see the problem is there and they just don't pay attention to that. Because we still have this punishment system…"* (National Staff, International Agency).

Other factors included the existing bureaucracy within the health system and beyond (an example in support of this view was over-approval of training by the MOH) and the MOH capacity in other areas (for example, coordination between the different actors).

Most respondents reflected that there is no single 'central' resource in relation to the MOH capacity and a combination of different resources is needed. Furthermore, some respondents referred to the need for the appropriate organisational structures to ensure effective utilisation of skills and expertise available within the MOH and wider.

Lastly, one respondent referred to the fact that "*surviving in the ministry of health is not easy"* (National Staff, International Agency), referring to the delicate balance between the technical and the political dimensions of the MOH work, the uncertainty associated with

frequent changes of the MOH leadership and the perceived internal rivalry within MOH (for example, between core staff and the HPAU).

10.3.3 Discussion

Most national respondents referred to the advisory and support structures and none of the respondents identified the decision structures (the MOH collegiums, referred to in Chapter 9) as potential resources to support of health policy processes. This may reflect a lack of conceptual understanding of resources, but may also reflect the culture of acceptance of the authoritarian decision structures as given, with little questioning of their roles within health policy processes.

Implicit was the respondents' recognition of the interdependence between the individual elements of the conceptual framework. From the perspective of capacity, the interdependence between the financial and human resources may contribute towards a clearer distinction between the *ability* and the *willingness* in understanding the concept of capacity. For example, the organisational structures or politics within the MOH can be regarded as part of an enabling (or disabling) environment affecting the 'unleashing' of the existing capacity reflected in skills and expertise (Development Assistance Committee, 2006; UNDP, 2006).

Different resources are funded externally (for example, the HPAU) or are available outside the MOH (internationally-funded skills and expertise). Although these can be interpreted as potentially contributing to the capacity of the RT's health sector as a whole, these may not always be available to the MOH. Resulting from this, the MOH, given the funding constraints, needs to consider ways of a) *effective utilisation of expertise available outside MOH* – for example through the wider involvement of experts in WGs and b) *further capacity strengthening for core MOH staff on health policy issues*, for example, through the continuous interaction with internationally-funded experts, such as the HPAU.

From the perspective of the sustainability of the MOH capacity, the effects of internationally-funded expertise, though perceived helpful by many, can be questioned. In the longer-term the investment in core MOH staff might be more effective. Obviously, this should be coupled with the various staff retention strategies in order to avoid the emigration of skilled experts as was the case of the SOMONI group (see Chapter 7).

According to most respondents, the MOH capacity to establish and effectively use available resources is improving. However, when probed further it was difficult to ascertain the specific case studies in support of this view, which may be related to the lack of the conceptual understanding of resources identified earlier. It is important for the MOH to recognise this and to develop the ability to distinguish the specific components, such as establishing and using resources, which would become areas for MOH capacity strengthening.

The MOH capacity to establish and effectively use the available resources is dependent on the wider context and the degree of bureaucracy. This suggests that complex interrelationships exist in different areas of MOH capacity. This complexity is also complemented by the distinction made earlier in the MOH capacity to effectively use the different resources, for example, through appropriate structures.

Lastly, the differences between the views of national and international respondents, once again, confirm the different perceptions between these two groups.

10.4 Conclusions

Three broad types of specific resources can be distinguished: staff numbers, expertise and skills, finance and evidence. The MOH is faced with a challenge to be able to recognise the different perspectives (including their own) of the usefulness of these resources within health policy processes.

Significant resources exist outside the MOH and the MOH need to develop its capacity to utilise these. The sustainability of the internationally-funded expertise can be questioned and the MOH, where appropriate, needs to strengthen its capacity through a closer interaction with internationally-funded experts.

The next Chapter summarises the MOH capacity, drawing on the individual components and discusses the study implications on the understanding of the concept of the MOH capacity to conduct health policy processes in a form of revised conceptual framework.

11 RELATIONSHIPS WITHIN THE CONCEPTUAL FRAMEWORK AND IMPLICATIONS ON UNDERSTANDING OF MOH CAPACITY

11.1 Introduction

The previous six Chapters explored the findings in relation to the individual components of the conceptual framework. This penultimate Chapter aims to achieve four objectives in an attempt to bring together the findings from Chapters 4-10. These objectives provide the structure for the Chapter and are:

1. to summarise the assessment of the MOH capacity to conduct health policy processes in the RT,
2. to improve understanding of the concept of MOH capacity though identification of different inter-relationships between its different components,
3. to identify the relationships between findings and existing theories,
4. to revise the conceptual framework for assessing the MOH capacity to conduct health policy processes, based on the lessons learned from the study.

11.2 MOH capacity to conduct health policy processes in RT

MOH capacity to conduct health policy processes is ultimately aimed at ensuring the achievement of different characteristics of robust health policy processes. At the same time, it is important to understand the MOH capacity in relation to the individual components of the conceptual framework (MOH capacity comprising the elements of policy cycle, evidence, leadership and governance and resources, policy context and policy actors). This section summarises the MOH capacity in relation to both the characteristics of health policy processes and the three components of the conceptual framework.

11.2.1 MOH capacity to achieve specific characteristics of robust health policy processes

Six characteristics to guide the understanding of robust health policy processes were developed earlier: holistic, evidence-informed, efficient, effective, feasible and sustainable (see section 2.2.2). Chapters 4-10 identified implications on MOH capacity in relation to these different characteristics. Table 17 provides an overview of the key issues of MOH capacity in relation to the characteristics of robust health policy processes.

Table 17: Overview of MOH capacity to ensure robust policy processes in RT

Characteristic of robust policy processes	Overview of MOH capacity to conduct health policy processes
Holistic	• Different health policy processes are not fully integrated though decision structures (MOH collegiums) exist to allow this integration • There are attempts to integrate different health policy processes in the MOH through representation of MOH staff in working groups
Evidence-informed	• Many MOH officials are unable to recognise the different types of evidence and their relevance to policy processes. • The processes for evidence generation, dissemination and use are implicit and are not explicitly considered in policy processes • The MOH is unable to ensure systematic involvement of key actors to ensure availability of robust evidence to inform policy decisions
Efficient	• Efficiency is sometimes compromised by lengthy consultations with other government ministries and existing bureaucracy within the MOH related to the creation of working groups for each policy theme • The membership of heads of MOH departments in thematic working groups compromises the efficiency of policy processes, because of the limited availability of MOH staff
Effective	• The timing and duration of health policy processes are related to the formal government protocol and are often project-driven. Although the MOH ultimately submits health policies for approval by the President's EA, it has a limited role in donor-funded projects • The MOH is unable to always ensure wide representation of policy actors in health policy processes, not least because of centralised decision-making • The increasingly inclusive policy processes by the MOH are likely to ensure wider representation of different views and, potentially, better responsiveness to different needs
Feasible	• The MOH does not explicitly assess the feasibility (financial, cultural and political) of different health policy processes. However, no evidence was found to assert whether this is a reflection of lack of ability or lack of willingness in this area.
Sustainable	• The sustainability of health policy processes is compromised by the low availability of resources (finance, human) to support these processes • The sustainability is also jeopardised by the MOH bureaucratic approaches in managing policy processes in RT as reflected in proliferation of numerous working groups.

Different characteristics interrelate, with the resultant implications for both health policy processes and the MOH capacity. For example, the feasibility and effectiveness of health policy processes can be counter-balanced by the need to ensure efficiency of the process.

The next sub-section provides a detailed summary of the MOH capacity in relation to the three components of the conceptual framework.

11.2.2 MOH capacity in relation to the main components of the conceptual framework

Table 18 summarises the main study findings in relation to the individual components of the conceptual framework.

Table 18: Summary of MOH capacity to conduct health policy processes in RT

Component/ Element	Main findings in relation to the MOH capacity
MOH capacity to conduct health policy processes	
Stages of policy processes	• Seven characteristics of robust health policy processes distinguished from the respondents' views are broadly similar to the characteristics derived from the literature (see 5.4.8) and the MOH is faced with the need to address and, where possible, manage, these perceptions • Policy processes follow government procedures and the MOH has little influence over the policy processes, compared to the MOJ, the President's EA and the local *Hukumats* • Health policy processes occur largely behind closed doors and the mechanisms for raising awareness about formal government procedures do not exist or not effective • No evidence was found of the MOH capacity to recognise and effectively manage the different stages of health policy processes, for example to ensure consistency and coherence between the often project-driven policy processes • The lack of recognition of policy implementation as a separate stage of policy processes suggests a possible lack of responsibility of the national-level officials for the local-level implementation • No evidence was found of M&E of policy *processes* by the MOH, particularly at the policy development stage.
Use of evidence for policy processes	• Different types of evidence can inform health policy processes in the RT and different perceived characteristics of robust evidence exist, including those of the MOH itself • The MOH is unable to fully recognise how the different interpretations of robust evidence vary across the different policy actors, reflecting their values, agendas and roles in health policy processes • The MOH uses a limited number of forms of evidence in policy processes, reflecting their views, practices and preferences • There is little demand for evidence by the MOH and other government officials in health policy processes leading to limited involvement of academic institutions and other national actors in evidence generation and dissemination • Evidence used by the MOH focuses mostly on a single policy option, despite the availability of different policy alternatives • Limited evidence, if any, exists in relation to policy *processes*, compared to the policy *contents* • The MOH prefers evidence with clear practical applicability, which is timely, accessible and originates from the reputable policy actors

Component/ Element	Main findings in relation to the MOH capacity
	• The quality of evidence is affected by the pressure to present positive results, including from the MOH itself • Different evidence processes exist alongside the health policy processes thus posing a challenge of ensuring evidence-informed nature of policy processes – for example, in relation to timeliness of evidence • The lack of reliance, by the international community, on the mainstream HMIS diverts potential funding for strengthening, and potentially weakens, MOH capacity to ensure availability of health statistics in the RT
Leadership and governance	• The MOH governance and leadership practices has improved since independence though the exact degree and pace of improvements is less clear • The MOH is often unable to ensure the application of principles of good governance and effective leadership in relation to health policy processes • Different leadership and governance-related issues specific to the RT negatively affect MOH capacity and are related to the wider context (for example, the fault-finding nature of some decision mechanisms such as MOH collegiums) • The MOH leadership style is based on reinforcement with little application of incentive-based approaches • The MOH focuses largely on routine operational issues and less on providing strategic policy direction
Organisa-tional structure	• The MOH is able to establish structures, with support from existing projects, in support of health policy processes though it is not clear whether sustainability and issues of duplications are thought through (for example, in relation to various WGs) • The lack of mandate to review the internationally-funded research agenda and the centralised functions of the MRC raise questions with regards to the MOH technical ability to review research proposals • The MOH is too subordinated to the President's EA and the organisational hierarchy within the MOH itself negatively affect the participatory and evidence-informed nature of policy processes
Decision structures	• The MOH collegiums were interpreted as authoritarian and ineffective decision forums with little scope for participation of other policy actors in health policy processes • The MOH is unable to ensure the effective utilisation of internationally-funded advisory structures, such as the HPAU or WGs, in health policy processes
Decision-making styles	• The MOH decision-making style is centralised with limited involvement of other actors in policy decisions, including within the MOH itself • Although views differed, many policy actors referred to the lack of rational (transparent, inclusive and evidence-informed) MOH decision-making style • The MOH often lacks initiative in health policy processes, especially those initiated by donor-funded projects

Component/ Element	Main findings in relation to the MOH capacity
Resources	• The MOH and other policy actors were unable to identify specific resources in support of health policy processes • The MOH capacity to establish and effectively use resources is limited – though improving since the independence – not least because of their limited power in internationally-funded projects • The MOH roles, routine and frequent changes in leadership are the main factors affecting the availability of MOH staff for making policy decisions
Actors' roles and interrelationships	
Actors' characteristics	• The MOH is increasingly recognising that actors' agendas and values affect their roles and practices in health policy processes • The roles of powerful individuals appear important in health policy processes often affecting the views and agendas of their respective organisations, including the MOH itself • The MOH possesses less power compared to the President's EA and the international community and can be left in the middle with limited flexibility and low motivation to strengthen its capacity • The ability of different international policy actors to effectively use existing structures and power relationships may undermine the MOH authority and contribute to low motivation of MOH staff • The actors' power and the limited MOH flexibility in policy processes provide examples where the existing MOH *ability* may not be supported by *willingness*
Actors' roles and inter-relationships	• Differences exist between the characteristics of a large number of national and international health policy actors, most notably power • The MOH is unable to ensure wide participation of policy actors in health policy processes though participatory nature of policy processes is improving since independence • The MOH is mostly involving the other government departments and the powerful international community in policy processes and does not appear to recognise the value of involvement of other national policy actors (for example, academia and CSOs) • The identified lack of involvement of CSOs and media in policy processes is either a reflection of the lack of MOH ability to recognise their true potential or genuine lack of expertise of national CSOs in the RT • The MOH is gradually recognising that the composition of health policy actors, particularly international organisations, is not static and is changing in line with the RT's transition from the relief to the development stage • A shift was identified in MOH priorities and practices from accepting any externally-available technical assistance towards a more careful prioritisation of inputs (as shown by the MOH becoming increasingly critical of knowledge and skills within the internationally-funded projects)
Policy context	
Contextual factors and their	• The same issues related to the wider context can have both positive and negative effects on health policy processes,

Component/ Element	Main findings in relation to the MOH capacity
effects on the MOH capacity	depending on the MOH ability to take them into account in health policy processes • The former soviet heritage can still be seen in various contextual influences on the MOH capacity, for example in relation to work culture, and need to be considered when involving the international community and the post-soviet generation of the national actors in the RT. • The culture of a lack of critical appraisal reinforces a strong sense of authority of higher-management which limits the MOH role in relations with the President's EA • The MOH is facing the need to ensure donors' trust, whilst reconciling the short-term needs of individual donor-funded projects with long-term policy priorities • No evidence was found of MOH recognition of the implications of the RT's transition from the relief to the development stage on its capacity, including the changing nature of aid, the changing composition of actors and the changes to the attitudes and practices of different policy actors, including the MOH itself • The different aspects of the working culture in the RT's public sector negatively affect the MOH capacity to conduct health policy processes, for example, through pressures not to make mistakes or avoid critical appraisal.

The findings from this study revealed that the MOH capacity is lacking in relation to all components, though improvements were identified since independence. The differences in opinions between national and international policy actors suggest that the MOH capacity might be better than perceived by many respondents.

If guided by Tables 17 and 18 only, the MOH capacity to conduct health policy processes in the RT would appear to be very limited. However, similar to the results of different studies of health policy processes in various African and Asian contexts (Cliff et al., 2004; Leeds HEPVIC team, 2009; Tantivess and Walt, 2008; Thomas and Gilson, 2004), none of the components operates in isolation, as discussed further in this Chapter. Furthermore, the distinction identified earlier between ability and willingness raises the question whether a) the lack of evidence of the application of capacity found in the study is a reflection of lack of the MOH capacity or b) the MOH ability to successfully perform task(s) exist and the lack of enabling environment prohibits its application. It is impossible to find a definite answer to this, not least because of the complex relationships within and between the different components. Therefore, the study conclusions need to be approached carefully in the context of the above distinction between ability and willingness.

Three broad issues are worth emphasising at this point, as a background for the subsequent discussions in this Chapter. First, the MOH capacity is not static and can be interpreted as a process itself with inputs, processes and outputs. Second, there are complex intra-relationships within the different components of the conceptual framework – for example, different actors 'competing' for places in policy processes. Last, the different inter-relationships can be identified between the different components of the conceptual framework. These are set out next as a summary of the understanding of the concept of MOH capacity.

11.3 Understanding the relationships in the MOH capacity

Health policy processes and the other elements/components of the conceptual framework are not static and include a series of inputs, processes and outputs. For example, different actors' skills and expertise (inputs), various processes, including structures such as working groups, for making the best possible use of those skills and expertise (processes) and different strategic documents developed as a result of these (outputs).

The concept of capacity mapping was proposed as a way of depicting "…*the role of capacity in health system performance"* (Brown et al., 2001 p.iv). Capacity mapping is also based on a distinction between inputs, processes and outputs and can be used as a way of understanding the dynamic and the process-based nature of capacity (Brown et al., 2001; LaFond and Brown, 2003; LaFond et al., 2002). The underlying assumption is that in reality it is difficult to take an objective measure of capacity as its outputs and outcomes – often used for measuring capacity - are subject to adequate inputs and processes. In other words, the capacity to carry out a task may exist but the lack of inputs may prevent the processes of applying this capacity.

Table 19 illustrates the input-process-output nature of MOH capacity in relation to the different components to aid the understanding of the dynamic nature of the MOH capacity.

Table 19: Examples of inputs, processes and outputs of MOH capacity

Framework adapted from: (LaFond and Brown, 2003)

Component	Inputs	Processes	Outputs
MOH capacity:			
Policy processes	Existing government protocol	Conducting policy processes	Degree of addressing characteristics of robust health policy processes
Evidence	Availability of different types	Managing generation and dissemination of	Degree evidence-informed nature of

Component	Inputs	Processes	Outputs
	of evidence	evidence to inform policy decisions	policy processes
Leadership & governance	Public-sector decision styles and structures	Decision-making processes, including the use of available decision structures	Degree of effectiveness of decision processes and structures
Resources	Skills and expertise in the MOH and beyond	Utilisation of skills and expertise in policy processes	Establishment and degree of effectively use available resources in support of policy processes
Context	Pressures from individual projects/donors	Managing policy processes within the wider context, including influences from projects/donors	The degree of recognition of the effects of the wider context on policy processes
Actors	Different actors with own agendas, interests and practices	Coordination and communication; Managing involvement of different actors in policy processes	Degree of effective coordination, for example, reflected in the organisation of monthly coordination meetings

Three methodological challenges prevent the application of the capacity mapping tool as a framework for assessing the MOH capacity to conduct health policy processes. Firstly, the input-process-output process refers to the stages of application of capacity and there is a need to relate these with at least two other processes identified earlier in this study (policy processes and evidence processes). Secondly, there is a limited scope for the consideration of different characteristics of robust health policy processes identified in section 2.2.2. Lastly the tool as is allows little scope for the identification of complex intra- and inter-relationships between the different components of the conceptual framework, which are discussed next.

11.3.1 Intra-relationships within the components

Complex intra-relationships exist within the individual components of the conceptual framework, with implications on the MOH capacity. For example, the power of actors affects their roles in health policy processes and as such has implications on the MOH ability to ensure inclusive health policy processes. Table 20 summarises examples of intra-relationships within the individual components of the conceptual framework, drawing on the findings from Chapters 4-10.

Table 20: Examples of intra-relationships within the conceptual framework

Component	Examples of intra-relationships
MOH capacity	
Process	The degree of participation of CSOs in health policy processes is related to the degree of transparency of the processes to the national policy actors and existence of clear guidelines providing 'windows of opportunity' for involvement of CSOs and other policy actors
Evidence	The degree of use of informal types of evidence in health policy processes is counterbalanced by the reliance on formal government statistics and monitoring and evaluation data from donor-funded projects
Leadership and governance	The MOH centralised decision-making style is reinforced by the authoritarian decision structures (MOH collegiums)
Resources	Different types of resources such as the HPAU and thematic WGs are complementary in health policy processes
Context	The difficult socio-economic situation causes emigration of MOH staff
Actors	International NGOs are able to use existing power hierarchies in order to ensure agreements of local Hukumats, for example through memorandums of understanding with the MOH

The above is not an exhaustive list of possible intra-relationships but an illustration of the complex nature of individual components. The above intra-relationships inevitably have implications for MOH capacity. For example, MOH capacity to effectively manage involvement of different actors in health policy processes is affected by the inter-relationships and networking between the CSOs and the international community; or the MOH capacity to ensure evidence-informed nature of health policy processes is influenced by the perceptions of characteristics of robust evidence.

It is clear that the effects of above intra-relationships make a comprehensive assessment of the MOH capacity more challenging and almost impossible, not least because of the dynamic nature of capacity itself. Therefore, this is outside of the scope of this study though future research may explore the intra-relationships within the individual components in more detail.

11.3.2 Inter-relationships between the components

The different components of the conceptual framework are inter-related. For example, skills are needed to use resources effectively; relative roles of policy actors can be prerequisites for the different decision structures – as with the four inter-dependent levels of capacity pyramid (Potter and Brough, 2004). The same argument can be applied to the implications of

the different components/elements on the MOH capacity. Effective communication can, for example, be seen as a prerequisite for robust coordination.

Table 21 illustrated the examples of the inter-relationships between the different components, as a background for the identification of different types of inter-relationships further in this sub-section.

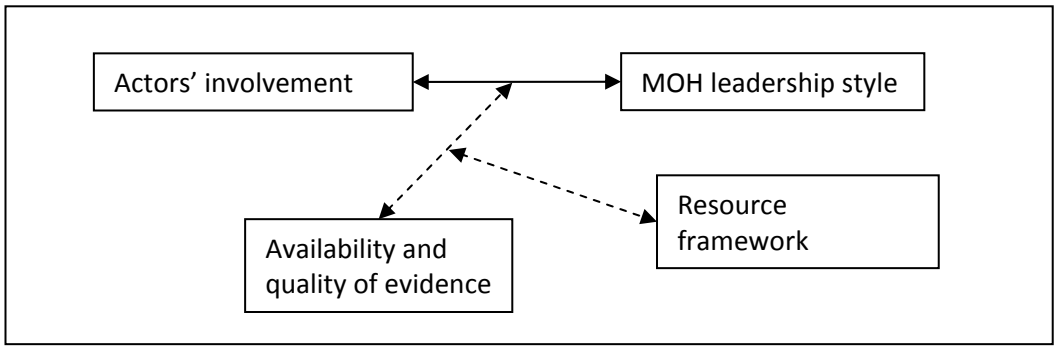
Table 21: Examples of inter-relationships between the different components and elements of the conceptual framework

	Context	Actors	Evidence	Governance and leadership	Resources
Process	Many issues prompting agenda-setting and catalysing other stages of policy process are related to the wider contextual environment	The limited references to policy implementation in the discussion of stages of health policy processes may be linked to the perceived lack of responsibility of the national-level officials for the local-level implementation	The timeliness of evidence for health policy processes is one of the main factors affecting accessibility and practical applicability of evidence.	The numerous references to the minister's approval of research projects reinforces the hierarchy within MOH, makes the MRC somewhat ineffective (as a structure) and redundant and adds to the bureaucracy of health policy processes.	Different resources are required for each stage of health policy process
Context		The work culture affects actors' roles and involvement in health policy processes The existence of a powerful and capable champion is relevant to RT where individuals are particularly valued	The limited academic evidence around health systems and policy reflects the wider government research priorities (e.g. RT's Strategy for Science and Technology Development) Quality of evidence is affected by pressure to present positive results.	The low delegation of duties in RT suggests a lack of trust from MOH to other levels of the health system. The perceived fault-finding nature of MOH approaches in relation to other actors is related to the working culture	A number of resources are funded externally or available outside of MOH
Actors			The MOH is faced with a challenge to recognise the different actors' perceptions of evidence, including that of the MOH itself	There is some pressure from international actors and a willingness of the President's EA, to move from command and control to a more incentive-based governance system	Expertise and skills were identified amongst the three specific types of resources in support of health policy processes

	Context	Actors	Evidence	Governance and leadership	Resources
			The Interpretations of robust evidence vary across the different policy actors, reflecting their values, agendas and roles in health policy processes. International funding of research by NGOs, results in competition with academia and jeopardises the capacity development of local academic institutions	The perceived lack of transparency and unaccountability amongst the high-level officials may deter some international agencies from engaging in health sector in RT The practices of international agencies and President's EA are important to ensure availability of space for MOH to lead and govern health policy processes	Different actors are involved in using resources with authority in the policy process.
Evidence				The lack of mandate to review internationally-funded research agenda hinder MOH ability to affect generation of evidence in health policy processes	Evidence was identified amongst the three specific types of resources in support of health policy processes
Leadership and governance					Appropriate structures were identified amongst the three specific types of resources in support of health policy processes

The above table is not exhaustive and provides a summary of some of one-to-one interrelationships between the different components of the Conceptual Framework. This is done to aid the understanding of the different types of inter-relationships between the components, including their implications on MOH capacity to conduct health policy processes. It is recognised that in practice even more complex inter-relationships can be found amongst the different components. For example, as shown in Figure 19, the involvement of actors is affected by the MOH leadership style, which is informed by the availability and quality of evidence informing health policy processes and is affected by the adequate resource framework in order to allow the timely generation and use of evidence.

Figure 19: Example of complex inter-relationships amongst the components



Another example of the complex inter-relationships is the effects of the contextual environment on the MOH leadership and governance style with the latter determining the degree of actors' participation at different stages of health policy processes.

It is outside the scope of this study to map out all these inter-relationships between and amongst the different components. However, this area represents an interesting area to explore in the subsequent analyses of the MOH capacity and health policy processes in the RT and beyond.

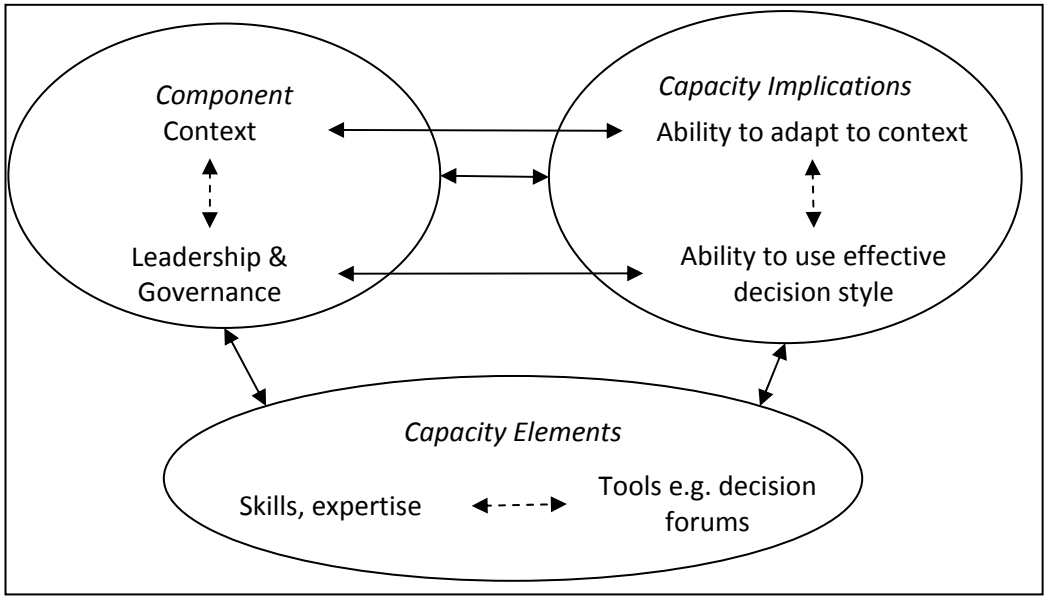
It is also important to distinguish between a) the different levels and b) different types of inter-relationships, as set out next.

Different levels of interrelationships

As shown in Figure 20, three levels of inter-relationships can be identified and include those between the different *components* (for example, actors and evidence), between the different aspects or *elements* of capacity (for example, skills in policy analysis and decision

styles) and between the different *implications of components on MOH capacity* (for example, MOH ability to manage involvement of actors and to ensure consistency between the different stages of health policy processes).

Figure 20: Example of inter-relationships within and across the three levels



However, it appears that various inter-relationships may also exist across the different levels of capacity. For example, the MOH organisational structures (part of leadership and governance) can be regarded as a reflection of the enabling or prohibiting environment (part of context) and affect the 'unleashing' of existing capacity reflected in skills and expertise – a concept recognised in some definitions of capacity strengthening (Development Assistance Committee, 2006; UNDP, 2006)

From another perspective, the different processes were identified earlier in the document – for example, health policy processes (agenda-setting, policy development and implementation), evidence processes (identification of information needs, evidence generation, dissemination and use) and the processes of application of the MOH capacity. These can also be interpreted as different levels involving complex inter-relationships. For example, evidence processes impact on policy process, with the resultant implications on the application of MOH capacity. Examining these is outside the scope of this research though this may be another potential area for future studies.

Different types of interrelationships

In theory, three types of inter-relationships may be possible between the different components of the Conceptual Framework: mutually-reinforcing, mutually-dependent and mutually-exclusive relationships, as set out below.

Mutually-reinforcing relationships are when one component contributes to better performance of another though both can perform well in isolation. Examples of mutually-reinforcing relationships between the different components include the inter-relationships between leadership and governance and the availability and use of evidence or between the wider context and the stages of policy process.

Mutually-dependent relationships are when one component is a clear prerequisite for better performance of the other. Examples of this type of inter-relationship include the need for adequate resource levels to ensure evidence-informed policy processes or the need for the adequate governance arrangements to ensure actors' involvement in policy processes.

Mutually-exclusive relationships are possible where achievements within one component are at the expense of another. For example, the desire to generate reliable evidence may lead to the commissioning of research from established research institutions and thus may limit the participation of other actors (for example, civil society organisations) in health policy processes in general and in the production of evidence in particular.

Examples of all three types of inter-relationships were found in the current study, with some implications for the MOH capacity to ensure the achievement of characteristics of robust health policy processes (such as the evidence-informed nature). Although it is outside the scope of the current study to examine those in detail, it is important to be aware of these types of inter-relationships, particularly if planning any capacity strengthening initiatives.

11.4 Study relationship with existing theories

Although some attempts were made very recently to understand the role of the ministries of health in health systems strengthening and policy-making (Briatte, 2010; Greer, 2010; Mätzke, 2010; Omaswa and Boufford, 2010), no literature was found exploring the MOH capacity to conduct health policy processes. The previous six Chapters (Chapters 4-10)

discussed the relationships of the study findings with the existing body of knowledge in relation to the individual components of the conceptual framework and this will not be repeated in this section. The purpose of this section is to identify the types of relationships of the study findings with the existing theories.

As mentioned earlier, no studies were found focusing on capacity to conduct health policy processes, preventing the comparison of the study findings (as a whole) with existing literature. Therefore, this section identified the broad types of relationships of the study findings with existing theoretical frameworks.

Most of the findings support existing theories, as discussed in Chapters 4-10. The relationships between the findings and existing theories can be categorised in four broad groups.

A number of theories appear to be *explicitly evident* – for example most respondents identified the different stages of health policy processes or the MOH ability to establish and effectively use resources.

Most existing theories were found to be *partially consistent* with the study findings. This also includes new findings, contributing to further understanding of the existing theories. Examples of these include the confirmation of the perceived importance of MOH power within the policy processes (similarly to Gaventa's power cube), though the recognition that relative power of the MOH (compared to the international community) is not static and may change at different stages of health policy processes.

A number of theories were *implicitly verified* by the findings. One example of this is related to the concept of capacity: the MOH knowledge and ability to recognise the different stages of health policy processes were implicit in the key skills and abilities identified by the study respondents though none of the respondents identified this in the interviews.

Some theoretical frameworks were *not directly confirmed* by all data sources though subsequent triangulation helped in confirming the applicability of findings. For example, the concept of actors' networks was not identified at all by the study respondents though was evident in reviewing some documents, as shown by the case of the collective letter from the international community to the President's EA in relation to the BBP.

Two issues are worth emphasising at this point. First, the dynamic changes in all components of the conceptual framework result in a need to interpret the existing theories flexibly. For example, the composition of policy actors was found to have changed since independence. The wider context itself is also not static, as is evident in RT's transition from the relief to the development stage. This is particularly important for transitional countries such as the RT where the rapid changes are introduced over a relatively short period of time and the MOH needs to develop capacity to accommodate the emerging agendas, actors' values and practices. Secondly, most existing theories explore the individual components in an isolated way and the various intra- and inter-relationships identified earlier in this Chapter between the different components and their capacity implications are important and contribute to our understanding and appreciation of the 'messiness' of the concept of the MOH capacity to conduct health policy processes.

The study findings suggest modifications to the original conceptual framework (see 2.4.7) for assessing the MOH capacity to conduct health policy processes, which are set out next.

11.5 Updated conceptual framework of MOH capacity to ensure the achievement of robust health policy processes

In this section the conceptual framework is revised and described in detail, drawing on the lessons learned from this study. This is then followed by the discussion of possible applications of the proposed conceptual framework in future studies.

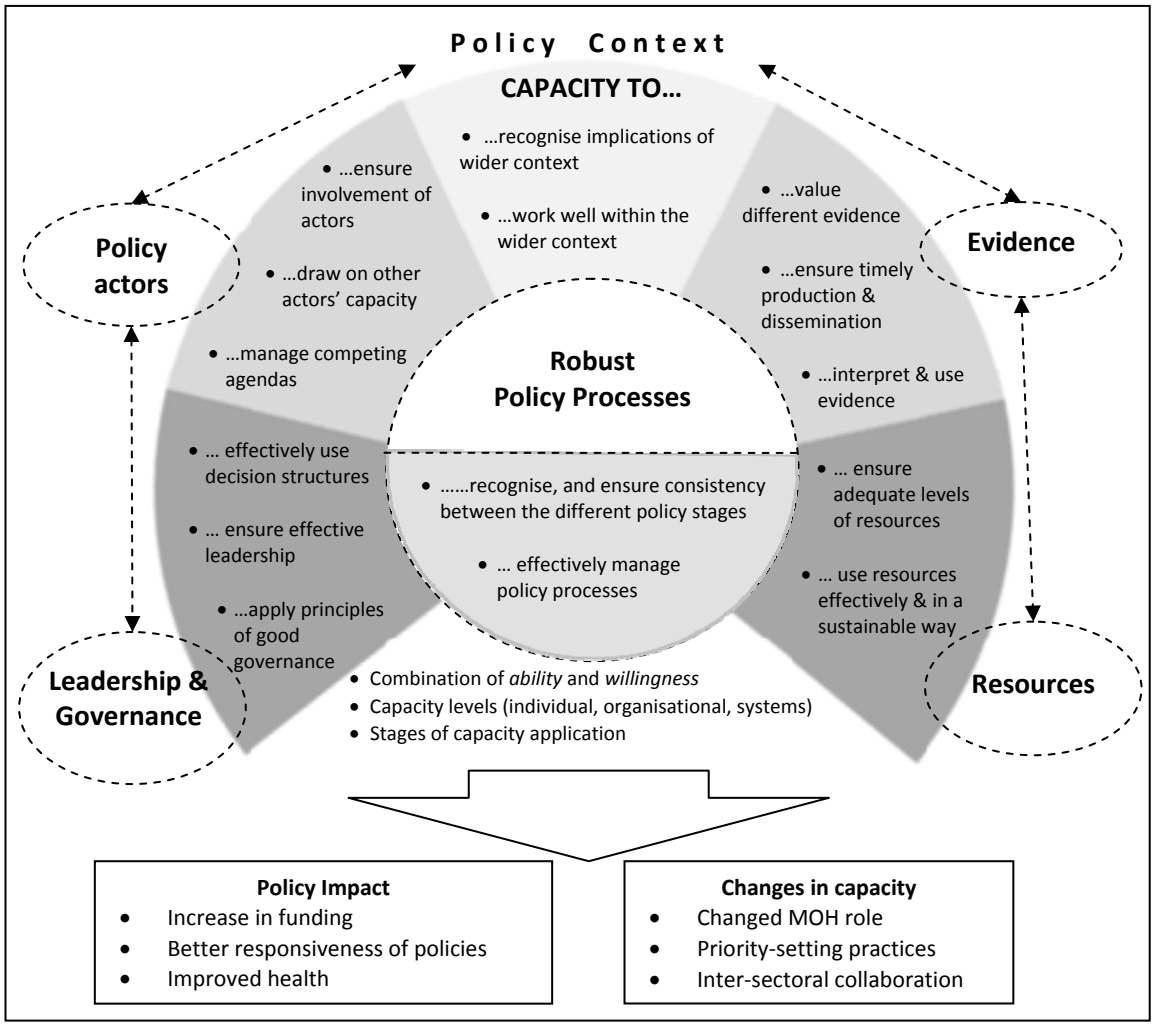
Four lessons were learned, suggesting the need for revision of the conceptual framework:

1. The four elements of the MOH capacity component (policy cycle, evidence, leadership and governance and resources) need to also be interpreted as factors affecting the MOH capacity, alongside the actors and context. This suggests the need to remove the distinction between the four elements of the MOH capacity and the other two components of the conceptual framework (actors and context) and interpret those as six areas at the same level.
2. Each of the six areas (policy cycle, evidence, leadership and governance, resources, actors and context) has specific areas of application of the MOH capacity which overlap, because of the complex interrelationships between the six areas themselves.

3. The policy cycle, being one of the six areas, is central to the understanding of the MOH capacity to conduct health policy processes, through the application of characteristics of robust health policy processes.
4. The context although regarded as one of the six areas, needs to be interpreted as an overarching environment in which all other components operate.

As shown in Chapter 2, two questions are important in understanding capacity: capacity of *whom* and capacity to do *what?* In the revised framework (see Figure 21) these refer to the MOH capacity to ensure achievement of robust health policy processes.

Figure 21: Updated Conceptual Framework of MOH capacity to ensure achievement of robust health policy processes



The ***robust health policy processes*** represent the ultimate objective of application of the MOH capacity and, therefore, are central to the framework. The six characteristics of robust health policy processes developed in Chapter 2 (holistic, evidence-informed,

efficient, effective, feasible and sustainable) provide a framework for understanding this. Different ***determinants*** affect their attainment and are:

1. Wider policy context
2. Health policy actors and their inter-relationships
3. MOH leadership and governance arrangements
4. Utilisation of evidence by policy actors
5. Availability and effective use of resources

In addition to the above determinants, the internal characteristics of health policy processes (such as their internal consistency) affect the degree of achievement of characteristics of robust policy processes and as such are shown both as an end and as means to it. This is discussed later.

The different determinants overlap and complex inter-relationships exist within and between the different determinants. For example, international policy actors can be regarded as part of the context and the actors' involvement shape the stages of health policy processes. Examples of these inter-relationships are shown in the figure as dotted arrows but are not exhaustive.

Different ***domains of MOH capacity*** (shown as shaded segments surrounding the health policy processes) are required to address, or take account of, each determinant of robust health policy processes. Each domain comprises different specific ***capacity characteristics.*** These domains and characteristics overlap and inter-relate, both within and between each other. For example, the ability to ensure the timely production of evidence is related to the ability to ensure the involvement of different actors in evidence generation and dissemination.

Three underlying issues are important in interpreting the MOH capacity. First, there is a need for both *ability* and *willingness*. Second, the different *levels* of capacity are inter-related and inter-dependent - for example, the MOH (organisations) capacity includes some elements of individual capacity. Last, the different stages of application of capacity correspond to both a) the classical input-process-output continuum which provided the basis for some of the capacity assessment tools (LaFond and Brown, 2003; LaFond et al., 2002)and b) different stages of policy processes (agenda-setting, policy development, implementation and policy evaluation).

Next a brief overview of the key issues is provided in relation to each determinant of robust health policy processes (drawing on the literature review in Chapter 2), together with its corresponding capacity domain and examples of specific capacity characteristics.

11.5.1 Policy Context

The importance of context is well-understood in the literature (Buse et al., 2005; Walt and Gilson, 1994). The context is defined as a complex set of external factors affects health policy processes or its determinants. Six groups of contextual factors can be identified (Collins et al., 1999): demographic and epidemiological change; processes of social and economic change and conflict; economic and financial policy; politics and the political regime; ideology, public policy and the public sector and other external factors.

Contextual factors particularly affecting organisational capacity to ensure robust health policy processes include the political environment, socio-economic factors, cultural and traditional factors; population's health status; public sector organisation and reforms; health system structures; and decision structures and styles in related sectors. The context differs from the other determinants in its overarching nature, which provides a supportive (or otherwise) environment.

The capacity domain of this determinant is the MOH ability to recognise and take account of the wider context in the health policy processes. An example would include the MOH ability to ensure the adequate participation of key actors and deployment of effective decision styles in health policy processes within the established hierarchy and culture of the wider public sector.

11.5.2 Policy Actors

By actors within the policy processes we understand individuals and/or organisations who are associated with, and involved, or not involved, in health policy processes. The policy actors are diverse with different levels of power (Erasmus and Gilson, 2008; Gaventa, 2005; Walt, 1994). Examples of health policy actors include both individuals and organisations: the MOH itself, civil society, donors, academic institutions and professional associations. Policy actors engage in complex inter-relationships. *Networks models* of policy processes interpret policy processes as the result of interrelationships within, and between, networks of actors, each with their own values, agendas, interests and motivations (Exworthy, 2008).

A distinction can be made between *policy networks* and *issue networks*, which are differentiated by their characteristics and in particular their shared interest in a focal policy issue (Exworthy, 2008; Tantivess and Walt, 2008; Walt et al., 2008).

The related capacity domain refers to MOH ability to effectively communicate with, and manage involvement of, different actors in health policy processes. Implicit in this is the ability of the MOH to develop and effectively utilise skills and expertise available both internally and in other policy actors, and to manage competing values, agendas and practices of different actors.

11.5.3 Policy Processes

Different classifications of policy processes suggested in the literature range from relatively simple models involving few consecutive stages to a more complex sub-division of major stages into sub-processes. The policy stages approaches are helpful as a "…*heuristic device which helps to disaggregate these complex [policy] phenomena into a series of events*" (Tantivess and Walt, 2008 p.330).

In the framework we distinguish four-stages of policy process - agenda-setting, policy development, policy implementation and monitoring & evaluation. The distinction between these stages is often blurred though, as discussed earlier, this provides a useful analytical device.

The capacity domain of this determinant refers to the MOH ability to design, interpret, understand and effectively manage health policy processes. Examples of specific capacity characteristics within this domain are the ability to ensure consistency/coherence between the different stages of policy process (for example, consideration of implementation issues in policy development through adequate involvement of relevant policy actors).

11.5.4 Governance and Leadership

Three sub-elements of this determinant are distinguished in the framework: *organisational structures* - the structural composition of the government which affects its ability to govern and lead health policy development and implementation; *decision structures* - any formal decision-making forums such as working groups or committees established to support health policy processes; and *decision styles* - which may range from authoritarian through to more inclusive practices.

The capacity domain of this determinant refers to MOH ability to establish effective governance and leadership arrangements for health policy processes. Examples of specific characteristics of capacity within this domain include the MOH ability to establish and effectively utilise, in health policy processes, organisational and decision structures; ability to deploy effective decision-making style in policy decisions; and the ability to recognise the inter-relationships between different actors (e.g. public, private) and at different levels (e.g. national, local), in health policy processes.

11.5.5 Evidence

The importance of evidence-informed policy is well-recognised. Dobrow *et al* (2004) suggest a three-stage framework for evidence-informed policy decisions, which includes introduction, interpretation and application of evidence. This is similar to the one suggested by Bowen and Zwi who also suggested a three-stage model comprising a) sourcing the evidence, b) using the evidence, and c) implementing the evidence, terming them as "adopt, adapt, and act" (Bowen and Zwi, 2005). The identification of information needs is implicit in the above frameworks yet is important from the perspective of capacity. This determinant includes four-stage classification of evidence processes, which includes identification of information needs, evidence generation, dissemination and use.

The capacity domain of this determinant refers to the MOH ability to promote evidence-informed health policy processes through adequate identification of information needs, generation and dissemination of evidence by actors. Examples of capacity characteristics include the MOH ability to value and use evidence at different stages of policy processes as well as the availability of skills and expertise to interpret different types of evidence.

11.5.6 Resources

Examples of resources required to support health policy processes (rather than the delivery of services) include finance, skills (Greer, 2010; Mätzke, 2010) and different types of information (before it becomes evidence in policy decisions).

The capacity domain of this determinant refers to the ability of the MOH to establish and effectively utilise resources in support of health policy processes. Examples of specific capacity characteristics include MOH ability to ensure adequate levels of financial and human resources (both in terms of numbers and skills) for policy analysis.

The framework, adapted as necessary for specific contexts provides, we suggest, a useful framework for assessment of MOH capacity, and we now turn to discussion of its application.

11.5.7 Possible applications of the Conceptual Framework

The above framework can be used in a number of areas. The primary purpose of the proposed framework is to guide the analysis of the MOH capacity to conduct health policy processes, mostly in developing countries. In the process of this, a deeper understanding was developed of the key issues in relation to both capacity and health policy processes. Therefore, the proposed framework can also be used to explore the degree of robustness of health policy processes, building on the initial work in Chapter 2.

While the framework is primarily intended to assess the MOH capacity, it can also be adapted for assessing the capacity of other organisations (policy actors) involved in health policy processes. For example, the capacity of international donor agencies (as policy actors) can be assessed in terms of their contribution to robust health policy processes.

Furthermore, in addition to the element of *assessment*, the framework can also be used as an operational framework for *strengthening* MOH capacity to conduct policy processes as well as *improving* health policy processes themselves. Many international organisations are involved in various capacity strengthening initiatives, for example of human resources to manage health facilities, and the proposed framework can be used as a model for strengthening policy-making capacity of MOH in different contexts.

The framework focuses primarily on MOH capacity in the context of developing countries. Two specific characteristics are important to highlight. First is the presence of different, and often powerful, policy actors representing the international community, for example donors, development agencies and international NGOs. These operate in addition to the 'regular' array of policy actors which can be found in developed countries (for example, government, civil society, private sector and professional associations) and thus contribute to the complexity of context of developing countries. Second is the severe resource-constrained nature of the developing countries. Although the capacity domain refers to MOH ability to both establish and effectively use resources, there is limited availability of resources in developing countries in general (including policy-related resources), thus

emphasising the importance of capacity to ensure the effective utilisation of what exists. The broad nature of the proposed framework suggests that it can also be applied to the contexts of high-income countries. It is important, however, to consider the policy environment when translating the proposed framework into specific assessment tools or models for capacity strengthening.

The framework is developed for assessing the MOH capacity in relation to *health* policy processes. Examples of the specificity of health sector include the professionally-dominated field of health requiring specialised knowledge and skills; and the asymmetry of information between health professionals and patients. Many of these clearly affect different characteristics of robust health policy processes such as clarity, transparency or participatory nature of policy processes. The proposed framework can however also be adapted and/or applied in assessing and strengthening capacity in other social sectors, building on the specificity of respective sectors.

The application of the proposed framework can be in different types of studies (or capacity strengthening initiatives). As the main thematic area is related to health policy processes, different types of policy studies seem to be appropriate. The application of the framework can be as a whole (i.e. to cover all determinants) or in relation to the individual determinants of health policy processes and their respective capacity domains as well as the different combinations of the determinants (for example, actors and evidence). The framework can be applied to assess capacity in relation to individual policies as well as in comparative analyses of different policies within, and between, different countries.

The different types of relationships are important to remember when interpreting and applying the conceptual framework. The *complex inter-relationships* between the determinants of health policy processes and the domains of capacity need to be considered. For example, all determinants of capacity can have an impact on the "involvement of actors" (as a domain of capacity). Therefore, it cannot be expected that there would be a single linear relationship between one determinant and one domain of capacity to conduct robust health policy processes. Implicit in the framework also are the *intra-relationships* within different determinants and respective capacity domains (for example, ability to effectively use decision structures is related to ability to ensure timely production and dissemination of evidence). The conceptual framework focuses on MOH

capacity as an organisation; however the *relationships with individual and systems levels of capacity* are important in interpreting and applying this framework.

The list of questions, shown in Table 22, is an illustration of potential issues for consideration when applying the conceptual framework. The framework makes a distinction between ability and willingness to conduct health policy processes. As a result, questions on MOH capacity should be formulated in a way that will provide data separately on these aspects of capacity. Further development and expansion of these questions is needed to adapt to different thematic policies.

Table 22: Sample questions for assessing MOH capacity to conduct policy processes

Determinant	Sample questions in relation to:	
	Determinant	**Capacity domain**
Policy Context	• What wider public sector policy reforms affect health policy processes and how? • Are there any inter-relationships between the contextual factors?	• What is the MOH capacity to take account of the degree of social hierarchy in society and/or cultural norms in health policies? • What is the MOH capacity to recognise inter-relationships between contextual factors?
Policy Actors	• Who (group/individuals) is involved in the health policy processes and in what role? Who should be, but is/are not involved? Why? • What are the similarities and differences amongst actors' values, agendas and practices	• What is the MOH capacity to recognise the strengths and weaknesses of actors' involvement in policy processes? • What is the MOH capacity to manage differences in actors' values, agendas and involvement practices?
Governance and Leadership	• What decision-making structures exist within the MOH and wider? In what way do these affect health policy processes? • How effective is the overall approach to governance and leadership for ensuring robust policy processes?	• What is the MOH capacity to establish and effectively use decision structures in policy processes? • What is the MOH capacity to govern effectively and provide leadership for health policy processes?
Evidence	• What evidence is normally used to support health policy processes and how? • What are the strengths and weaknesses of the current approaches for obtaining and using evidence?	• What is the MOH capacity to use evidence in the various stages of the health policy process? • What is the MOH capacity to recognise strengths and weaknesses of use evidence throughout policy processes?
Resources (availability	• What resources have been established in support of	• What is the MOH ability to ensure effective and efficient use

Determinant	Sample questions in relation to:	
	Determinant	Capacity domain
and use)	health policy processes and how effectively are they used throughout policy process?	of available resources?

Lastly, the assessment of capacity in relation to health policy processes requires multidisciplinary skills and can build on strengths of policy and capacity research.

11.6 Conclusions

The findings from this study revealed that the MOH capacity is lacking in relation to all components, though improvements can be identified since the independence. The MOH capacity is not static and the differences in opinions between national and international policy actors suggest that MOH capacity might be better than perceived by many respondents. Complex inter-relationships exist within and between individual components of the conceptual framework and are important to recognise in assessing MOH capacity. Most study findings confirmed the existing theories though the degree of similarities varied and most theories need to be interpreted within the dynamic nature of policy environment.

The revised conceptual framework distinguished between the six determinants of robust health policy processes, their respective capacity domains and the specific capacity characteristics. Each determinant includes a number of elements as well as separate processes, indicating a possibility of complex inter-relationships within, between and across the different determinants and the capacity domains. The framework is broad and can be applied in different contexts and specific thematic policies. The framework focuses on the assessment of the MOH capacity to conduct health policy processes in developing countries though can be applied in other sectors, or countries, and for strengthening capacity.

Further studies are needed to test the applicability of the suggested framework to different health policies and contexts. A number of considerations, including a list of sample questions, to aid the application of the proposed framework are provided. Further theoretical and empirical research is also needed to develop a clearer understanding of the different characteristics of robust health policy processes including their importance and inter-relationships with health policy processes in different contexts.

The final Chapter sets out conclusions and the study implications.

12 STUDY CONCLUSIONS AND IMPLICATIONS

12.1 Introduction

The study set out to achieve eight objectives (see 1.4). This final Chapter concludes the study by addressing two issues. First, conclusions are drawn in relation to the study objectives, which are followed by a set of policy recommendations for strengthening the MOH capacity to conduct health policy processes in the RT. Second, key implications of the study for future research are identified.

12.2 Study conclusions

The study revealed that the MOH capacity to conduct health policy processes in the RT is low, but improving in relation to each component of the conceptual framework. Perceptions differ between national and international respondents with the former being more positive than the latter.

MOH capacity to conduct health policy processes in RT is complex and includes at least six groups of inter-related influences: health policy processes, wider context, health policy actors, use of evidence, leadership and governance, and use of resources. Some of these groups can also be interpreted as basic elements of MOH capacity as well as factors affecting it- for example, use of resources. A detailed description of the study findings is provided in section 11.2 and Table 23 sets out the key study conclusions in relation to the specific study objectives.

Table 23: The key conclusions in relation to the study objectives

Study objectives	Conclusions
1. To identify and assess the understanding among the key policy actors in RT of the concept of MOH capacity to conduct health policy processes	• The concept of capacity to conduct health policy processes is understood differently by the health policy actors in the RT, posing a challenge to reconcile these different interpretations • It is important to make a distinction between *ability* and *willingness* in understanding of capacity; the question is whether the lack of evidence over the application of the MOH capacity indicates a lack of capacity or the existence of ability to perform task(s) which is constrained by the lack of an enabling environment • Different levels and elements of capacity inter-relate, for example, the MOH capacity as an organisation includes the cumulative capacity of its staff members.

Study objectives	Conclusions
2. To identify and assess the health policy processes in RT and explore their interrelationships with MOH capacity	• Health policy processes in the RT largely follow government procedure and the MOH has less influence over the policy processes, compared to the MOJ, the President's EA and, often the local *Hukumats* • The MOH capacity to recognise and effectively manage the different stages of health policy processes is limited; the lack of recognition of policy implementation as a separate stage of policy processes suggests a lack of responsibility of the officials at national level for local level implementation • Up to seven characteristics of robust health policy processes can be distinguished from respondents' views (similar to literature-based characteristics), and the MOH is unable to ensure the achievement of these characteristics though improvements were identified since independence
3. To identify the key elements of the wider context of health policy processes and analyse its effects on MOH capacity to conduct health policy processes	• The former soviet heritage can still be seen in various contextual influences on MOH capacity, for example the negative implications of working culture on policy processes • The same issues related to the wider context can have both positive and negative effects on health policy processes • The MOH has a limited recognition of the implications of the RT's transition on its capacity, including on the nature of aid, on the composition of actors and on the the attitudes and practices of different policy actors, including the MOH itself
4. To identify and discuss the composition, and practices of, health policy actors and analyse their interrelationships with MOH capacity to conduct health policy processes	• The MOH is unable to ensure the wide participation of policy actors with different agendas, values and practices in health policy processes though this is thought to be improving • The roles of powerful individuals appear important in health policy processes often affecting the views and agendas of their respective organisations, including the MOH itself • A shift was identified in MOH priorities and practices from accepting any externally-available technical assistance towards more careful prioritisation and critical appraisal of inputs such as internationally funded technical assistance
5. To identify the extent of evidence-informed nature of health policy processes and assess its implications on the MOH capacity to conduct health policy processes	• Limited evidence, if at all, exists in relation to policy *processes*, compared to the policy *contents*, and the MOH is unable to ensure the availability of the former; most evidence focuses on a single policy alternative • Different types of evidence can inform health policy processes and there are different perceptions of the characteristics of robust evidence, including those of the MOH itself. The MOH is unable to fully recognise the different interpretations of robust evidence of different policy actors • There is little demand for evidence by the MOH and other government officials in health policy processes leading to limited involvement of academic institutions and other national actors in evidence generation and dissemination • The lack of reliance, by the international community, on mainstream HMIS diverts potential funding for strengthening, and potentially weakens, MOH capacity to

Study objectives	Conclusions
	ensure availability of health statistics in the RT
6. To identify and discuss the current governance and leadership arrangements in RT and analyse their interrelationships with MOH capacity to conduct health policy processes	• MOH governance and leadership practices improved since independence though differences were identified with regards to the degree and pace of improvements • Although views differed, many policy actors referred to the lack of a rational (transparent, inclusive and evidence-informed) MOH decision-making style and lack of initiative in policy processes • The MOH is too subordinated to the President's EA and the organisational hierarchy within the MOH itself negatively affects the participatory and evidence-informed nature of policy processes
7. To identify and assess the MOH capacity to establish and use resources effectively in support of health policy processes.	• The MOH and other policy actors were unable to distinguish the specific resources in support of health policy processes • The MOH capacity to establish and effectively use resources is limited – though improving since the independence – not least due to the limited power over internationally-funded projects.
8. To develop a set of recommendations for strengthening the MOH capacity to conduct health policy processes	• A number of recommendations are developed further in this section

The next sub-section sets out the key recommendations, to the MOH and other health policy actors, in relation to strengthening the MOH capacity to conduct health policy processes in the RT.

12.2.1 Recommendations for strengthening the MOH capacity

The following recommendations need to be considered, if a decision is made to strengthen MOH capacity to conduct health policy processes in the RT. Many are not for the MOH alone and require agreements from, and involvement of, other actors, for example the President's EA. Different risks and pre-conditions exist in the implementation of these recommendations, for example the need for funding, the need to change working styles and approaches and potential resistance from old and powerful bureaucrats. These need to be considered in the design of plans if a decision is made to operationalise the recommendations.

As capacity strengthening is often a long-term process, the recommendations are subdivided into short-, mid- and long-term issues, as set out next.

Short-term issues

The starting point for MOH capacity strengthening should be addressing the issue of knowledge and expertise of staff. Gaps in the conceptual understanding of different components were identified amongst MOH staff, related both to the concept of capacity and the concept of health policy processes. Examples of these include, but are not limited to, the following and could be addressed through various training opportunities within individual projects:

- The recognition of different stages of health policy processes and the role of the government protocol in policy processes
- The recognition of roles of various policy actors in health policy processes, including those of civil society and the general public
- The understanding of value of different types of evidence (particularly informal) in informing all stages of health policy processes
- The recognition of the implications of different leadership and governance styles/approaches on the effectiveness and efficiency of health policy processes.

Various duplicating and non-functioning working groups need to be avoided and a comprehensive review of their roles and degrees of effectiveness should be performed, in order to guide a decision on the necessity of different WGs. The database developed by the MOH secretariat is one step in this direction.

Severe resource shortages (for example, staff skills and expertise) can be addressed through using the expertise from the internationally-funded projects. One example of this is the WB-funded HPAU. These structures need to be formally recognised by the MOH (for example, in the statute) and, where appropriate, given power to be involved in decision processes.

Frequent changes in MOH leadership and the subsequent effects on MOH technical personnel often exacerbate the lack of knowledge and institutional memory so an agreement should be sought with President's EA in relation to the long-term appointments.

Various practices of the international community can undermine the capacity strengthening, for example in relation to the production of evidence or the management of resources. Whilst some of these are dependent on the existence of the MOH capacity (for example, the planning of future donor-funded projects), the MOH should promote the

involvement of the mainstream structures within the RT's health sector, for example wider involvement of academia in conducting internationally-funded research.

Mid-term issues

The shortages of the MOH staff skills and expertise need to be addressed more sustainably in the medium-term. For example, this could be through the recruitment of qualified staff by the MOH. It is important, however, to ensure that these experts are not 'swallowed' by MOH routine work and addressing the next recommendation may help with this.

The frequent changes in MOH leadership and the subsequent effects on the lack of knowledge and the lack of institutional memory need addressing with the President. For example, clear terms of employment and clearer dismissal procedures could be agreed, for example in relation to the post of the Minister of Health.

Wider involvement of different actors can improve health policy processes. In particular, the involvement of civil society is rather limited and the MOH should develop mechanisms for involving CSOs more in policy processes. This could be achieved, for example through their wider involvement in the WGs and in the discussions with the international community. The MOH should also encourage, where possible, a wider use of CSO expertise and knowledge in the donor-funded projects.

Long-term issues

The change in working culture is one example of a long-term issue which can only be addressed in the long-term, for example in a generation. It is important to develop a like-minded critical mass within the MOH.

Linked to the above, the issue of the wider context and the established hierarchy within the RT's public sector need to be addressed in the long-term. One examples of this is the over-subordinated role of MOH in relation to the President's EA. There will likely be significant resistance from the powerful other government departments and the issue needs to be introduced carefully, for example, as part of reforms in the wider public sector.

The relative influences on policy processes between the MOH and the international community need to be revisited in the long-term. The RT is likely to remain dependent on aid in the near future and novel ways of coordinating efforts with the international

community the in post-soviet context need to be explored. Implementing a health SWAp might be one of the frameworks to consider.

The issue of the private sector is complex. The governments in some countries allowed the uncontrolled growth of the private sector and are now suffering from an over-powerful and largely unregulated private sector. The RT's MOH could continue to encourage private sector growth, not least because of the possibility for addressing some resource challenges, but need to carefully plan the regulatory framework in order to avoid repeating mistakes of others.

Lastly, it is important to be aware, and where possible take advantage, of the regional and international trends and influences. For example, the on-going instability in the neighbouring Afghanistan is likely to attract significant attention of the international community to the region, including large amounts of aid. The inter-relationships with the Russian Federation and other FSU republics and the subsequent policy trends and influences may also be affected by the growing power of the neighbouring China.

12.3 The study implications on future research

A number of specific areas for further studies were identified earlier (see 11.4.2) and this section summarises the key study implications for assessing/strengthening the MOH capacity to conduct health policy processes.

The concept of capacity can be related to the concept of health policy processes as shown in this study and the proposed conceptual framework (see 11.5) can be one way of analysing this. The proposed conceptual framework is not another tool, complementing the existing array of instruments, but is a theoretical basis for understanding the application of the concept of capacity in health policy processes.

The study has four key implications on future research in this field. First, it is important to distinguish between ability and willingness in the understanding of the concept of capacity. Second, there is a need to identify the level of capacity to be assessed or strengthened and to recognise the interdependence between, for example, individual and organisational capacity. Third, each of the components of the conceptual framework can be studied in isolation though complex interrelationships with other components need to be considered. Last, the proposed framework can be used for assessing capacity as well as a model for

strengthening capacity in relation to health policy processes and wider health policies in developing countries and beyond.

The next sub-section identified specific areas for future research in this field.

12.3.1 Areas for further research

The study was limited to assessing the MOH capacity to conduct health policy processes. Further studies are needed to explore further the relationships between the MOH capacity and the other levels of capacity (for example, systems) as well as other aspects of health policies (such as policy content). Examples of areas for further investigation, in the RT and beyond, include the following four broad areas, as set out next.

First, the concept of networks, though well-covered in the literature (Exworthy, 2008; Walt et al., 2008), was not evident in the data from RT, suggesting either that the networks may exist but may not be recognised by respondents or that actors' networks may still be at rudimentary stage in a state-controlled policy environment of RT. Either way, this represents an interesting area for further exploration in future research.

Second, health policy processes are becoming increasingly inclusive and the importance of CSOs is increasingly recognised in the RT as contributing towards the responsiveness of health policies. Another area for further research is exploring the reasons for the identified lack of MOH trust in CSOs in health policy processes, leading to under-representation of this group in policy processes.

Third, the MOH clearly needs to manage the culture shift towards more evidence-informed policy processes, alongside the efforts to increase the quality of information itself. Ways of ensuring the transition towards an evidence-informed nature of health policy processes alongside efforts to ensure availability of robust evidence represents an area for further studies.

Last, the study found that all policy actors in RT were very willing to discuss MOH approaches to, and principles of, governance. However, when asked about governance principles in relation to their own organisations, many were not particularly keen to discuss. This may reflect the degree of transparency and clarity of governance principles within other policy actors, and represents an interesting area for further research.

At a more detailed level, different statements emerged as a result of the study in relation to each component of the conceptual framework (see Table 24).

Table 24: Potential research hypotheses for further research

Component	Potential hypotheses
Policy context	
Political system	The transition from a single- to a multi-party political system contributes towards effectiveness of health policy processes
Degree of donors' influence	Health policy processes would become increasingly complex because of the greater involvement of different donors
Health system structure	Decentralised context allows wider actors' involvement and, therefore, facilitates robust policy processes though may require greater capacity to manage these.
Actors' roles and interrelationships	
Actors' characteristics	Actors' agendas, ideologies and values (including hidden) affect their involvement in health policy processes and good coordination and networking can be effective in recognising and managing these.
Involvement of actors	The wider involvement of policy actors improves the effectiveness of health policy processes
Private health sector	Private health sector growth is an indication of MOH ability to ensure wide involvement of actors in health policy processes
Stages of health policy processes	
Stages of policy processes	The MOH capacity to recognise the different stages of health policy processes improves the transparency of health policy processes and leads to enhanced participation of key actors.
Use of evidence for policy processes	
Use of evidence for policy processes	The ability of the MOH to use evidence in health policy processes is important in ensuring wider involvement of actors in generation and dissemination of evidence
Governance and leadership	
Governance and leadership	A shift in MOH role from operational to strategic issues would contribute towards better governance and leadership practices and help to achieve characteristics of robust policy processes
Organisational structure	The transition from a centralised to a decentralised decision system improves health policy processes, particularly the effectiveness of policy processes and the degree of integration of health policy processes
Decision structures	The existence of formal decision structures contributes towards better health policy processes, particularly the transparency of policy processes
Decision-making styles	The transition from authoritarian to inclusive decision-making may improve the health policy processes, particularly the enhanced participation of local actors in policy processes
Resources	
Resources	The MOH ability to establish and effectively use resources is important in ensuring the efficiency and feasibility of policy processes

Since most of these were not directly confirmed by the study findings, these statements can be interpreted as a set of hypotheses for further research in RT and beyond.

12.4 Conclusions

This Chapter concluded the thesis by summarising the study conclusions in relation to the achievement of the study objectives. Different policy implications and broad short-, medium- and long-term recommendations were developed, for the MOH and other policy actors, in relation to strengthening the MOH capacity to conduct health policy processes in the RT.

The study has different implications for future research in this field. Four broad areas identified for further research and the potential hypotheses for further studies were developed in relation to each component of the conceptual framework.

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APPENDICES

Appendix 1: Examples of available capacity assessment tools

Based on: (Anonymous, 2010; LaFond and Brown, 2003)

No.	Tool	Source	Assessment level	Methodology	Self or External	Notes/description
1	Assessing Institutional Capacity in Health Communication: A 5Cs Approach	Johns Hopkins University	Organisational	Quantitative	External & Self assessment	
2	Community-Based Distribution Interview Guide: A Gems Management Tool	Family Planning Management Development Project (FPMD)	Organisational	Qualitative & quantitative	Self assessment	
3	Decision-Oriented Organization Self Assessment (DOSA)- Using PROSE methodology	PACT and USAID	Organisational	Qualitative & quantitative	Self assessment	
4	Enhancing Organisational Performance: A Toolbox for Self Assessment	International Development Resource Centre (IDRC)	Organisational		External and self Assessment	Measures the results of an organization's programs, products and services and then integrates these results with the techniques of formative assessment in which the assessment team becomes involved in helping the organization meet its goals.
5	Family Planning Effort	The Futures	Health System	Qualitative &	External	

No.	Tool	Source	Assessment level	Methodology	Self or External	Notes/description
	Index (FPE)	Group/ Population Council		quantitative	Assessment	
6	Outcome Mapping: A Method for Reporting on Results	IDRC	Health System Organisational	Qualitative & quantitative	Self assessment	Outcome Mapping characterizes and assesses the contributions a project or organization makes to significant and lasting changes (outcomes). In Outcome Mapping a program is assessed against its activities that contribute to a desired outcome, not against the outcome itself.
7	Systematic Approach Scale (SAS)	PASCA/USAID	Organisational	Quantitative	External and self Assessment	
8	Integrated Health Facility Assessment (IHFA)	BASICS (USAID)	Organisational	Quantitative	External Assessment	This manual outlines the key steps for planning and conducting an integrated health facility assessment at outpatient health facilities in developing countries. This assessment is designed for use by primary health care programs that are planning to integrate child health care services.
10	Management and Organisational Sustainability Tool (MOST)	FPMD/MSH (Management Science for Health Inc)	Organisational	Qualitative	Self assessment	The Management and Organisational Sustainability Tool (MOST) is a package (instrument and user's guide) designed to facilitate management self-assessment and to support management improvement. MOST uses an instrument to help focus an organization on the actual characteristics of

No.	Tool	Source	Assessment level	Methodology	Self or External	Notes/description
						their management, identify directions and strategies for improvement, and set priorities for the management development effort.
11	Participatory, Results-oriented, Self-evaluation (PROSE)	Education Development Center and Pact	Organisational	Qualitative & quantitative	Self assessment	
12	The Manager: Capacity Assessment Toolkit Series	FPMD/ Family Health International/ MSH: Management Science for Health Inc.	Organisational	Quantitative	Self assessment	
13	Institutional Assessment Instrument (IAI)	World Learning Project Inc.	Organisational	Qualitative & quantitative	External Assessment	
14	Participatory Evaluation Workbook for Community Initiatives	Maltrud, Polacsek, & Wallerstein (1997)	Organisational	Qualitative	Self assessment	
15	Community Tool Box-Documentation and Evaluation Approach	Fawcett et al, 2003 Work Group for Community Healthand Development,	Organisational	Qualitative	Self assessment	

No.	Tool	Source	Assessment level	Methodology	Self or External	Notes/description
		University of Kansas www.communityhealth.ku.edu Prevention Research Centers Program				
16	REACH 2010- Racial and Ethnic Approaches to Community Health	Giles, WH et al, 2004	Organisational	Qualitative & quantitative	Self assessment	
17	Results Mapping	Barry Kibel (1997)	Organisational	Qualitative	Self assessment	
18	Management Development Assessment (MDA)	FPMD/MSH	Organisational	Quantitative	Self assessment	This tool includes four steps: 1) develop a preliminary management map to guide assessment; 2) develop & administer MDA questionnaire to collect information on the management capabilities of org.; 3) analyze survey results and develop a post-survey management map; and 4) develop action plan for making improvements.
19	International Training in Health Program (INTRAH)	Alfredo Fort, PRIME Project INTRAH/University of N Carolina	Organisational	Numeric score	Self assessment	
20	Private Agencies Collaborating Together (PACT)	Evan Bloom, PACT	Organisational	Qualitative	Self-assessment tool	

No.	Tool	Source	Assessment level	Methodology	Self or External	Notes/description
21	Community Participation Assessment Tool	Karen Lehman,1999	Organisational	Numeric score	Self assessment	
22	Facilitative Evaluation Approaches	Action Evaluation Research Institute	Organisational	Qualitative	Collaborative Evaluation	
23	MEASURE framework of capacity measurement	MEASURE Evaluation, Carolina Population Center, University of North Carolina at Chapel Hill	Organisational	Qualitative	Self assessment	
24	FOCUS (Client Capacity Level)	Bangladesh Rural Advancement Committee (BRAC),USAID	Organisational	Qualitative	Self assessment	
25	Health Professional Capacity Level	Jennifer Macias, JHPIEGO	Organisational	Qualitative	Self assessment	
26	In sourcing Model for small Community Based Organization's (CBO's)	National Research Center, Inc.,2006	Organisational	Qualitative	A cross between in-house and outsourced evaluation	

Appendix 2: Initial and final lists of respondents for SSIs

1. Initial list of respondents

Level	Institution	Possible respondent/organisation
National	Executive Administration of President of RT	• Department of health, women and family affairs (head/deputy) • External Aid Coordination Unit (head/deputy)
	MOH	• Minister/Deputy • Health Policy Analysis Unit • Department of health service organisation • Department of health reforms • Department of international relations • Department of economics and financial planning • HR and educational institutions • Department of Academia and Science
	Donor agencies including project implementation units	• WHO country office (head/deputy) • DFID/British Embassy (head/deputy of health programme) • World Bank (Task Leader; head of PIU) • Asian Development Bank (Task Leader; head of PIU) • ZdravPlus/USAID (head/deputy) • SDC/SINO project (Health specialist in SDC/Task leader; SINO project manager)
	Educational Institutions	• Tajik State Medical University (rector/vice-rector) • Tajik Post-Graduate Medical Institute (rector/vice-rector)
	Civil society/professional organisations	• Trade Union of Medical Workers • Local NGOs (Avesto)
Oblast	Department of Health	Head /deputy of health department
	Regional projects/INGOs	
Rayon	Central Rayon Hospital	Chief doctor / deputy

2. Final list of respondents

No	Institution	MOH respondent	Staff
1	International Agency (NGO, project)	No	National staff
2	Donor (Banks, Embassies)	No	National staff
3	International Agency (NGO, project)	No	Expatriate staff
4	International Agency (NGO, project)	No	National staff
5	International Agency (NGO, project)	No	National staff
6	International Agency (NGO, project)	No	National staff
7	Policy-maker (national)	Current	National staff
8	Policy-maker (national)	Current	National staff
9	Development partner (WHO, UNICEF)	No	National staff
10	Donor (Banks, Embassies)	No	National staff
11	Policy-maker (national)	Current	National staff
12	Policy-maker (national)	Current	National staff
13	National Agency	ex-MOH	National staff
14	Donor (Banks, Embassies)	No	Expatriate staff
15	International Agency (NGO, project)	Current	National staff
16	Donor (Banks, Embassies)	No	National staff
17	International Agency (NGO, project)	ex-MOH	National staff
18	Development partner (WHO, UNICEF)	ex-MOH	National staff
19	Policy-maker (national)	Current	National staff
20	Development partner (WHO, UNICEF)	No	Expatriate staff
21	Donor (Banks, Embassies)	No	National staff
22	Development partner (WHO, UNICEF)	ex-MOH	National staff
23	Policy-maker (national)	Current	National staff
24	National Agency	ex-MOH	National staff
25	National Agency	No	National staff
26	International Agency (NGO, project)	ex-MOH	National staff
27	International Agency (NGO, project)	No	Expatriate staff
28	International Agency (NGO, project)	No	National staff
29	Donor (Banks, Embassies)	No	Expatriate staff
30	Development partner (WHO, UNICEF)	No	Expatriate staff
31	International Agency (NGO, project)	ex-MOH	National staff
32	Development partner (WHO, UNICEF)	Current	Expatriate staff
33	Donor (Banks, Embassies)	No	National staff
34	International Agency (NGO, project)	ex-MOH	National staff
35	Health authority (sub-national)	No	National staff
36	Health authority (sub-national)	No	National staff
37	Development partner (WHO, UNICEF)	ex-MOH	National staff

Appendix 3: Format for informed consent agreement in semi-structured interviews

Good morning/afternoon. My name is Tolib Mirzoev from the Nuffield Centre for International Health and Development. I am conducting a research project towards my PhD degree focusing on capacity of the Ministry of Health in relation to the policy processes in Tajikistan. The overall aim of this research project is to assess trends in the development of health policy processes in Tajikistan since the independence focusing primarily on MOH capacity to conduct and govern health policy-making. You should have received summary information about the project in advance of our meeting.

Given your experience and position, I thought it is important to include you in the research as one of the respondents. I would like your permission to talk with you today about your ideas, experiences and reflection related to this topic. During the discussion, I will also be taking notes to keep track of what has been discussed, and to remind myself if I forget to cover any important areas.

It is up to you if you wish to answer any or all of my questions. You may end our discussion at anytime. Everything you say will be kept private and confidential. To ensure I have a complete record of everything you say, I would like to audio record our conversation. However, only I and, possibly, my supervisors from the University of Leeds will listen to the tape, and no one will be able to identify you. Similarly, your identity will not be revealed in any published research findings.

Do you agree to participate in this interview? [If you not, thank you for your time]
Do you agree to the interview being tape recorded? [If not, take hand-written notes]
Do you have any other questions before we begin?

If respondent agrees to participate and agrees for the interview being audio recorded, start the recorder, and mention - Interview on *date*, and for the benefit of the tape, the respondent has consented to this interview.

Appendix 4: Generic guide used to guide the SSIs

GUIDE FOR CONDUCTING A SEMI-STRUCTURED INTERVIEW

Sections covered in this guide:

1. Generic notes/issues
2. Key issues for each stage of the interview
3. Main questions/prompts for SSIs
4. Description of key informants

Generic Notes/issues

1. The sequence of sections may be changed depending on the flow of the conversation;
2. The coverage of elements [of conceptual framework] as well as the depth of discussion in an interview will depend on the type and level of respondent;
3. The approach to and focus of, questioning will be guided by the description of key informants at the end of the document;
4. There may be a need to prompt the respondent in order to explain the question/elicit more specific response;
5. For each informant a specific policy(ies) will be identified in the beginning of the interview and will be used where possible as a case study to ground the questions in the specific examples/experiences;
6. The following questions ARE APPLICABLE TO ALL SECTIONS and will be included in each theme/component
    a. In what way has your understanding/interpretation [of the main issues/questions] changed since the independence/early 1990s?
        i. Any trends in understanding by other actors, particularly MOH?
    b. Can you think of examples of health policies illustrating particularly good or bad MOH practice/ability?
        i. For each example, why do you think this has happened?
    c. What is the role of the MOH in this process/issue?
        i. In what way this has changed since independence?
7. The following questions are concluding questions which will be asked AT THE END OF EACH INTERVIEW:
    a. Can you suggest any other respondents that might be useful for our project?
    b. Do you know of any documents or reports that might be relevant to the study? If so, where can they be obtained from?
    c. Do you know of any policy events such as meetings attendance of which might be useful for our study?

Key issues for each stage of the interview

Stage of the interview	Issues to consider
Before the interview	Decide what are the priority questions to ask.
	Check the recorder is working
At the beginning of an interview	After introduction, briefly explain the objectives of the research project and obtain informed consent.
	Check the overall time available for the interview.
	Briefly introduce the areas for discussion (sections of the interview guide)

Stage of the interview	Issues to consider
During the interview	Remember to focus on the respondent's own knowledge, experiences and explanations, so let the respondent speak freely, and try to interrupt as little as possible. Do not try to always fill the silence with a next question or probe – the respondent may need some time to think about the issue.
	Use the guide flexibly, allowing the respondent to address the questions in any order but ensuring that all the key issues are covered
	The 'prompts' are only a checklist of possible issues to raise. There is a need to use judgement and ask these prompts only if the conversation is faltering, or if the respondent is deviating too much from the main topic
	Throughout the interview keep checking if any major issues have been left out and try to cover them at the appropriate moment (towards the end of the interview?).
At the end of the interview	Thank the respondent.
	Check that the recorder has worked
	Remember to catalogue the file/tape.
Shortly after the interview	Reflect on and clearly note down any other issues (for example, respondent's mood during the pauses, general impressions of the interview, good questions to ask) that may be important for future interviews, and the data analysis. If the recorder hasn't worked then shortly after the interview (while the memory is fresh) there is a need to re-create the conversation in as much detail as possible.

Main questions and prompts

Theme/Issues to cover	Main questions	Prompts
Introduction, terminology		
Respondent's interpretation of key terms such as 'health policy', 'policy processes' and, where possible, components of health policies (context, processes, actors)	1. When I say 'health policy' what are the issues come to your mind? How important do you think health policy *processes*? 2. What characteristics in your opinion determine <u>good</u> health policy processes?	Processes, Actors, Context, Content; Feasibility, sustainability, Involvement of actors, Use of evidence, Holistic nature.
Policy processes		
Ability of MOH to: • Recognise different stages of policy processes • Ensure transparency of health policy processes to the different actors	3. What stages can you distinguish in health policy processes in Tajikistan? Do you think the MOH is also interpreting this in the same way? Why do you think yes or why not? 4. How does MOH inform other actors about the health events related to policy processes such as meetings?	Stages: Agenda setting, development, implementation, evaluation Other actors include government and non-

Theme/Issues to cover	Main questions	Prompts
	Any differences in processes between particular health policies that you are aware of? 5. Can you think of any strengths of the current MOH practices to inform others about policy events? 6. Can you think of any weaknesses of the current MOH practices to inform others about policy events	government actors; local and international
Use of evidence		
Ability of MOH to: • Recognise different types and forms of evidence and their application in health policy processes • Manage involvement of different actors at different stages of the process in order to ensure the availability of evidence for health policy decisions	7. What types of information or knowledge do you think can be useful for health policy processes in Tajikistan? Why? 8. What [information] do you think is generally being used in health policy processes and how? What could be used but is not? Why? What is the role of the MOH? 9. Can you distinguish any stages of the process of generating/using evidence? What actors and how are involved in each stage of the process? What is the role of the MOH in this process?	Information, knowledge, evidence – use respondent's preferred term Different stages include production, dissemination and use of evidence in policy processes
Governance and leadership		
Ability of MOH to: • ensure adequate participation of actors from different levels and at different stages of health policy processes • take into account or adapt to the organisation of health system in health policy processes • establish decision structures to support health policy processes • establish and maintain appropriate decision-making style in health policy processes	10. In what way the actors from different levels of health system are involved in health policy processes? How does the MOH manages this involvement? 11. In what way the structural hierarchy within the health system affects health policy processes? 12. What are the strengths of different decision structures established in order to support health policy processes? 13. What are the weaknesses of different decision structures established in order to support health policy processes? 14. What factors affect MOH decision-making style in relation to health policy processes and how?	Decision structures may include working groups, task forces
Resource framework		
Ability of MOH to	15. When I say 'resources in support of	For example, do

Theme/Issues to cover	Main questions	Prompts
• Recognise different types of resources and their possible contribution towards health policy processes • Establish and maintain appropriate resource framework to support health policy processes	health policy processes' what comes to your mind? What do you think MOH recognises as resources and why? 16. What types of resources in your opinion may improve health policy processes in Tajikistan? 17. What types of resources exist in support of health policy processes in Tajikistan? Who and how established them? What has been the MOH role in this process? 18. What resources are inhibiting/redundant in relation to the health policy processes in Tajikistan? Why is this? Why they exist and what is the role of MOH in this?	you see HMIS as a resource? Resources may include such as Health Policy Analysis Unit; Aid Coordination Unit
Policy Actors		
Ability of MOH to: • Ensure wide participation of key actors in each stage of health policy processes • Manage relationships between different actors in order to ensure good health policy processes	19. Who has typically been involved in the health policy processes and in what role? Who do you think should be, but is/are not involved? Why? 20. Can you describe a particularly good example when the MOH succeeded in involving all key actors in health policy processes? Why has this happened? What was the role of MOH in the process? 21. Can you describe particularly poor example of involvement of actors in health policy processes? Why has this happened? What was the role of MOH in the process? 22. Do you think participation of actors improves policy processes? How does participation of actors characterise MOH capacity?	Use any other preferred term instead of 'key actors' Actors may be groups and individuals Prompt for leadership role of actor(s) Role of World Bank? Influence of Russia?
Policy context		
Key factors influencing health policy processes: • Political environment • Socio-economic situation • Cultural/traditional norms • Wider public sector reforms • Integration of health policies with other policies	23. What is the capacity/ability of MOH to take into account the wider political environment in health policy processes? Can you think of a good/bad example of this? 24. What is the relationship between the organisation of the health system (such as decentralisation) and health policy processes? Any	These may include Taj-specific and

Theme/Issues to cover	Main questions	Prompts
• Health system organisation	examples? 25. What wider public sector reforms affect health policy processes and how? 26. To what degree social hierarchy in the society and/or cultural norms affect health policies (such as involvement of some actors)? 27. In what way health policy processes are affecting wider contextual factors?	regional/FSU
MOH Capacity		
To test conceptual framework and identify any further elements of capacity from respondent's perspective	28. When I say 'MOH capacity in relation to policy processes' what keywords/elements/components come to your mind and why? 29. What elements of MOH capacity in your opinion we haven't covered in our discussion and could have been? Why are they important? 30. What aspects of MOH capacity in your opinion could have been omitted from our discussion and why?	

Description of key informants from initial list of respondents for the SSIs

LEVEL/ACTOR(S)	NOTES/FOCUS OF THE INTERVIEW
<u>1. National level:</u>	
a. Executive Administration of President of Tajikistan	• Knowledge of broad country context • Involvement of national-level actors • Agenda setting and development/formulation of policies • Political aspects of policy processes • Inter-sectoral issues (involvement of other ministries in approval/consultation of MOH policies) • Broad knowledge of external aid and international actors
b. MOH (HPAU; health reforms, service organisation, external relations, science, others)	• Knowledge of broad country & sector-specific contexts • Technical and political aspects of policy processes • Involvement at all stages of policy processes • Technical aspects of consultation with other sectors • Detailed knowledge of sector-specific external aid and sector-specific international actors • Use of evidence in policy processes
c. Donor agencies including project implementation units	• Knowledge of country context • Political and technical aspects of collaboration with MOH • Involvement mostly at one level (national, local) • Inter-donor consultation of priorities; negotiations with government (demanded spaces in policy processes) • Generation and communication of evidence to the MOH

LEVEL/ACTOR(S)	NOTES/FOCUS OF THE INTERVIEW
d. Educational Institutions	• Knowledge of health system priorities; involvement in generation and/dissemination of evidence for policy processes; • Capacity development for implementation of policies (such as Training; development of clinical guidelines) • Lack of recognition leading to [limited] involvement/'invited' approach in policy processes
e. Civil society (such as media, NGOs, professional organisations)	• Knowledge of local context and local health needs • Historically limited role in policy processes; • Favoured by international counterparts; 'parallel' [to the policy processes] initiatives • Potentially opportunity for local-level inter-sectoral collaboration; • Invited spaces in policy processes
2. *Oblast* level	
a. Health department in regional administration (head /deputy)	• Broad knowledge of mostly local context; • Invited spaces in national-level policy processes; combined with the decision-making authority at the regional/local level; • Involvement at implementation of national and all stages (development, implementation) of local health policies; • Dual subordination resulting from the deconcentrated system.
b. Regional projects/INGOs	• Mostly knowledge of local context • Often, vertical branches of national-level headquarters/projects • Involvement mostly at the implementation of policies • Invited spaces in regional policy processes

Appendix 5: Guidance notes and format for observation of policy event

General Notes:

1. Preference will be given to *passive* and not active observation;
2. Where possible from each event output(s) such as meeting minutes/list of agreements, action plan and/or policy decision(s) will be requested;
3. For each event a proforma below will be filled in;
4. For each event a set of notes will be compiled reflecting on the *description* of the event as well as *interpretation* of the key aspects of the event (based on the elements of the conceptual framework).

	Aspect	Expected output (notes)
1.	Physical setting	• description of the setting, • timing and duration of the event; • links with the previous/subsequent event(s) if available;
2.	Links with the stages of the policy process	• Clarity of the objective of the event; • Description of where the event fits within a policy cycle (based on objectives)
3.	Dynamics of the event	• interaction between actors, for example particular dominance/passive, • element of discourse/disagreement in opinions
4.	Practices of different actors	• … of MOH to manage the event • … of other actors to influence the process • … of all actors to use evidence, utilise resources • participation of actors (such as Invited vs demanded); • formality of the process vs relative power
5.	Efficiency and effectiveness of the event	• Achievement of objectives of the event; • Distribution of tasks for the next steps; • Transparency of the processes; • Decision-making styles.
6.	Use of evidence in the process	• Capacity of all actors at different stages of the process (of the event & policy cycle) • Output of the event – i.e. use of evidence in the policy processes/decisions (including any written outputs)
7.	Feasibility and sustainability of decisions	• Capacity of all actors to take into account the context leading to: a) Feasibility (technical, political) of policy decisions and b) Sustainability of decisions

Format for OBSERVATION OF A POLICY EVENT

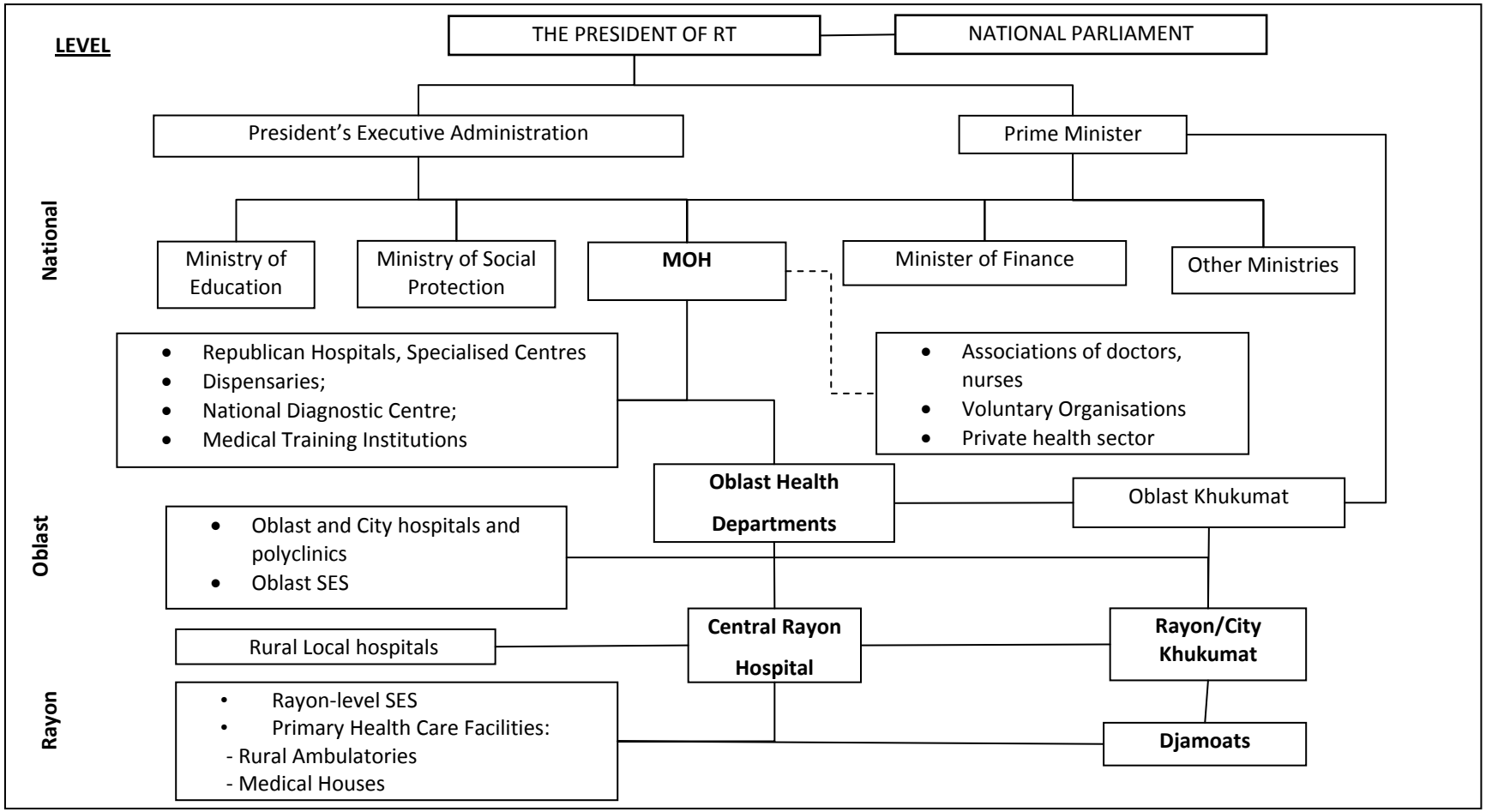
	Aspect of observation	Notes
1.	Physical setting	
2.	Links with the stages of the policy process	
3.	Dynamics of the event	
4.	Practices of different actors	
5.	Efficiency and effectiveness of the event	
6.	Use of evidence in the process	

Appendix 6: The data coding framework

Code		
Grandparent	**Parent**	**Child**
Capacity to conduct health policy processes	Process	Stages of the process Good process, Transparency Importance of the process, events Integration
	Context	Importance Integration Mentality Barriers Trends/shifts Intersectoral collaboration
	Actors	MOH motivation Roles Communication Participation Power Characteristics
	Capacity	MOH technical skills Changing roles Communication (actors) Coordination Trends Defining capacity Sustainability
	Evidence	Quality of evidence Defining evidence Types used Actors power/involvement Access to evidence Evidence use Process of evidence
	Leadership and Governance	Consultation, communication Consultants Corruption Initiative, decisions Changing role in L&G
	Resources	Defining resources Attitudes, motivation Redundant resources Trends in resources Coordination Constraints
	Others	Defining policy, defining good policy Methodology SWAp Technologies

Appendix 7: Organisation of public health system in RT

Modified from: (Mirzoev, 2004 p.57)



Appendix 8: MOH organogram

Based on: (GOT, 2006a, 2008)