A DECADE OF MAKING A DIFFERENCE: THE POLICY PROJECT (1995–2006)

September 2006

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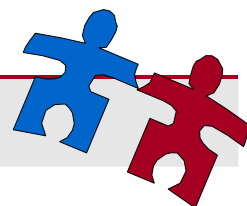
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The POLICY Project, funded by the U.S. Agency for International Development (USAID), led a major effort to improve the policy environment for family planning/reproductive health (FP/RH), HIV, and maternal health in developing countries. Implemented in two phases (1995–2000 and 2000–2006), the project combined several USAID technical assistance areas—namely awareness raising, policy dialogue, and policy formulation—into a single program. POLICY's mandate was to improve policies for an expanded range of reproductive health issues, including HIV and maternal health and to strengthen these policies by promoting multisectoral involvement in policy development processes.

Together, POLICY I and II garnered $230 million in USAID core and field support, with the majority of funding received from USAID Missions. POLICY II, for example, established dozens of country offices and worked with four USAID regional programs. Overall, the project achieved nearly 1,100 strategic objective- and intermediate-level results in response to the project's results-based framework. What this means is that, under POLICY II alone, the project:

- Fostered the adoption of more than 140 policies and plans to guide FP/RH, HIV, and maternal health services;
- Helped to form or build the capacity of more than 100 civil society networks, including reproductive health advocacy networks and networks of people living with HIV;
- Brought groups such as faith-based organizations and businesses into the health policymaking process;
- Awarded more than 250 small grants to support grassroots policy dialogue and advocacy efforts;
- Conducted groundbreaking policy analyses to raise awareness of issues such as contraceptive security, resource needs, women's inheritance rights, and HIV-related stigma; and
- Assisted countries and partners allocate, mobilize, and/or leverage more than $200 million in additional funding for FP/RH, HIV, and maternal health.

These results directly contributed not only to the project's objective of creating an enabling policy environment, and helped meet the strategic goals of USAID's Bureau for Global Health, USAID Missions, the President's Emergency Plan for AIDS Relief, and host-country governments and partners. For the POLICY Project, *how* it achieved its objective was as important as *what* it accomplished. The project's innovative model for implementing the work was both a facilitator and indicator of its overall success. Recognizing that sustainable policy processes must inevitably come from within a country, POLICY set out to establish a project model that put its principles—country focus, multisectoral engagement, capacity development, decentralization—into practice. POLICY transferred authority to local country directors and staff and equipped them with the necessary training, technical assistance from U.S.-based staff, and operational systems to effectively carry out their work. The project employed more than 600 field staff and worked closely with hundreds of local consultants and partners, thereby fostering "policy communities" in each country that will sustain policy work long after the project ends.

ABBREVIATIONS
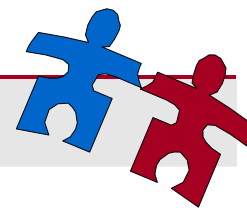
AIDS	acquired immune deficiency syndrome
AFR	Sub-Saharan Africa
ANE	Asia and the Near East
ANERELA	Africa Network of African Leaders Infected and Affected by HIV/AIDS
CA	cooperating agency
CEDPA	Centre for Development and Population Activities
CEPREC	Center for the Prevention and Resolution of Conflicts in Health (Peru)
COP	Country Operational Plan
CTO	cognizant technical officer
DAP	district action plan (India)
DOH	Department of Health (South Africa)
E&E	Europe and Eurasia
ESA	East and Southern Africa
FBO	faith-based organization
FP	family planning
GH	Bureau for Global Health
GOI	Government of India
HIV	human immunodeficiency virus
ICPD	International Conference on Population and Development
IDU	injecting drug user
IFPS	Innovations in Family Planning Services [Project] (India)
IGSS	Social Security Institute (Guatemala)
IPPF	International Planned Parenthood Federation
IR	intermediate results
KENERELA	Kenya Network of Religious Leaders Infected an Affected by HIV/AIDS
KNASP	Kenya National HIV/AIDS Strategic Plan
LAC	Latin America and the Caribbean
MOH	Ministry of Health
MOHF	Ministry of Health and Family (Romania)
MOHP	Ministry of Health and Population (Egypt)
MSM	men who have sex with men
NACA	National Action Committee on HIV/AIDS
NACC	National AIDS Control Council
NCASC	National Center for AIDS and STD Control (Nepal)
NGO	nongovernmental organization
NRHM	National Rural Health Mission (India)
NRHP	National Reproductive Health Plan (Guatemala)
OHA	Office of HIV/AIDS
OPRH	Office of Population and Reproductive Health
OVC	orphans and vulnerable children
PDG	Policy Development Group (Ukraine)
PEC	Policy, Evaluation, and Communications Division
PSC	personal services contract (or contractor)
PMTCT	prevention of mother-to-child transmission
QA	quality assurance
RCH	reproductive and child health
REDSO	Regional Economic Development Services Organization

RH	reproductive health
RHAP	Southern Africa Regional HIV/AIDS Program
RHAP	Reproductive Health Action Plan (Jordan)
RNM	Resource Needs Model
RTI	Research Triangle Institute
SIFPSA	State Innovations in Family Planning Services Agency (Uttar Pradesh)
SO	strategic objective
TDY	temporary duty
SUMI	Maternal and Infant Integrated Health Insurance Program (Peru)
UNICEF	United Nations Children's Fund
URHN	Ukrainian Reproductive Health Network
USAID	U.S. Agency for International Development
WARP	West Africa Regional Program
WHO	World Health Organization

WHAT IS THE POLICY PROJECT and HOW DID IT COME ABOUT?

The POLICY Project was a decade-long initiative (1995–2006) on the part of the U.S. Agency for International Development (USAID) aimed at improving the policy environment in family planning and reproductive health (FP/RH), HIV, and maternal health.[1] The project combined several areas of USAID's previous technical assistance—namely awareness raising, policy dialogue, and policy formulation—into a single consolidated program. The project also brought with it some new challenges and opportunities. In response to key tenets in the 1994 Cairo Program of Action, USAID asked the new project to explore policy development activities that went beyond family planning and included broader aspects of reproductive health, such as HIV and safe motherhood as new focus areas for the work. In addition, USAID recognized the need to strengthen the foundations of policymaking and thus called for an emphasis in the new project on expanding participation in policy dialogue beyond government ministries.

USAID also called for seeking "long-term advisors" (LTAs) who could serve as local consultants and partners for country programs. Previous policy projects (e.g., RAPID and OPTIONS) had shown that local experts could play important roles in supporting project activities. Thus, from the outset of the POLICY Project, the Futures Group team and USAID managers emphasized that all project activities should have a strong country focus. Emphasis was placed on building countries' institutional and human resource capacity as an essential component of the program.

POLICY I (1995–2000) and subsequently POLICY II (2000–2006) were designed to address the "policy environment" in the broadest sense of the term. Policies, strategic plans, laws, legislation, and operational guidelines are the starting place for accessible, high-quality healthcare and services. However, an enabling policy environment goes beyond what appears on the printed page. One must consider: Who has a voice in the policymaking process and who is excluded? On what factors are policy decisions based? Who has responsibility for putting the policy into practice? Are resources and systems in place to implement policy directives? Are there any barriers to effective policy implementation? How will policy approaches be assessed and reformed? Therefore, strong political commitment, meaningful multisectoral participation, effective resource mobilization, accurate data for decisionmaking, and a trained cadre of people with the capacity to guide policy formulation and implementation are critical elements of an enabling policy environment.

USAID set up the POLICY Project in a "results-based" structure formulated in a manner that would provide a fundamental strategy for the program. Recognizing the comprehensive nature of the policy environment, POLICY worked toward achieving intermediate results (IRs) that underpin the overall strategic objective (SO) of improving the policy environment. Thus, USAID and the Futures Group team agreed upon a strategic or results framework that specified, in advance, the overall goal of the project as well as the results the project would work toward. The SO and the IRs had indicators that were measured periodically against targets to assess progress and effectiveness of the project's work. Table 1 presents the SO, IRs, and additional information for POLICY II.

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[1] The Futures Group, in collaboration with the Centre for Development and Population Activities (CEDPA), Research Triangle Institute (RTI), and hundreds of host-country organizations implemented the POLICY Project.

Table 1. A POLICY II Primer		
Strategic Objective:	▪	Facilitate the development of policies and plans that promote and sustain access to high-quality FP/RH, HIV, and maternal health information and services
Intermediate Results:	▪ ▪ ▪ ▪	Broaden political and popular support Improve planning and financing Ensure that accurate, up-to-date, and relevant information informs decisionmaking Enhance in-country and regional capacity to provide policy training
Project Period:	▪	July 7, 2000–June 30, 2006
Total Funding:	▪	$160 million
Geographic Coverage:	▪	33 countries and 4 regional programs

Although POLICY was a centrally funded and managed project of the Office of Population and Reproductive Health (OPRH), the project also played a major role for the Office of HIV/AIDS (OHA) and in USAID's country programs. Therefore, POLICY's work was simultaneously geared to the project's strategic framework; the Bureau for Global Health strategic framework for FP/RH, maternal health, and HIV; and Mission strategic frameworks. After 2003, with the launch of the President's Emergency Plan for AIDS Relief, POLICY also contributed to Country Operational Plans (COPs) for HIV. Thus, the project helped produce results for USAID Missions as well as the Bureau for Global Health.

A SUCCESS BY ANY MEASURE

By almost any indicator, the POLICY Project was an overwhelming success. The project met and surpassed the targets set for the strategic objective of the program and its lower-level results. In achieving its objectives, the project pioneered innovative technical approaches—including state-of-the-art research and multisectoral, participatory policy processes—many of which have been adopted globally by host-country government, local partners, and collaborating agencies. To do so, POLICY successfully created more than 30 in-country programs, decentralized project responsibility to the field, and strengthened the operational systems and in-country capacity of staff and local partners to carry out and sustain policy work at the country level. Meanwhile, funding levels for the project reached an all-time high within USAID and helped establish policy work as an essential approach in many USAID country programs. Measures of the project's success are presented here.

☑ **The POLICY Project dramatically improved the policy environment in many countries.**

The policy environment is best characterized as an ever-changing mix of direct and indirect determinants. Direct determinants include stakeholders, bureaucratic systems, politics, policy champions, funding flows, data, laws, regulations, and policies themselves. Indirect determinants are more difficult to influence, but nevertheless must be taken into account in designing policy interventions and building local capacity. Indirect determinants comprise national economies, democratic systems, social conditions, culture, religion, ethnicity, and people's educational levels to name a few (see Box 1). An unsupportive policy environment can make it difficult for countries to respond effectively to its population's health needs. For example, POLICY documented hundreds of cases where policies, strategies, funding, laws, regulations, and norms adversely affect the ability of governments and private organizations to improve health services.

> **Box 1. The Importance of Context: POLICY Capitalized on Socioeconomic Trends to Increase Project Effectiveness and Sustainability**
>
> Several factors can influence the overall policy environment. POLICY was able to take advantage of various shifts in the socioeconomic landscape to improve how project inputs were used in countries. In particular, POLICY was able to capitalize on the following key changes:
> - Higher levels of educational attainment, which increased the availability of local professional staff;
> - Expansion of democracies, which paved the way for greater stakeholder participation;
> - International agreements, which pressured countries to improve policies; and
> - New communications technologies that provided mechanisms for rapid intra-project communication and feedback.
>
> These trends were instrumental in the project's success and allowed POLICY to multiply its impact at the country level.

POLICY's main objective was to work within this policy environment to help countries achieve results or outputs in terms of improved national policies; expansion of government and private stakeholders; more resources for FP/RH, HIV, and maternal health programs; better information for evidence-based policymaking; and greater local capacity to carry out policy development into the future. The project was successful not only in the specific areas related to its two contracts, but it also obtained a wide variety of results across many technical areas by partnering with national to local governments, NGOs, faith-based organizations (FBOs), the medical community, and businesses.

Over POLICY's 11-year history, the project documented nearly 1,100 results at the SO and IR levels, as presented in Table 2. These results span the range of policies and policy inputs necessary to support expanded and more effective programs. They include highly visible kinds of policies, such as national FP/RH and HIV policies and laws as well as national strategies, plans of action, and detailed implementation blueprints. The results also cover critical inputs into effective policymaking processes, such as the formation of sustainable NGO networks, research and data analyses, improved program planning, and increased financial resources, to name a few. Importantly, POLICY achieved many results in the area of stimulating a sustainable local capacity to carry on policy dialogue and policymaking long after the end of the POLICY Project.

Table 2. POLICY I and II Results			
Level of Result	1995–2000	2000–2006	Total
SO	88	258	346
IR	149	599	748
Total	237	857	1,094

To document results, the project used its strategic framework to develop the definitions, criteria, indicators, and systems to record and verify policy achievements. Thus, POLICY created a highly effective monitoring system that played a major role in guiding project staff in program conceptualization, design, and implementation. This new rigor greatly enhanced the overall performance of the project.

☑ **POLICY built in-country capacity to improve current programs and meet future policy needs.**

Project and USAID management embraced the view that policy analysis and change is best carried out in partnership with local experts and stakeholders. Therefore, strengthening the ability of local staff and their local partners to lead policy processes was critical to POLICY's country programs. POLICY employed more than 600 field staff and collaborated with 200 local subcontractors and consultants. By working with hundreds of local experts and institutions in project countries, POLICY not only helped to strengthen the current policy environment, but perhaps more important, stimulated the creation of an established "policy community" that will continue to address local policy concerns well into this century. This kind of local policymaking capacity did not exist in many countries before the advent of the POLICY Project.

☑ **POLICY created a cadre of expert country directors and local staff to lead and sustain policy change at the country level.**

POLICY successfully put into practice an organizational model that was designed to build local capacity to guide and sustain policy change. Over time, POLICY devolved key project functions to the recipient countries and delegated authority for program design and implementation to local POLICY staff. Local country directors became the main project implementers in the field and were responsible for the majority of field support programs. Supported by U.S.-based experts and managers, project operations shifted to the countries. The empowerment of local directors and their staff played a major role in the success of POLICY and in the types, quality, and numbers of results it achieved.

☑ **POLICY implemented country-oriented operational, financial, and administrative systems to support its decentralized programs.**

Fully embracing a country-focused approach, coupled with decentralization of authority, meant that the project needed to adopt a variety of new systems to support a widely dispersed and devolved structure. These new systems were needed to accommodate strong central management and accountability while also delegating program oversight to in-country teams. POLICY staff developed and implemented improved communications mechanisms, designed and put into place up-to-date financial tracking

procedures, established continuously updated subcontract and consultant databases, and provided all staff with clear monitoring and evaluation guidance and training. In addition, project staff designed a new system for awarding and tracking small grants that became instrumental in achieving project objectives in many countries. Improved operational and financial systems helped staff to manage the large, diverse global project effectively and efficiently.

☑ POLICY fostered major advances in evidence-based decisionmaking and expanded countries' capacity for policy analysis.

Good policy is underpinned by good information and analysis. POLICY staff advanced not only the types of data collection and analysis undertaken, but they also became more adept at ensuring that the information was used in policy formulation. POLICY devised state-of-the-art techniques and research to improve understanding of a range of cutting edge issues, including contraceptive security and HIV resource needs. The richness and depth of POLICY's work in demographic and HIV and AIDS projections, policy and legal review, data for decentralized planning, operational policy analysis, program evaluation, and stigma and discrimination assessments not only improved the quality of policies and targeting of resources, but also helped provide a solid foundation for ongoing policy reform in USAID-assisted countries.

☑ POLICY opened up policy processes to include a broad array of stakeholders.

Participatory approaches to policy dialogue and policymaking in 1995 were rare in the developing world. Thanks in part to the POLICY Project, health policymaking has opened up and is now routinely more inclusive today than could have been imagined a decade ago. Under POLICY II, the project formed or strengthened more than 100 NGO networks as a way of promoting civil society participation in policymaking, as well as brought in various sectors into the policy process. The approach of increasing stakeholder capacity and involvement in policy processes, now ingrained in USAID's global and country programs, has greatly increased the quality and effectiveness of policies in USAID-assisted countries.

☑ POLICY's funding levels demonstrated increased demand for policy work.

Launched in 1995, POLICY I spanned the period from September 1995 to December 2000. The first year (FY95) of POLICY had modest beginnings with field support amounting to just $4 million. USAID expected the project to work in about 20 countries over its lifetime. No one at the time believed that the project had a chance of reaching its ceiling level of $80 million. The POLICY Project predecessors (RAPID, OPTIONS) were considered successful, but had not exceeded a combined $40 million in funding over any five-year period. In fact, POLICY I reached a funding level of $70 million as USAID Missions increasingly found a need for policy work in implementing their programs. The second phase of the POLICY Project, 2000–2006, took up where the first phase left off, with a contract ceiling of $96 million. The project managers from both Futures Group and USAID believed this was a more-than-ample level to accommodate expected demand. They were wrong. Because of the high demand and rapid growth of the project, USAID extended the project's term to 2006 and raised the ceiling to $160 million. Together, the two phases of the POLICY Project garnered $230 million in funding. In terms of funding, therefore, the POLICY Project thrived as a centrally designed initiative, and it was one of the largest global projects in USAID's history. But, the funding levels and trends are only proxies for what the project really accomplished.

A Guide to This Report

The remainder of this report is divided into three sections, plus supplementary materials. The first section describes how POLICY developed a unique organizational model that was inherently linked to the project's successes, noted above. The major components of the model, as exemplified by the Nigeria case study presented at the end of the section, are explored in detail. In the next section, we review POLICY's major achievements in terms of improved policies, stronger political and popular support, and increased resources as well as better approaches for addressing gender, human rights, and the needs of youth. The final section reflects on POLICY's legacies. Appendix A contains five country case studies that demonstrate how project components acted together to help improve local policy environments. Appendix B lists references that provide additional information about different aspects of the project.

THE POLICY PROJECT MODEL

The POLICY Project's successes were fundamentally linked to the project's innovative organizational model. Based on our analysis of the project's major technical and functional inputs, we have identified seven key components that taken together define POLICY's model. As depicted in Figure 1, these seven components contributed in synergistic ways to implementing the project's country programs. In turn, the country programs—combinations of Mission and core inputs—helped the project realize its goal of improving the policy environment in USAID-assisted countries. (For more information on the project's organizational model, see POLICY Project. 2005f. "The POLICY Project Organizational Model and Contributions to Project Outcomes.")

Figure 1. POLICY Project Model
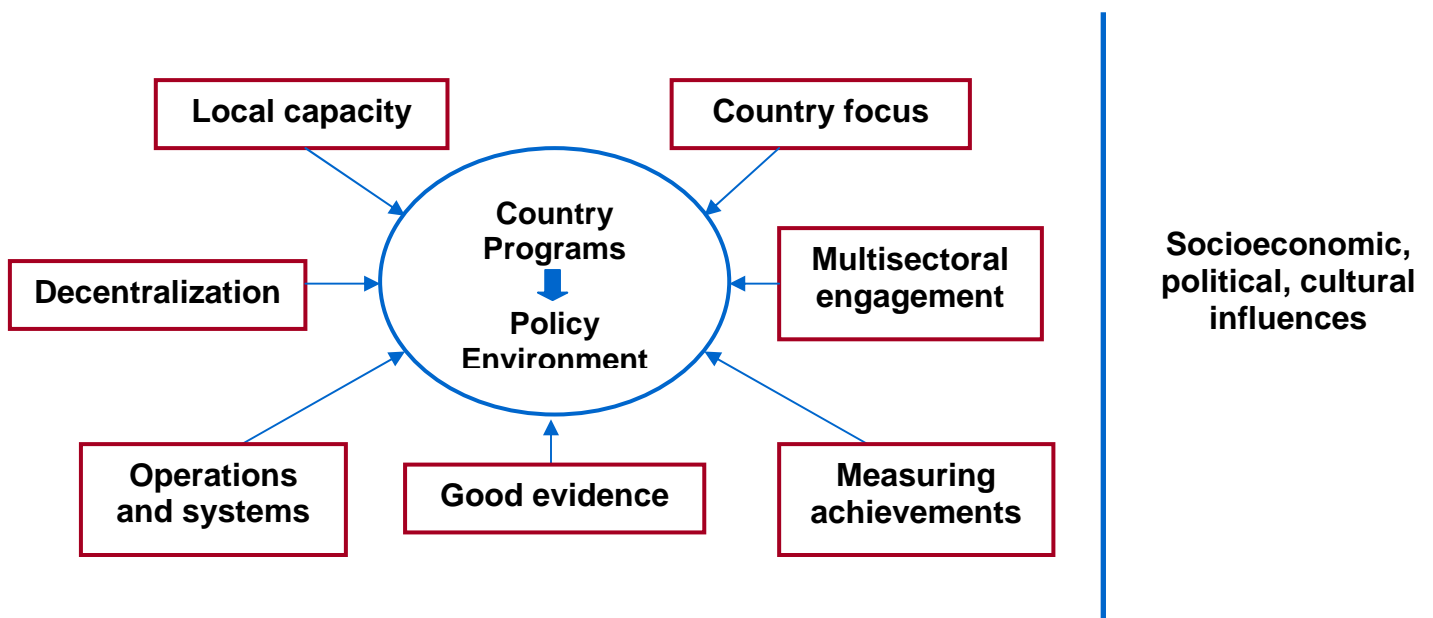
The seven components represent a variety of inputs into country programs (see Figure 1). The inputs were conceptualized and carried out within the specific socioeconomic, political, and cultural milieu of each country. The components have different characteristics: some are technical, some are philosophical, and some are functional. And in the implementation of POLICY programs, the components were not all equally applied in all settings. However, it is safe to say that where the project achieved success, these components were all present and functioned together to help achieve the project's many results.

The POLICY Project model took some time to develop and evolve. First of all, not all of the components existed in their current form at the outset of the effort in 1995. In addition, some of the components emerged as stronger forces in the project's development. Building local capacity and measuring performance are two components that gained in importance and had more influence over time as the project emphasis evolved. There were also substantial challenges as the model evolved and was implemented. Developing the "good evidence" and "measuring achievements" components were relatively straightforward and relied on experienced senior experts who served as staff on the project. The "decentralization," "local capacity," and "multisectoral engagement" components required re-orienting staff in a variety of ways and changing many of the ways that people were used to doing business. This

took several years in some cases as well as occasional and forceful directives on the part of management. Moreover, as the POLICY model matured and gained traction, the productivity of the project measured in terms of results and contract funding levels increased dramatically. From the POLICY I to POLICY II contracts, the overall funding increased from the first five-year period to the next by about 130 percent. The numbers of results over the same period rose by 230 percent.

The main components of the POLICY Project model are not new. In one way or another, other programs—past and present—have employed these approaches in their work. What distinguishes the POLICY model is how the project brought the components together to realize the project objectives and made them function harmoniously at the global and country levels. At the same time, advances in technical and organizational approaches within specific components strengthened the model over time. The synergistic functioning of all the components not only helped achieve project objectives but also multiplied project impacts.

Thus, the POLICY Project took existing knowledge and approaches to health policy assistance and combined them in new and more effective ways to carry out the work. The innovations and results emanating from the POLICY model are one of the project's main legacies.

> **"Innovation** is the process of converting knowledge and ideas into better ways of doing business or into new or improved products and services that are valued by the community."
>
> —Queensland Government, 2006

A Closer Look at the Components

In this section, we examine the main components of the POLICY Project model in greater detail—how the components were conceptualized, how they evolved, what was achieved, and what challenges were faced. At the end of this section, we present the case study of Nigeria, which shows how the model operated at the country level to make lasting, positive impacts on that country's policy environment.

Country Focus

Early on in the project, the Futures Group team and USAID managers began to instill a philosophy among managers and staff of viewing the entire project and its efforts through the country perspective. The idea was to ensure that the project's programs and services would be designed and carried out so as to have the greatest effect in the field. The long-term benefits of this approach would also be greater prospects for sustainability at the country level. This is not to say that previous global projects did not focus on the field, but it did imply changes in many of the ways that previous policy development projects had functioned. Thus, POLICY began to direct the majority of its core funding to countries, and to ensure that all methodological tools, data, and information would be readily available to people working in the field. Project managers also emphasized the linkages between the POLICY contract and its strategic framework and the Missions' strategic frameworks and expected results. Staff were encouraged to be especially responsive to Missions, adopt collaborative approaches, and to guide policy work from development to implementation. Not least, the project started from the beginning to build "assets" in countries, which will be described later.

With respect to core funding, the country-centered approach meant that there would be less relative focus on developing project products and materials in the United States and that there would be a premium on developing them in countries in collaboration with local partners. POLICY adopted this approach and used various mechanisms to drive the country focus with the project's core programs. One of these mechanisms was the "core package."

The idea of core packages was to marshal resources and innovative technical approaches to achieve policy breakthroughs at the country level that would also have global significance. Core packages were carried out at the country level and involved the close interaction of U.S.-based technical staff as well as POLICY's country team. In most cases, there was also a local collaborating institution that participated in the activity. Core packages helped develop new methodologies, expand policy analysis capacity, achieve notable results in recipient countries, and provide blueprints for other countries to adopt similar approaches. During POLICY II, the project implemented 12 core packages addressing key issues in FP/RH, HIV, and maternal health (see Table 3).[2]

Table 3. POLICY Project Core Packages, 2000–2005	
Country	**Thematic Area**
Romania (FP/RH)	Operational Policy Barriers to Contraceptive Security
Ukraine (FP/RH)	Operational Policy Barriers: Improving Resource Use
Guatemala (FP/RH)	Removing Reproductive Health Operational Barriers
Jamaica (FP/RH)	Operational Policy Barriers to Integration of RH and HIV Services
Peru (SM)	Operational Barriers to Safe Motherhood in Poor Rural Areas
Nigeria (FP/RH)	Young Adult Reproductive Health Strategy in Edo State
Ukraine/Ethiopia (FP/RH)	Resource Allocation Model for Reproductive Health
Kenya (FP/RH)	Financial Barriers to Access for Poor/Underserved
Mexico (HIV)	Measuring Stigma and Discrimination to Improve Programs
South Africa (HIV)	Measuring Stigma and Discrimination to Improve Programs
Swaziland (FP/RH and HIV)	Reproductive Health Needs of HIV-positive Women
Nepal (HIV)	Prevention Policies and Programs for Injecting Drug Users

POLICY's strong country focus had many impacts on the project's internal working, which in turn helped further USAID's global initiatives in improving the policy environment in recipient countries. Because POLICY was so focused on countries and because staff became accustomed to work from a country-level perspective, the project's senior staff began seeking out opportunities not only to improve policies but also to help *implement* those policies. This approach helped the project to move beyond the basic aspects of policy assistance such as high-level awareness raising, research, and policy analysis to operational aspects of policies.

While the project continued to work at the higher policy levels and fostered better national and ministerial FP/RH and HIV policies and strategies, it also started to fill policy gaps that extended down through health and other systems—many of which touched the essence of programs and service delivery. Before long, POLICY was involved in assisting Kenya to prepare home-based care guidelines for the Ministry of Health, promoting detailed district-level operational plans for RH programs in India, and supporting budgeting and resource decisionmaking in Ukraine, to name a few examples.

**Figure 2.
Project Funding by Core and Field Support, 2000-2005**

Core: $36,000,000 (22%)
Field Support: $124,000,000 (78%)

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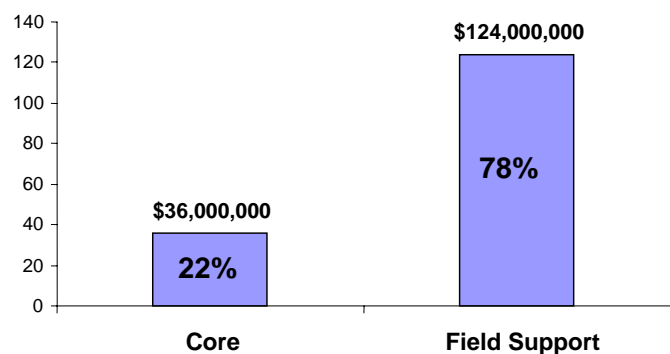
[2] See POLICY Project (2005d and 2005e) for reports summarizing the significance and impacts of core packages.

By undertaking these kinds of implementation activities, POLICY became more relevant to USAID Missions and their individual country programs. In a real sense, the more policy implementation that POLICY was able to accomplish, the more funding those Missions allocated to the project in support of their bilateral programs. In the end, more than three-quarters of POLICY II's $160 million was field support from Missions (see Figure 2).

Because of its attention to country needs, the POLICY Project also developed excellent and close working relationships with many USAID Missions. Historically, there has been a natural tension between centrally funded global projects and USAID Mission programs because they often have different objectives, priorities, and functions within the U.S. foreign assistance program. Sensitive to Mission needs and the global objectives of the project, POLICY staff largely negotiated the territory between global and country bilateral programs and managed to serve the needs of both. The combination of U.S.-based experts and support staff combined with country leadership and local staff helped merge the objectives of the two parts of USAID into coherent, results-producing programs that received high marks from both.

Because POLICY had a strong country focus and capable leadership from both the United States and recipient countries, many Missions relied heavily on POLICY to set directions and strategies in policy development. As one country manager wrote, *"The USAID Mission was incredibly supportive and allowed us the flexibility to respond strategically to opportunities as they arose. The same can be said of the central management of the POLICY Project and the USAID/Washington CTOs."*

Local Capacity

In keeping with the project's country focus, POLICY's management actively promoted the idea of hiring local staff and using local consultants as much as feasible from the beginnings of the project in 1995. The fundamental philosophy throughout the project's life span was that sustainable improvements in a country's policy environment must come from within. The only way to achieve this would be to enlist the continuous presence of local leaders and experts with a full understanding of the local cultural and political environment that could bring about and implement locally determined policies and programs. External assistance was to be focused on introducing new technical approaches and research, global leadership initiatives, and support to field programs through sharing of best practices and lessons learned from other countries. In addition, the philosophy also emphasized the transfer of management and administrative skills with the objective of ensuring that, in the future, the majority of policy work, including local management, would be carried out in the field by host-country professionals.

Thus, POLICY management embarked on a course that changed the face of the project in a few short years. Prior to 1995, in predecessor projects, all country leadership and control was held by U.S.-based staff members who would travel periodically to the countries to look after activities. In the first months of the project, Dr. Gadde Narayana was appointed to be the County Director for India. He was especially successful in developing his program, recruiting and employing local staff, and producing highly desirable results for the USAID Mission in Delhi. In many ways, Dr. Narayana and the India program became the model that the project would try to emulate in other countries. So, as the project progressed, POLICY began to dramatically increase the numbers of country staff.

Figure 3 depicts the growth of locally hired staff over the 11-year life of the project.[3] In-country staff grew from three persons in 1995 to over 300 at the high-water mark of overseas employment in January 2004 (not depicted in chart).

By the project's fifth year in 1999, the number of local staff (65) exceeded the number of U.S.-based staff (62) for the first time. From that time, nearly the entire increase in the total number of staff was due to the addition of local hires. Meanwhile the number of U.S.-based staff leveled off in the 60–75 person range through the end of the project. During the last four years of the project (2002–2006), the proportion of overseas staff reached and remained at 70–80 percent.

Figure 3.
Local Project Staff, 1995-2005
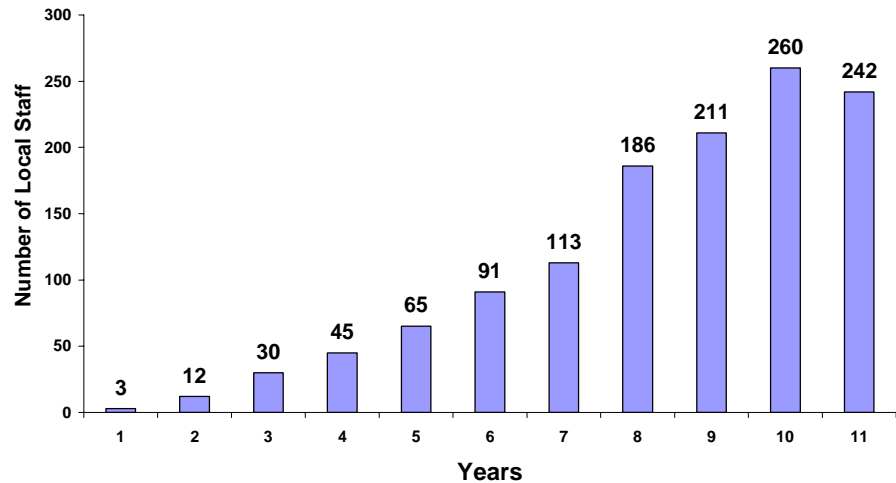
As the numbers of local staff grew, POLICY stepped up its activities to train them and offer diverse opportunities to improve their technical and management skills. The project held training programs in all of POLICY's regions[4] as well as in the United States that included sessions on SPECTRUM,[5] policy analysis, advocacy, and strategic planning among others. In addition, U.S.-based POLICY staff consistently carried out informal capacity development during TDYs and through jointly designed and implemented technical activities. POLICY also provided all staff with procurement, financial management, and operations training, including periodic refresher training. Not only did POLICY make a long-term concerted effort to build local capacity directly through in-country staff, but the project also undertook capacity-building activities with hundreds of consultants and partner organizations (and staff) through project activities.

Two other features distinguished our capacity-building efforts over the past 11 years. POLICY fostered "south-to-south" capacity development by promoting technical assistance by one POLICY country to another. Under this mechanism, POLICY's Peru Country Director made several trips to Guatemala to help local staff and partners to improve their skills. In other instances, operations managers from Kenya and Malawi spent time in Tanzania training operations staff there, and Ukrainian staff conducted advocacy training for NGOs in Russia. This capacity development has occurred at all levels of the project

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[3] The term "local staff" in this report refers to people who were contracted to work on the POLICY Project either as employees, personal services contractors (PSCs), or long-term consultants. Historically, we defined a staff member as someone who worked 50 percent or more on the POLICY Project. The definition also covers U.S.-based staff who may have occasionally worked on other projects in their respective institutions, but who worked predominantly on POLICY.

[4] POLICY fielded country and regional programs in Asia and the Near East (ANE), Latin America and the Caribbean (LAC), Sub-Saharan Africa (AFR), and Europe and Eurasia (E&E).

[5] SPECTRUM is a suite of policy models that make use of a unified set of Windows-based commands that can be easily learned. The models constituting SPECTRUM are used to project the need for reproductive healthcare services and the consequences of not addressing reproductive health needs. The models included in the SPECTRUM system are: DemProj, FamPlan, AIM, RAPID, Ben-Cost, NewGen, PMTCT, Safe Motherhood, Condom Requirements, and Allocate. GOALS and other models are scheduled to be incorporated into SPECTRUM in the Health Policy Initiative follow-on project.

including technical, operational, financial, and administrative processes. The project also made significant and successful efforts to expand the diversity of its country personnel to include more women and persons living with HIV and focused special capacity-development attention on these groups. We were able to give country staff and local partners the opportunity to attend national, regional, and international meetings where they were exposed to the larger world of policy development and where they expanded their capacity to network and share experiences.

Besides a quantitative increase in the number of staff, POLICY also experienced a tremendous diversification of staff during its 11 years—both in the United States and overseas. The characteristics of staff also reflect a wide range of skills and experiences (see Box 2). POLICY enlisted staff overseas according to emerging technical and program operations demands. In addition, POLICY recruited and hired at different levels from the most senior experts available, to mid-level technical professionals, to junior program officers. The latter two types of staff had career paths in front of them under the project's organizational model. POLICY staff not only reflected an expanding range of disciplines but also reflected backgrounds especially relevant to the work and local capacity development. The project actively recruited staff and partners, such as persons living with HIV and maternal health advocates, who could represent the issues and concerns of vulnerable groups. So, the model not only expanded capacity in terms of skills and disciplines, but it also expanded staff mix in terms of levels, functions, and backgrounds.

> **Box 2. Characteristics of POLICY Staff, 2004**
>
> - **47 different nationalities**
> - **60+ languages spoken**
> - **Multidisciplinary composition**
>   - Physicians, nurses, and midwives
>   - Economists, statisticians
>   - Modelers, econometricians
>   - Demographers, sociologists
>   - Political scientists, historians
>   - Public health, administration, social welfare experts
>   - Psychologists, lawyers
>   - Anthropologists, senior civil servants

One of the benefits of POLICY's philosophy to build capacity of local staff is that virtually all of them (98+ percent) stayed in their countries and are still working in the development field. A project such as POLICY was by definition a time-delimited program. And even though the project existed for 11 years, no one expected staff to stay on for the entire decade. In fact, POLICY management recognized from the outset that it would be desirable for local country staff to work on the project for some period of time and then have the opportunity to use the skills learned and experiences gained to work with their own government and internal institutions/NGOs. Project management also recognized that some POLICY "graduates" would no doubt take jobs with international and bilateral donors and other cooperating agencies (CAs). Both prospects were welcomed because it meant that policy development capacity would remain, for the most part, in the country and would be sustained well after POLICY ended. When the project ended, the majority of staff transitioned to jobs doing similar work and a number of them continued with the follow-on to the POLICY Project (the USAID | Health Policy Initiative) and POLICY successor bilaterals in countries such as Nigeria, India, Nepal, and Bangladesh.

In addition, many POLICY staff members departed the project long before its end and took important jobs in their countries using the experience they had gained while working on the project. There are many examples of this important legacy. For example, in 2003 Sandra Aliaga from Bolivia became the Director of Social Communications for the government of Bolivia reporting to the president. Dr. Jerome Mafeni and Dr. Gadde Narayana became chiefs of party for major USAID bilateral projects in Nigeria and India, respectively. Edgar Gonzalez was the first Country Director for Mexico. In 2002, Edgar left the POLICY Project and joined the office of Vicente Fox, President of Mexico, where he is currently the director of the President's Liaison Office for Transparency in Government. Edgar also founded the government's HIV/AIDS antidiscrimination agency in 2004. Mary Kincaid, current Mexico technical advisor observed that, *"Edgar credits his drive and success in these areas to his work on POLICY, where he learned the*

importance of citizen participation, saw the good and bad of public policy, and learned that information is power and that citizens can use information and power effectively to affect positive social change. I talked with him last week and he again spoke about how his time at POLICY will define his life's work."
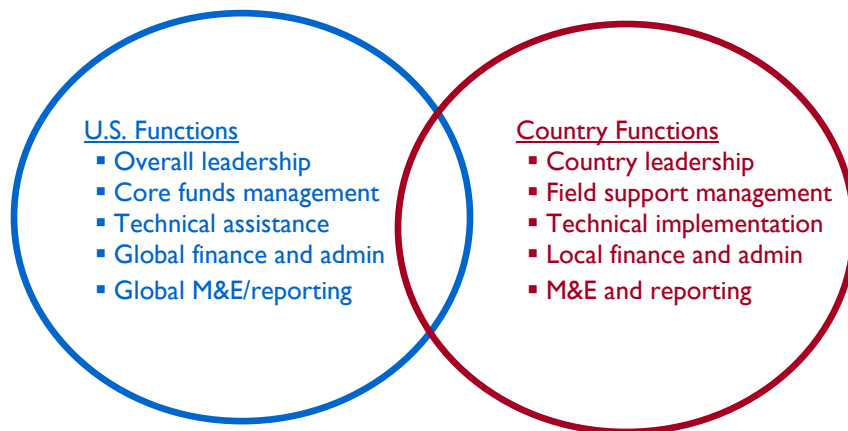
Decentralization

Decentralization reinforced the project's country focus and development of local staff capacity. It was not only central to how the project was managed, but ultimately, decentralization was also a main factor in the quality of the work performed at the country level and the quality of the results.

As we have seen, for the first few years of the project, almost all management and operations functions were carried out in Washington, D.C. This was also true for field support-funded programs. U.S.-based staff designed country programs, organized workplans, arranged for the activities to be carried out in country, and monitored outputs. However, achieving the project's objectives of obtaining results, putting a strong focus on countries, and building local staff meant that some if not all of the program development and day-to-day management of the activities needed to move to the countries themselves. Therefore, as policy work became more complex, involved more stakeholders, and relied on a continuous presence with rapid response capability, a significant level of local autonomy became a fundamental necessity in most countries.

To carry out decentralization of the project, management put in place a division of responsibility and labor that is depicted in Figure 4. Once a country program had a Country Director and technical and operations staff, POLICY started moving responsibilities to the country offices. The Washington, D.C.

office managed the global functions of the project in all aspects from core-funded programs to tracking finances and preparing all required reports. Country management oversaw all aspects of local activities, including interactions with USAID Missions, program design, technical implementation, and local operations. Country staff were also responsible for preparing various country reports and tracking and documenting local results.

Figure 4. U.S. and Country Functions

U.S. Functions
- Overall leadership
- Core funds management
- Technical assistance
- Global finance and admin
- Global M&E/reporting

Country Functions
- Country leadership
- Field support management
- Technical implementation
- Local finance and admin
- M&E and reporting

This division of responsibility relied on close working relations between U.S.-based and country staff at all levels as well as the devolution of key management responsibilities from U.S. staff to in-country staff. Shifting the organizational model in this manner required that senior U.S.-based staff "buy-into" the decentralized model and work toward hiring, training, and mentoring local staff and developing systems to support the new paradigm. There are many cases of U.S-based technical and operations managers taking on this role and personally working with local staff to help build their capacity to take on greater responsibilities. These mentoring relationships were initially focused on providing technical training and on-the-job experience, and later expanded to improving management skills more broadly. In fact, various U.S.-based senior and mid-level managers acted as advocates for country staff in terms of ensuring their participation in formal and specialized training sessions, international conferences, and Technical

Development weeks.[6] U.S.-based staff provided technical and professional consistency and support to country staff over the transition from a centralized project to a country-based one.

The most powerful indicator of the project's commitment to decentralization is the number of POLICY countries whose programs were led by a local Country Director. Figure 5 shows the progression of local Country Directors in place for each year over the life of the project.[7] Identifying, hiring, training, and orienting new Country Directors was not a task that could be done quickly. The market for such highly skilled people in POLICY countries was generally limited and once hired, Country Directors had to learn an enormous amount of new information and procedures to succeed at their jobs. The process of putting Country Directors in place began slowly and picked up momentum going into POLICY II in 2000.

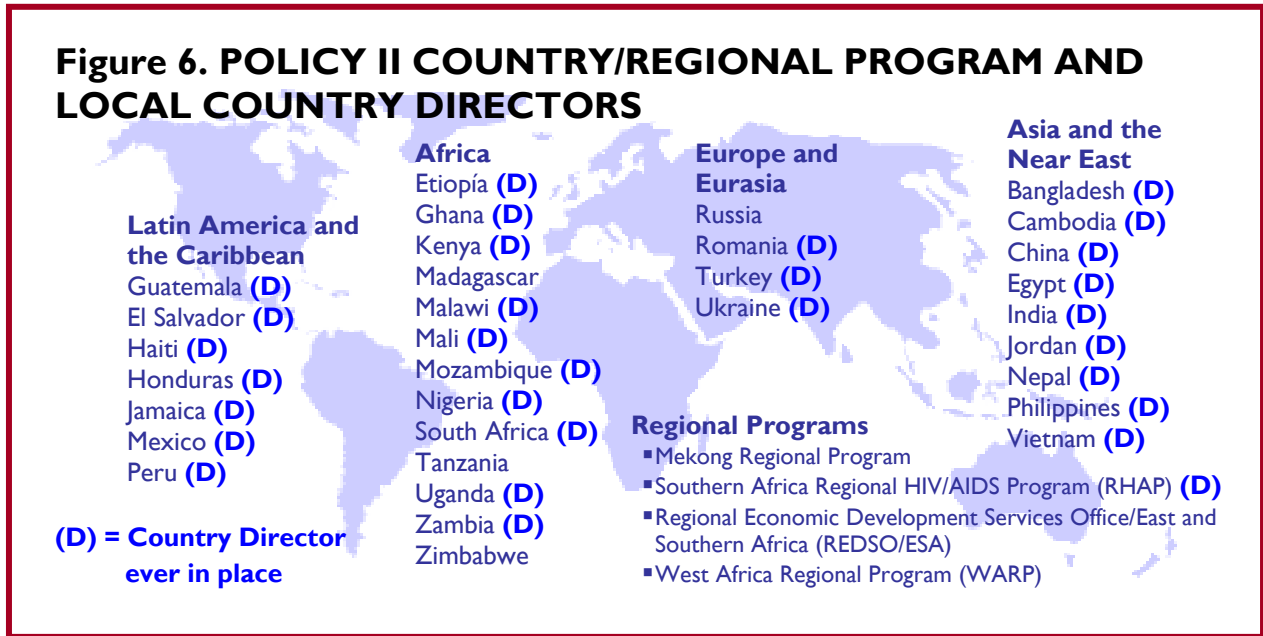**Figure 5.   Local Country Directors in Place, 1995 - 2005**
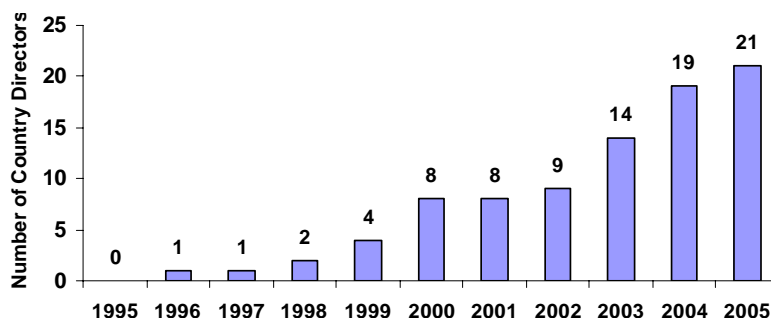
For the POLICY II Project, management made leadership capacity and establishment of Country Directors one of the main organizational and structural priorities of the project. POLICY proposed in 2000 that the project would have 50 percent of all POLICY countries led by local directors by 2005. As a result, the number of POLICY Country Directors increased from 4 in 1999 to 21 in 2005, which far exceeded the target.

The development of leadership capacity goes beyond the 21 Country Directors in 2005 represented in the chart. Overall, 30 of POLICY's country and regional programs were led by a Country Director. These individuals and their experiences signified a major step forward in the creation of local leadership capacity in the area of policy development. Figure 6 presents countries and regions where POLICY II carried out significant multi-year programs. Countries and regions that had Country Directors in place for a year or more over the life of the project are noted with the letter "D." (For additional information, see POLICY Project. 2005b. "POLICY II Project: Role of LTAs in Achieving POLICY Results.")

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[6] Technical Development weeks were global or regional meetings of project staff held periodically to update staff technical expertise, share experiences, develop strategic plans, foster linkages between U.S. staff and in-country staff, and improve management and administrative skills.

[7] Country Directors were defined as host-country nationals. U.S.-based staff who directed country programs were called "Country Managers." Figure 5 shows the number of Country Directors in place at a given moment during that year.

Figure 6. POLICY II COUNTRY/REGIONAL PROGRAM AND LOCAL COUNTRY DIRECTORS

Latin America and the Caribbean
Guatemala **(D)**
El Salvador **(D)**
Haiti **(D)**
Honduras **(D)**
Jamaica **(D)**
Mexico **(D)**
Peru **(D)**

(D) = Country Director ever in place

Africa
Etiopía **(D)**
Ghana **(D)**
Kenya **(D)**
Madagascar
Malawi **(D)**
Mali **(D)**
Mozambique **(D)**
Nigeria **(D)**
South Africa **(D)**
Tanzania
Uganda **(D)**
Zambia **(D)**
Zimbabwe

Europe and Eurasia
Russia
Romania **(D)**
Turkey **(D)**
Ukraine **(D)**

Regional Programs
- Mekong Regional Program
- Southern Africa Regional HIV/AIDS Program (RHAP) **(D)**
- Regional Economic Development Services Office/East and Southern Africa (REDSO/ESA)
- West Africa Regional Program (WARP)

Asia and the Near East
Bangladesh **(D)**
Cambodia **(D)**
China **(D)**
Egypt **(D)**
India **(D)**
Jordan **(D)**
Nepal **(D)**
Philippines **(D)**
Vietnam **(D)**

Besides Country Directors, POLICY country programs hired and trained local staff to support program operations in our local offices. As noted above, the project trained support staff in how to handle USAID-funded operations, administration, and finances as well as Futures Group and POLICY procedures and practices. As with the technical and management staff overseas, operations staff were key assets in country programs and many of them are continuing to contribute in the new project. As of September 2005, after several large country programs already closed out, there were 52 program operations staff serving in 21 POLICY countries.

Operations and Systems

This component includes three critical operational functions. First are the day-to-day functions of sustaining a large project including finances, administration, and program support. Second is the oversight for the preparation, quality control, and production of the main project deliverables, publications, documentation, and reporting as well as technical assistance to countries for the same. Third is the communications and information sharing that was essential to the project's good performance.

Day-to-day functions. In 1995, with program operations completely centralized in Washington, D.C., administrative and financial management support to the project was fairly straightforward. The tremendous growth in the project's scope, funding levels, and overseas staff created significant challenges in terms of program operations and systems development to support such a large and dispersed structure. To give one example, at the outset of the project, all staff were employees paid in the United States by local banks. Similarly, all offices were in the United States and leased by the Futures Group or a partner. Overseas purchases were carried out by travelers using travel advances from the United States. At the end of the project, POLICY had established and managed over 40 offices in other countries, and employed a cumulative number of at least 1,000 PSCs and consultants. The project had also made thousands of local purchases of equipment, supplies, furniture, computers, and even vehicles. This transformation was complex and time consuming as it involved setting up systems for currency transfers, establishing local bank accounts, preparing operations manuals, registering with local authorities, reviewing local labor laws, developing in-country personnel policies and procedures, determining local salary scales, designing

benefit plans including health insurance, and establishing complete offices with all utilities, telephones, internet access, transportation, computer networks, and much more. In short, to expand the POLICY Project to meet the demand, the project had replicated all aspects of the U.S.-based POLICY offices in more than 33 different country environments.

To deal with this expansion, project management strengthened program operations, put new systems in place, and added personnel to provide the necessary support. Over time, this small group of a few people in the United States initially reporting to the project deputy director grew into an established, worldwide program operations unit that had grown continuously since the first year of the project. Expanding this unit required developing standardized systems; working out a variety of financial management and reporting structures and rules with the Futures Group and its two partners; preparing guidance for hiring staff and setting salaries; establishing offices; determining administrative reporting formats; and preparing and revising various contract mechanisms such as PSCs, letter agreements, subcontracts, small grants, and more.

Besides establishing a formal program operations unit, complete with job descriptions, organizational structure, and written procedures, POLICY management led an effort to train all country directors, country project staff, and local operations staff in all project administrative and financial procedures. Box 3 shows the training modules that were used over the life of the project to train both U.S.-based and local staff. Because of the emphasis on building in-country operations capacity, by the time POLICY ended, there were operations managers in POLICY country offices that functioned at a very high level and were almost interchangeable with U.S.-based operations managers.

Box 3. Administrative Finance Training Modules
- Project structure, operations structure   - Intranet and online project databases   - Obligations (fiscal year, directive, activity)   - Charge code/general ledger numbers   - Office voucher preparation/reconciling advances   - Monthly finance reports   - Country pipeline reports   - Mission financial quarterly report   - Procurement training   - Small grants administration   - Equipment/purchase orders and cable concurrence   - Financial accountability/audit procedures   - Travel vouchers/advances/reconciliation

The establishment of the operations unit and its systems was central to POLICY's expansion and the smooth functioning of country programs. This unit and the staff who worked in it, both in the United States and overseas, helped make it possible for the project to succeed technically. One good example of how new systems supported innovative approaches is the development of the small grants mechanism. Small grants had not been used in the past for policy development work because they were thought to be too complex and costly to administer on a large scale and because policy development work had not included small, fledging NGOs in the past. Although the project's small grants program began as an experiment, it evolved into one of the important mechanisms in the project. Operations staff designed and prepared all of the procedures, manuals, tracking systems, and financial guidelines to support the small grants program. Without this support and systems development, the small grants mechanism would not have been used in the project. Box 4 provides a summary of the small grants program and shows how the small grants affected even the highest-level results of the project. (For more

Box 4. A Snapshot of the POLICY II Small Grants Mechanism
252 grants funded $1,180,543 awarded in total   - Two-thirds of POLICY countries awarded small grants   - Field-supported grants outnumbered core grants by 2 to 1   - Grant-funded activities contributed to 23 SO-level results

information on small grants, see POLICY Project. 2005c. "POLICY II Project: Small Grants…Big Impacts."

Quality Assurance. As with internal operations, the project's support in the area of quality assurance (QA) grew over time and became an essential underlying factor in POLICY's success. The QA team was responsible for reviewing, editing, publishing, and disseminating all major reports emanating from the project and for providing QA assistance as requested by project staff. With respect to country-level products that receive wide dissemination, the QA unit was critical to the project's success in many countries because it quickly and efficiently helped local staff turn out first-rate policy documents when their timely production and country-level acceptance by government officials depended on a superior product. Other responsibilities of the QA unit included the timely submission of all basic reports including semi-annual reports and project workplans, inputs to the Bureau for Global Health portfolio reviews, and other reports required by the project.

Communications. The QA team also had the responsibility for communications via the web-based technologies, websites, and listservs. As the project grew in size and complexity, project management made email and internet communications a priority for country staff. By the advent of POLICY II in 2000, all senior staff overseas had email access, and by 2005 all overseas staff on the project, including all operations staff, had email and internet surfing capacity. Through individual email and group distributions, POLICY staff kept in close contact on a variety of issues and subjects. Email also allowed the project to collect and exchange information with country staff, plan more efficiently, work jointly on technical documents, and share operational documents such as subcontracts, consultant agreements, and proposals easily at any time of the day. While project staff continued to rely on telephone, cell phone communications, and fax, the email and electronic document exchange increased efficiency several fold.

Along with the widespread use of email, POLICY was an early adopter of an international intranet. In 1996, the project established an intranet intended as an in-depth resource for all POLICY staff and consultants around the world (see Figure 7). To our knowledge, POLICY was the first centrally funded project to put an intranet in place. It quickly became a well-used and essential part of POLICY Project communications. Staff members could find just about any major document, presentation, report, publication, or model produced by the project. The intranet contains complete guidelines to program operations including procurement, travel, USAID policies and guidance, biodata sheets, and more. It also contained administrative databases of PSCs and consultants with all of the details of scope of work, duration, and critical dates such as expected renewal. Similarly, there are up-to-date databases of all subcontracts and grants as well as monthly financial reports. By project's end, there were 80,000 pages in total on the POLICY intranet, including all documents.

Figure 7. Home Page of Project Intranet

In sum, the rapid spread of email access and use, combined with the creation of the POLICY intranet, stimulated round-the-clock communications, instant document and information exchange, and immediate access to all of the project's databases, materials, and guidelines. This phenomenon, along with other key factors mentioned above, fostered a sense of community beyond just one-on-one conversations and exchanges and helped POLICY forge a strong sense of identity based on solid organizational support.

Multisectoral Engagement[8]

The concept of increasing participation in policymaking was part of the design of the POLICY I contract in 1995. This idea turned out to be prescient and, in many ways, ahead of its time. In the first months of the project, the concept was not well understood by staff. However, within the first several months of start-up, the USAID managers definitively set the project on a pathway toward incorporating multisectoral approaches into almost all aspects of the work. POLICY and its staff never looked back. This approach became a hallmark of the project and was adopted in virtually all countries where POLICY had programs. The diffusion of "multisectoralism" throughout the project was a major reason that POLICY achieved such numerous and important results.

Multisectoral approaches started out as a concept in the original design of the project. Staff working on predecessor projects had been accustomed to working in large part with the government leaders who had direct responsibility for policy decisions and the high-level political leaders who influenced them. In the pre-POLICY world, decisionmaking around FP/RH and HIV was limited to the inner circles of government and influential donors. Most often, the single government stakeholder was the Ministry of Health. There were not a lot of "best practices" in participatory approaches in USAID-assisted countries at the time to guide project staff. There were examples from other non-policy areas of FP/RH, such women's mobilization efforts.

Several key factors made it possible for the POLICY Project to succeed in expanding multisectoral approaches to policy development. First, there were increasing pressures on governments by the international community to be more inclusive in their FP/RH policymaking in the early 1990s. This trend was especially evident in the 1994 International Conference on Population and Development in Cairo (ICPD) where the Program of Action put a strong emphasis on broadening the basis of policymaking to include more representation of NGOs and other stakeholders in decisionmaking processes. The conference leadership correctly predicted that more inclusive approaches to policymaking would result in stronger, more effective policies and programs.

Besides the new emphasis on greater participation in decisionmaking fostered by the international community, the political environment in the majority of USAID-assisted countries began to improve. Table 4 shows the Freedom House rankings for some of POLICY's

Table 4. Freedom House Rankings POLICY Countries, 1980–2004				
	1990	**1995**	**2004**	
Country	**Status**	**Status**	**Status**	**Change**
Ghana	NF	PF	F	improve
India	F	PF	F	improve
Kenya	NF	NF	PF	improve
Mali	NF	F	F	improve
Mexico	PF	PF	F	improve
Nigeria	PF	NF	PF	improve
Peru	PF	PF	F	improve
South Africa	PF	F	F	improve
Ukraine	NF	PF	PF	improve

F = Free PF = Partly Free NF = Not Free
Source: www.freedomhouse.org

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[8] In this report, we consider "participatory approaches" and "multisectoral engagement" as virtually synonymous. At the outset of the project in 1995, the contract called for "participation" as a key component. As the project evolved, multisectoral approaches gained more currency and this term came into greater use.

key countries. In all cases, the levels of political freedom increased during the life of the project. There is no doubt that this trend toward democratization opened up policy processes and worked in favor of the POLICY Project and its efforts to expand participation.

POLICY staff took advantage of the USAID mandates, the impetus given by the international community, and the opening up of political processes in many countries to incorporate multisectoral approaches into almost all aspects of its work. POLICY accomplished this by enlisting several "participation" experts from one of the project's team members (CEDPA) to work with U.S.-based and field staff to introduce the new approaches. As staff and partners became more comfortable with the approach, and as they learned to be more inclusive in thinking about policy development, the concept spread throughout the project. In addition, an early success in the approach—facilitating the formation of KIDOG (The NGO Advocacy Network for Women) and supporting its actions in securing government financing for contraceptives in Turkey—showed staff members and partners the value of participatory approaches.

"Participation" in the early years of the POLICY Project most often referred to bringing representatives of beneficiaries into the policy process. This meant that the focus of participatory approaches would be NGOs. However, POLICY quickly expanded the concept of participation and multisectoral involvement to include ministries and agencies in national and state governments other than health, businesses, employers, the commercial and private medical sectors, various religious groups, as well as beneficiaries. In particular, POLICY's work extended in some countries from the national level down to the district and community levels. In short, POLICY evolved in a few short years from a project that was accustomed to dealing mostly with national policymaking entities in government to a project that also routinely involved multiple sectors, organizations, and individuals at all levels.

POLICY worked with thousands of partners, including more than 200 local subcontractors in the countries where the project operated. Many of the new partners were brought into policy development activities either at the project's instigation or because they were attracted to participate in a POLICY-sponsored activity that promoted multisectoral engagement as a fundamental method of information sharing and policy dialogue. It should also be noted that POLICY was routinely working with new partners long before this became a requirement in USAID's HIV program. Good examples of this are the Southern Africa and Nigeria programs, where as early as 2001, the project helped the Anglican Communion and the Catholic Church, respectively, to adopt HIV policies and operational strategies.

Table 5 provides illustrative examples of the types of agencies and organizations that the project partnered with during the last six years.

Table 5. Examples of POLICY's Multisectoral Partners		
Type	**Name**	**POLICY Outputs**
Government	Women's and Veterans' Affairs (Cambodia)	Adopted 3-year HIV strategic work plan for women and girls
	Pangasinan Province, Philippines	Helped establish contraceptive security
	Agra District, India	Developed action plan and expanded FP/RH program
	Ministry of Home Affairs, Nepal Police	Implemented HIV strategy and training curricula
Faith-Based	Anglican Church of Southern Africa	Created provincial HIV policy, strategy, plan, and mobilized funding
	Islamic Network for the Fight Against HIV/AIDS (Mali)	Assisted Islamic leaders to create network, formulate HIV policy, and prepare a three-year strategic plan
	Catholic Bishops Conference, India	Adopted national HIV policy, strategy, and operational plan
NGOs	Women's Network for Peace, (Guatemala)	Assured passage and implementation of Law of Social Development and Population
	Kenya Association of Positive Teachers (KENEPOTE)	Hosted first national forum of HIV-positive teachers
Mixed	National Network for the Promotion of Women (Peru)	Fostered Citizen's Surveillance Committees to assure access to FP/RH; Committees legalized by government
	National Business Council on HIV/AIDS (Mexico)	Stimulated over 20 large businesses to advocate for and adopt internal HIV policies
	Journalists Against AIDS (Nigeria)	Supported formation of award-winning media organization that is now self-sufficient

While the partners identified here helped lead the efforts to produce policy change, most of POLICY's activities involved more than the main partner. In all of the examples in Table 5, there were strong multisectoral partnerships occurring across the activity. The India district planning activity was led by the district government but included all NGOs working in that district, agencies from the state government, and representatives from the village and community governments, private medical practitioners, large employers, and faith-based organizations. The Women's Network for Peace initiative in Guatemala involved government agencies, various NGOs and community groups, and donors.

Importantly, USAID and POLICY also put a premium on collaboration with other USAID CAs and donor agencies. For example, in the India district planning case, CAs were integral parts of the workshops, presentations, planning, and eventually the implementation of the plans. Later on, donors such as the World Bank participated in district planning activities. In Nigeria, POLICY formally collaborated with eight different CAs on joint activities to support USAID's health program. By the end of the POLICY Project, increased levels of participation and multisectoral partnerships had become part and parcel of the project's programs. (For more information, see POLICY Project. 2005a. "Commitment, Cooperation, and Coordination: Lessons Learned from POLICY's Collaborative Efforts," and Feranil. 2006. "POLICY II Project: Networking for Policy Change—What Works."

The success and permanence of POLICY's work in the areas of multisectoral engagement is perhaps best typified by a report documenting the achievements of POLICY's Nigeria country program:
"Participatory processes and the inclusion of stakeholders are now seen as valuable and routine parts of the policy formulation process. Participants felt empowered by these approaches. Before this round of policy development, people didn't conceive of inviting groups that are stakeholders to join in policy

development; now they wouldn't conceive of working on a policy <u>without</u> calling them into the process" (Evans and Okoiie, 2005, p.9). [9]

Good Evidence

Since the beginning of its FP/RH assistance program more than four decades ago, USAID has placed a strong emphasis on promoting the use of accurate, up-to-date information in awareness raising, policy dialogue, and decisionmaking (and this is a tradition that has continued in the Agency's HIV policy work). In response, POLICY staff and partners relied mainly on existing data from both qualitative and quantitative research and added "value" to this information by processing it in a variety of ways, depending on the activity.[10] In some cases, however, POLICY sought to fill knowledge or evidence gaps, which was particularly important for responding to sensitive and emerging issues (e.g., gender inequality, stigma) that affect health outcomes. Throughout the project, POLICY strengthened the capacity of government officials, civil society advocates, future health sector professionals, and the private sector to collect, analyze, and use data on their own (see Box 5), thereby having a multiplier effect on the investment in evidence gathering and utilization. POLICY's "value added" with regard to good evidence falls into several categories.

Policy Analyses. Devising or reforming policies must begin with a clear understanding of the consequences of policy decisions and their impacts on services, costs, and healthcare and related systems. Policy analyses examine all types of policies and intervening factors, from national policies that set a country's goals to operational guidelines that determine how services are to be implemented on the ground. Policy analyses can include legal and policy reviews, resource needs estimations, market segmentation surveys, HIV-related human rights audits, and assessments of the national program effort, among others. These analyses provide evidence at all levels to inform policy decisionmaking and monitoring. Donors such as UNAIDS, WHO, and UNICEF, for example, use POLICY's AIDS Program Effort Index to measure progress in the HIV policy environment. Policy analyses were at the center of much of the project's work, and were often used in conjunction with other types of evidence, facilitating important policy changes.

> **Box 5. The Next Generation of Policymakers in Egypt**
>
> POLICY/Egypt worked with counterparts to ensure sustainability of evidence-based decisionmaking after the project's end. POLICY assisted the Cairo Demographic Center to design, deliver, and integrate a SPECTRUM-based FP/RH policy analysis course into its General Diploma Program and post-graduate curricula. Supported by other partners—the South-to-South Initiative, the Ford Foundation, UNFPA, and the World Bank—this course provided a lasting mechanism for training the next generation of policy specialists. Furthermore, the Minister of Higher Education added a course on population and FP/RH for institutions of higher learning for the 2004/05 academic year. Investments, such as these, in building the capacity of future policymakers will help ensure that good evidence will inform policies and strategic plans in Egypt over the long term.

- In 2003, POLICY conducted rapid facility surveys in four districts of the state of Jharkhand, **India**, where many people have no access to healthcare. Using analyses of facility data, the Health Minister and Health Secretary convinced the Chief Minister and his Cabinet to support a massive expansion in the state's health infrastructure targeted to poor rural areas. The Jharkhand

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[9] At the request of the USAID Mission, two expert consultants documented POLICY's work in Nigeria. The experts reviewed documents and policies and interviewed 74 Nigerians and ex-pats from 17 NGOs, 14 government offices, five major multilateral donors, two churches, and two universities. For more information, see Evans and Okoiie (2005).

[10] Thus, original data collection and research constituted only a small proportion of the project's overall budget.

government received an allocation of US $912 million over an eight-year period from the central government for constructing more than 1,000 new primary and community rural health centers. The Secretary has repeatedly stated publicly that this would not have happened without the facility data.

▪ POLICY published an assessment of essential safe motherhood services in northwest **Peru** in 2004. It identified several operational barriers to accessing maternal healthcare, including confusion over which pregnant women were eligible for free health services; a lack of appropriate personnel at facilities; and lack of cultural awareness by staff. Local governments and civil society groups used these findings to convince regional health directorates to redistribute staffing levels and mandate respect for local cultural practices. In the following 12 months, deliveries in maternity centers increased by 60 percent. The Ministry of Health issued a national resolution specifying new prenatal and delivery care protocols that incorporate local cultural practices and customs.

Models. POLICY's analytic simulation models are user-friendly tools that in-country staff and partners, after training, use to explore future scenarios based upon changing policies today. These models compile existing demographic, health, and socioeconomic data and produce outputs that can inform strategic planning and policymaking. For example, models such as RAPID and the AIDS Impact Model (AIM) use demographic data to project the impact of population growth or the HIV epidemic—thus demonstrating the consequences of inaction. Models such as Goals and Allocate link intervention cost data to evidence on program impact to help countries estimate the resources needed to achieve a particular outcome, such as reducing the maternal mortality ratio or reaching the most at-risk populations with HIV prevention services. Models and their manuals were regularly updated with the most recent data and research and were translated into several languages. Making the models available online for free facilitated timely, cost-effective distribution of the models, which were downloaded more 15,000 times. In many cases, the use of models highlighted resource needs or policy gaps that were subsequently addressed by policymakers.

▪ To address under-funding of the Ministry of Health's FP/RH program in **Uganda**, POLICY worked with the Reproductive Health Department to revise its national strategy using outputs from the Safe Motherhood Model Costing Component. As a result of the model's findings and a strong advocacy effort, all district health departments incorporated increased RH programs and funding in their 2004–05 annual plans. The approval of the district workplans by the Ministry of Finance ensured that RH and FP activities received funding from central government conditional and unconditional grants beginning with the 2004–05 national budget.

▪ In June 2005, during television and radio broadcasts, the Minister of Health of **Mali** declared that caesarean sections should be performed free of charge. The President of Mali subsequently signed a decree implementing this important policy change. The minister's action came about after seeing a RAPID presentation highlighting data on maternal mortality in the country.

▪ In **Nigeria**, Evans and Okoiie (2005) observed that, *"Data developed by POLICY were instrumental in policy decisions at the highest political levels. The data came from surveys and studies, models such as RAPID and the AIDS Impact Model (AIM), and situation analyses. Perhaps the best example is the convincing presentation on the HIV/AIDS situation in Nigeria, based on the AIM, that was made to the president. This was the impetus for a major shift in both the official and public national perspective on HIV/AIDS. Other things have followed as a consequence of the president's directive, such as the formation of NACA* [National Action Committee on HIV/AIDS]*, programs for HIV/AIDS, and funding by donors for HIV/AIDS programs"* (p.xv).

Policy Advocacy and Development Tools. Aside from computer models, POLICY designed a range of well-tested tools and approaches to facilitate policy advocacy and development processes (see Box 6 for examples). With these tools, the users apply the techniques described to their own country or program. The outcome of the exercise may be a situational analysis that informs policy decisions, an advocacy campaign that promotes needed policy responses, or the creation of an actual policy or strategic plan. Some illustrative examples include:

- *Networking for Policy Change: An Advocacy Training Manual* (POLICY Project, 1999) was a key resource in the project's efforts to strengthen the voice of civil society. Over the life of POLICY II, the project formed, strengthened, or expanded more than 100 advocacy networks. The multiplier effect of investing in tools and training was particularly evident in **Russia**, which was still in a nascent stage of citizen participation and democratization. Following a training-of-trainers (TOT) advocacy workshop, the 18 participants went on to deliver nearly 110 workshops and train 2,600 people in FP/RH network building and advocacy.

> ### Box 6. Policy Tools, Manuals, and Approaches
>
> POLICY II developed more than 20 tools, manuals, and indices to facilitate policy advocacy and development. Some of the key new tools included:
>
> - HIV/AIDS and Gender Training: A Toolkit for Policy and Senior-level Decisionmakers
> - Maternal and Neonatal Program Effort Index
> - SPARHCS: Strategic Pathways to Reproductive Health Commodity Security (with USAID, CMS and DELIVER)
> - Strategic Planning for the Reproductive Health and Population Sector: Training Module
> - Strengthening Family Planning Policies and Programs in Developing Countries: An Advocacy Toolkit
> - Workplace Policy Builder

- Using the SPARHCS—Strategic Pathways for Reproductive Health Commodity Security—framework, **Madagascar** averted a contraceptive commodities shortfall. Following the SPARHCS assessment, POLICY prepared a presentation showing the cost-benefit of providing family planning in reducing future costs for educational and immunization services. POLICY and its partners also showed that a 1.5 to 2 percent increase per year in contraceptive prevalence could be achieved with a good program strategy and adequate financing. As a result, the World Bank revised its contraceptive prevalence goal for the country and the Ministry of Health confirmed the World Bank's financial contribution of the Bank to purchase contraceptives for FY2004.

- The Workplace Policy Builder software program helps employers design HIV company-specific policies based on international best practices. In **Mexico**, in 2005, POLICY provided technical assistance to the National Business Coalition on HIV/AIDS and IMPULSO, an HIV-positive network that provides sensitization training to the coalition, in applying the Workplace Policy Builder. As a result, 130,000 Mexican workers of the nearly 30 coalition member organizations are covered by HIV-specific workplace policies.

Policy Implementation Guidelines, Compendia, and Reference Materials. POLICY and its partners have often compiled evidence and best practices to prepare guidelines and other reference materials to facilitate the implementation of policy directives and programs. In many cases, the materials were developed in conjunction with in-country ministries and local organizations to help guide their daily work. Some examples include:

- Guidelines for Male Involvement in Reproductive Health (Cambodia)
- Managing HIV/AIDS in the Workplace: A Guide for Government Departments (South Africa)
- National Home-based Care Program and Service Guidelines (Kenya)
- What Works: A Policy and Program Guide to the Evidence: Module 1: Safe Motherhood
- Challenging, Changing, and Mobilizing: A Guide to PLHIV Involvement in Country Coordinating Mechanisms

Research. As needs and opportunities arose, POLICY sought to fill in knowledge gaps to improve policy and program responses, either through modeling or original qualitative and quantitative research. For example, it was the resource needs estimation work of POLICY staff and others[11] that U.N. Secretary General Kofi Annan used to support the call for a $10 billion fund to combat HIV and other diseases in 2001, and which eventually became the Global Fund to Fight AIDS, Tuberculosis and Malaria. Having reliable information and analyses readily available was critical in helping policymakers address issues that are culturally sensitive and/or where little was known about best practices, as the examples below show.

- Inheritance and property rights in **Kenya** leave recently widowed women increasingly without resources following the loss of their husbands due to AIDS. A POLICY situation analysis revealed that women and orphans rarely benefit from legitimate inheritance and property rights, either through the courts or traditional law systems. Using this evidence, the project brought women and village elders together to discuss experiences and human rights. Women's groups then successfully advocated for changes in community and legal practices. In 2005, for example, the Luo Council of Elders in Nyanza had resettled over 20 women and their children back on their family lands.

- Stigma is a barrier to improved service access and quality, yet program planners have been unsure about what stigma *actually is* and, even further, have not had the tools to assess whether efforts to address stigma and discrimination are effective. Based on fieldwork in **South Africa** and **Mexico**, POLICY led a multisectoral process to define stigma, including internal stigma and discrimination, and assess impacts. The project developed indicators and an index that now helps program managers conduct baseline surveys of stigma and measure progress toward reducing stigma and discrimination over time.

Measuring Achievement

A project that knows where it is going and what it wants to achieve has a much better chance of success. POLICY was fortunate not only that USAID had a clear idea of what it wanted the project to accomplish, but it also mandated that the project adopt a strategic framework methodology for measuring project performance. USAID set specific end-of-project targets that emanated from the strategic framework. Using the framework, project management set about in POLICY I to specify well-defined indicators for the SO as well as the IRs, or sub-results. USAID revised POLICY's strategic framework in 2000. In this manner, every major element of the project had pre-defined and mutually agreed upon indicators covering a range of policy outputs at various levels of the policy environment. POLICY, therefore, could use the strategic framework and indicators as a general guide for developing and implementing its program strategies.

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[11] Schwartländer, B., J. Stover, N. Walker, L. Bollinger, J.P. Gutierrez, W. McGreevey, M. Opuni, S. Forsythe, L. Kumaranayake, C. Watts, and S. Bertozzi. 2001. "Resource Needs for HIV/AIDS." *Science 292*: 2434–2436.

Through the periodic negotiation of performance monitoring criteria and end-of-project targets—both of which overlay the project's strategic framework—USAID was able to put emphasis on certain technical areas and specific policy outputs it desired to support the overall USAID program.[12] In this manner, the emphases of the project were shifted slightly over time. Together, the strategic framework, indicators, and the negotiated performance monitoring criteria helped set the direction and focus for the project's activities.

The challenges of translating the strategic framework into everyday staff activities were significant. At the outset, project staff were not familiar with results frameworks as an objective-setting and monitoring mechanism. Plus, the various indicators, their meaning, and their measurement were seen as complex and sometimes daunting. In addition, monitoring and evaluation information and procedures had to be made intelligible to worldwide staff from different cultural and socioeconomic backgrounds. To ensure that the strategic framework, indicators, and documentation requirements were fully used by staff, POLICY prepared reference, training and presentation materials, and designed a sortable database to record and analyze results. Thus, for the last five years of the project, staff operated with a comprehensive performance monitoring plan and the guidance and support to make it function as intended.

All staff were trained and given refreshers courses in POLICY's performance monitoring systems, which was a considerable task. The training in POLICY's M&E systems occurred during Technical Development weeks, regional meetings, specialized trainings, and orientations for new staff in the United States and in-country, and during myriad TDYs carried out by POLICY technical and operations staff over the years.

Another challenge apart from POLICY's own strategic framework and indicators was how to conceptualize and operationalize a strategic framework that could serve both the Bureau for Global Health and USAID Missions abroad. It was critical to be able to show Missions how POLICY's work contributed to their own objectives. POLICY staff worked out an integrated model in 1997 that became the standard for the project until 2006. It was subsequently adopted by Task Order 1 of the Health Policy Initiative. The model is depicted in Figure 7.

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[12] In concordance with the POLICY II contract, GH/PRH/PEC periodically set performance criteria in six areas that the project was expected to achieve. These six areas were: results, quality, timeliness, management, cost control, and collaboration. A Performance Evaluation Board independently reviewed the project's performance against the criteria set for each period.

Figure 7. Coordination of Policy Results at the Country and Project Levels
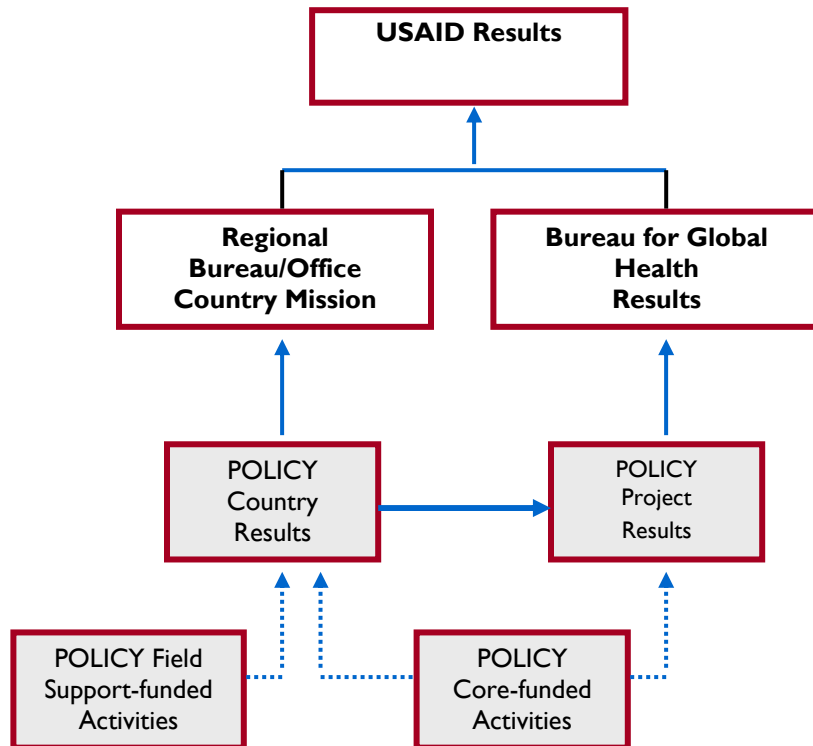
The model clearly linked project, the Bureau for Global Health, and Mission strategic objectives and indicators in a way that helped all stakeholders to understand how POLICY fit into a Mission's program. In one of POLICY's management reviews in July 1999, the six-person team summed up the utility and effectiveness of the project's results framework in the following manner:

"POLICY's results framework is its fourth legacy. This framework broke new ground in two ways: first, it defined and clarified specific policy objectives that can be achieved and measured, a particularly difficult task because policy activities deal with process outputs rather than with more tangible outputs. And, second, the POLICY framework provides a useful model for resolving the tensions that often arise for projects that must meet both Mission objectives and overall sectoral objectives as defined by AID/Washington. The Project's CTOs should make the framework better known in the PHN Center as one model for dealing simultaneously with Mission/AID Washington objectives. Overall, the development and use of the results framework helps the Project focus on the 'so what?' question and injects more rigor into the evaluation process."

Summary of the Project Model

In the sections above, we examined in some detail the project's main components, their purposes, and how they functioned. These components did not function independently but rather were integrated both in the United States and in countries to produce remarkable impacts on the policy environments of many POLICY countries. This is a case of the whole being much larger than the sum of the parts.

Simply stated, when the various components of the POLICY Project came together, they created synergies beyond most expectations. Building on the foundation of two decades of policy development programs largely based in the United States, in 1995, POLICY embarked on a pathway that would dramatically shift the majority of program work to countries while at the same time strengthening the centralized management and operations systems to support a highly decentralized project. Technical leadership remained in the United States through the project's core-funded programs, while project management emphasized and promoted the linkages between U.S. staff and local POLICY staff in the execution of both core and field support-funded activities. To sustain the new global structure, the project put a premium on evidence-based analyses, established a rigorous project monitoring plan, and developed highly effective quality assurance and program operations units. The interactions of these components, which occurred thousands of times over the 11-year period, seemed to energize and stimulate staff, and drive them to yet higher levels of achievement. In fact, there was a special spirit and energy borne out of these interactions that was once called "magical" by the project's principal CTO and similarly referred to by other knowledgeable observers. Indeed, to most close observers, the whole of POLICY's work was indeed much greater than the sum of the parts.

To conclude this section, we offer a snapshot of the POLICY Project in its first year and in its last year. Table 6 provides some key indicators that show how the project changed its structure and character over the life of the project. These transformations were largely due to the evolution of the project model and the

Table 6. POLICY Project Evolution, 1995–2005	
1995	**2005**
▪ Entirely located in the U.S. ▪ 98% U.S.-based staff ▪ 43 staff members ▪ $4 million in annual field support ▪ 19 country programs; 4 are core-funded ▪ No overseas offices	▪ Mostly located in the countries ▪ 23% U.S.-based, 77% overseas ▪ 313 staff members (July) ▪ $30+ million in annual field support ▪ 33 country programs, 4 regional programs ▪ 41 overseas offices

implementation of the seven components. These components, in turn, galvanized the project's vision of establishing sustainable local capacity while simultaneously improving the FP/RH, HIV, and maternal health policy environment for millions of people.

The POLICY Model in Nigeria

To illustrate how the model functioned at the country level, we provide here a brief analysis of the project's program in Nigeria. All of the model's components came together in the country to change the policy environment for FP/RH, HIV, and child survival in just a few years.

Country Focus. When Nigeria returned to civilian rule in 1999, POLICY was one of the first projects to respond to USAID's effort to resume foreign assistance activities in the country. Recognizing the need to foster close ties with the new civilian government to devise health policies that were responsive to local needs, POLICY moved quickly to establish an in-country presence. POLICY set up a country office and hired qualified local staff within six months of USAID's re-entry into Nigeria. POLICY also charted new territory as the first CA to work directly with the new government.

Local Capacity. POLICY's first action was to hire Dr. Jerome Mafeni (who literally worked out of his car until the project office was established). By the high-point of the project in 2004, POLICY employed 12 staff members and had 17 local expert consultants routinely carrying out project activities. Overall, POLICY/Nigeria employed 51 staff members and consultants. POLICY provided staff with technical and

managerial training; they, in turn, worked directly with and trained scores of local government and NGO staff. Many of these staff continue to work on health and development issues in Nigeria today.

Decentralization. Once the project office was established, POLICY began the process of devolving technical responsibilities for program design, implementation, and management to the local staff. All aspects of the program—from annual workplans to daily technical activities to tracking results—occurred at the country level. Within just a few years, Dr. Mafeni, as Country Director, had full oversight of the program. U.S.-based advisors worked closely with local staff to provide technical assistance as needed.

Operations and Systems. The POLICY/Nigeria staff and office were fully integrated into the project's worldwide systems through the internet, project intranet and databases, email, telephone, and weekly mail pouches. As such, POLICY/Nigeria used all headquarters systems to manage and monitor its operations. The country office had also an Administrative Officer to oversee operations, finance, and administration. These systems facilitated decentralization to the country level, increased communications capacity, and hastened the transfer of authority to the Country Director because technical and operational assistance could be easily and quickly provided at a distance.

Multisectoral Engagement. POLICY expanded the range of participants in FP/RH and HIV policymaking. POLICY mobilized government ministries and departments (e.g., Defense, Internal Affairs, and Labor) that were not traditionally involved in health policymaking. The project also facilitated formation of new NGO networks—such as the Nigerian Network for Population and Reproductive Health and Journalists Against AIDS—and brought major religious groups into national and state policy dialogue and policymaking (see Box 7).

> **Box 7. Some NGO Partners**
>
> - Journalists Against AIDS
> - Women's Health and Action Research Center
> - Center for the Right to Health
> - Life-Link Organization
> - Network of People Living with HIV/AIDS in Nigeria
> - AIDS Alliance in Nigeria

Good Evidence. Because Nigeria was emerging from a long period of military rule, POLICY and its partners faced a paucity of information essential for good policymaking. Thus, the collection, analysis, and use of data and original research were vital to Nigeria's progress in national health policymaking. POLICY supported 14 surveys and research studies covering a variety of health areas, such as attitudes and practices of military personnel regarding HIV; analysis of FP/RH surveys; sentinel surveillance studies for HIV; state and national estimates of the number of orphans and vulnerable children (OVC); and various policy impact analyses. All POLICY work in Nigeria was guided by up-to-date, accurate information, which is a hallmark of effective policy development.

Measuring Achievement. By demonstrating the importance of policy work to the Mission's overall goals, POLICY/Nigeria was successful in encouraging the Mission to expand its strategic framework by adding a policy component: SO4 or *Increased use of sustainable and effective FP, HIV/AIDS, and child survival services within a supportive policy environment*. Furthermore, POLICY's strength in clearly designing and adapting its program objectives and approaches, coupled with regular collection and analysis of results, played a key role in the project's effectiveness.

Results and Impact. By working in various technical areas, collaborating with numerous local and international partners, being responsive to stakeholders' needs, and consistently producing high-quality products, POLICY/Nigeria achieved 58 results over a five-year period. Table 7 presents some notable policy examples where the project played a critical role.

Table 7. Examples of SO Results in Nigeria, 2000–2004	
Policy Outputs	**Primary Partners**
National Population Policy	National Population Commission
National HIV/AIDS Policy	National Action Committee on HIV/AIDS
HIV/AIDS Emergency Action Plan	Office of the President of Nigeria
Armed Forces HIV/AIDS Policy	Ministry of Defense; Armed Forces Program on AIDS Control
National Action Plan on Nutrition	National Planning Commission
National RH Plan of Action; Contraceptive Security Plan	Federal Ministry of Health
Catholic Church HIV/AIDS Policy	Catholic Church of Nigeria
Church of Nigeria HIV/AIDS Policy	Church of Nigeria – Anglican
Edo State Young Adult and Adolescent RH Strategic Plan	Young Adult and Adolescent Reproductive Health Network; Women's Health and Action Research Center
OVC Plan of Action	Federal Ministry of Women's Affairs
HIV/AIDS Policy of the Federal Ministry of Education	Federal Ministry of Education
HIV/AIDS Policy of the Federal Ministry of Internal Affairs	Federal Ministry of Internal Affairs
National Strategic Framework and Plan of Action for Child Survival	Federal Ministry of Health

POLICY's legacy in Nigeria goes beyond the policies and activities outlined above. For example, a new USAID Mission-funded project called ENHANSE continues to support policy development activities and new results have already been achieved in the country. The new project employs many of the staff that worked on POLICY.

The involvement of new stakeholders, including religious groups, the military, NGOs, and different parts of government, is another important legacy. POLICY routinely included stakeholders outside the government, for example, in the development of the HIV/AIDS policy and the HIV/AIDS Emergency Action Plan. As a result, the public sector is increasingly including civil society as part of the policy process.

POLICY also increased the influence of USAID health programs. In addition to changing the government's position on HIV/AIDS in Nigeria, Evans and Okoiie (2005) noted: "*POLICY's involvement in policy aspects of child survival expanded USAID's visibility and recognition as a significant donor in the eyes of the Nigerian government*" (p. xiii).

POLICY's success in Nigeria is just one of many examples where the key components of the project model came together to facilitate high-quality, flexible, responsive, effective technical assistance activities that enhanced the country's health policy environment. In the next section of this report, we look at other notable examples of country level and global achievements.

In this section, we present examples of significant results. As noted earlier, there were more than 1,000 results during the last 11 years of POLICY, and it would be impossible to characterize all of them here. Rather, we will focus on six key results areas and endeavor to provide brief illustrations of what the project achieved in each of the technical areas. The six results areas covered here are:

- More and better policies supported FP/RH, HIV, and maternal health programs
- Stronger high-level commitment and broad-based support for FP/RH, HIV, and maternal health policies and programs
- More resources devoted to services, and resource decisions based on principles of efficiency and equity
- Policymakers better able to integrate gender in policy and program decisions
- Human rights advanced and stigma and discrimination reduced
- Policies and programs met the needs of youth and OVC

The first three technical areas are the main results areas associated with the project's strategic objective and intermediate results. The last three areas focus on the three main cross-cutting issues of the POLICY II Project—gender, human rights, and adolescents.

Each section below starts with a quantitative accounting of the results pertaining to the technical area, and then provides examples. In all of the examples, the POLICY Project played a key supportive role in the lead-up and final approval of the policy described. More details on the project's specific contributions to the results are available in POLICY's semi-annual reports. (See also POLICY Project. 2006b. *Policy, People, Practice: Enabling Local Responses to a Global Pandemic*.)

1. More and better policies supported FP/RH, HIV, and maternal health programs

Highlights

- ✓ 9 laws enacted in 8 countries for FP/RH, HIV/AIDS, social development, and women's rights
- ✓ 14 national FP/RH policies, strategies, or plans adopted in 9 countries
- ✓ 9 national HIV policies, strategies, or plans adopted in 5 countries
- ✓ 4 maternal health policies or programs in 4 countries
- ✓ 17 [13 RH and 4 HIV] subnational, regional, or local plans adopted in 7 countries and REDSO/ESA
- ✓ 20 operational policies[13] adopted in 7 countries
- ✓ 16 policies, plans, or guidelines adopted by faith-based organizations including Catholic, Anglican, Presbyterian, Muslim, and other faiths in 6 countries and the Southern Africa region
- ✓ 29 sectoral policies on issues such as orphans and vulnerable children, voluntary counseling and testing, antiretrovirals, home-based care, education, social services, nutrition, gender, and armed forces adopted in 12 countries
- ✓ 6 policies, strategies, or plans related to contraceptive security approved in 5 countries
- ✓ 6 HIV workplace policies adopted in 3 countries

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[13] Operational policies are the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services (see Cross et al., 2001).

Central elements of an enabling policy environment are the policies, strategic plans, laws, legislation, operational guidelines, and norms that guide programs and the provision of services. These policies and guidelines can determine everything from the national strategy and plan for FP/RH to the rights of patients with regard to HIV testing and disclosure, to the hours when staff will be posted at rural health facilities to provide emergency obstetric care. Appropriate policies and plans are the starting place for accessible, high-quality healthcare and services. Between 2000 and 2005 POLICY facilitated the adoption of 140 FP/RH, HIV, and maternal health policies, plans, and guidelines—from the national to the community levels—in 34 countries.

Governments designed and adopted national policies, plans, and laws

POLICY efforts resulted in the development and adoption of many national-level FP/RH and HIV policies and strategic plans. For example, POLICY contributed to the creation of a "model law" that Francophone countries used extensively to formulate their own reproductive health laws (see Box 8). **Egypt's** Ministry of Health and Population (MOHP) approved its first ever *National Strategic Plan of Population and Family Planning, 2002–2017* with POLICY support. The plan guides MOHP's future interventions, as well as its relationship with donors and the government for funding FP/RH activities. The Ministerial Council of **Jordan** approved the *Reproductive Health Action Plan* in February 2004, which outlines a five-year strategy designed to help Jordan meet the goals set out in the *National Population Strategy*. POLICY helped in the preparation of both of these documents. These national policies and plans serve as important guidelines for governments to establish or revise national FP/RH goals and provide directions for achieving those goals.

> **Box 8. WEST AFRICA | Six governments enact reproductive health legislation**
>
> Francophone African countries have historically not placed much emphasis on reproductive health nor have they revised outdated laws that hinder FP/RH in the region. In 1999, POLICY collaborated with the Forum of African-Arab Parliamentarians for Population and Development to conduct a workshop with parliamentarians to address this lack of attention. The workshop resulted in a "model law" that serves as a guide for countries to implement the ICPD Program of Action. Between 2000 and 2005, six governments—Benin, Burkina Faso, Chad, Guinea, Mali, and Senegal—used the model law to revise and enact FP/RH laws in their countries. Parliamentarians also produced a *Guide on Legal-Regulatory Reform in Francophone Africa* that will assist other countries in the region in drafting or revising their own legislation. These POLICY-assisted methodologies and tools are important resources for African countries embarking on improving their FP/RH policies. More important, these policy breakthroughs in West Africa are the result of the leadership and activities of parliamentarians, who counteracted years of government inaction in addressing the urgent need for major FP/RH legal reform in the region.

Efforts in national HIV policy formulation have been equally successful. For example, **Peru's** revised HIV law is now more responsive to the needs and rights of people living with HIV. POLICY worked with a local NGO, *Colectivo por la Vida*, to raise awareness among policymakers about the need for an amendment to this law. As a result of the NGO's advocacy efforts, Congress passed an amendment that provides provisions for free services and medication for people living with HIV, guidelines for pre- and post-test counseling, rehabilitation, and support for social integration.

In **Malawi**, the POLICY Project was instrumental in the preparation and adoption of the country's first *National HIV/AIDS Policy* in 2002. Not only did the project facilitate the participation of the main network of persons living with HIV (MANET+) on the policymaking committee, but POLICY's technical staff also provided support to the policy's development at every step in the process. POLICY's senior technical advisor, Rita Chilongozi, assisted in the design of the district community consultation process, and provided policy orientations to MANET+ support groups and the Health Equity Network (made up of

health-related NGOs), and served as a member of the policy drafting team.[14] Chilongozi also provided technical input on the organization and content of the draft policy, coordinated stakeholder input, and organized policy review forums involving the Multisectoral Policy Advisory Committee, and the parliamentary committees and in facilitating forum sessions.

POLICY also assisted countries in preparing and adopting maternal health policies and programs. In **Haiti**, POLICY collaborated with a Ministry of Health (MOH) steering committee to design the national strategic plan for reducing maternity mortality. Since May 2003, the MOH has been using the *Plan National de Réduction de la Mortalité Maternelle* as its blueprint for implementing activities to reduce maternal mortality over the next five years.

For more than four decades, the family planning programs of all states in **India** functioned under a single broadly defined national population policy. In 1997, POLICY began assisting state governments to create their own state-specific policies and strategic plans (see Box 9). One example was the new state of Uttaranchal, which adopted a comprehensive integrated health and population policy in 2002. POLICY played the central role in the state's decision to prepare an integrated policy, and helped state agencies use participatory processes to support a variety of multisectoral activities leading up to its adoption by state authorities.

> **Box 9. INDIA | State Policies**
>
> - Andhra Pradesh State Population Policy (1997)
> - Population Policy of Rajasthan (1999)
> - Madhya Pradesh Population Policy (January 2000)
> - Uttar Pradesh Population Policy (July 2000)
> - Health and Population Policy of Uttaranchal (2002)
> - Population and Reproductive & Child Health Policy of Jharkhand (2004)
> - Jharkhand State Health Policy (2004)
> - Jharkhand State Drug Policy (2004)

These policies spanned a period of eight years and on each new occasion of a state policy, the quality of the contents and strategic framework improved. State began to take more comprehensive approaches to their health programs as they experienced more ownership and empowerment during the processes of policy development. Scholars recently observed that these policies have had a major and positive impact on FP/RH in India: *"Rayappa and colleagues have argued that by formulating a state population policy the states have shifted their roles from the passive implementation of the central policy to committed active planners of their own population prospects and implementers of such plans. Some of the states have put forth a number of innovations in the approaches and have firmly committed additional resources in spite of the resource crunch experienced by such states."*[15]

Policies addressed different sectors and HIV-related issues (e.g., workplace policies, OVC, VCT, ARVs, police, military, FBOs, women and children, and education policies)

While national policies are critical to establishing an overarching framework for FP/RH, HIV, and maternal health programs, these broad policies are often only a first step. National policies are translated into programs by the adoption of a range of lower-level policies involving many sectors and civil society groups. To assist in translating these policies into specific actions, POLICY worked with public, private, and faith-based partners to establish policies and plans that provide guidance directing a response in specific areas. In **Peru**, POLICY helped update the *Childhood Feeding Regulations*, which encouraged

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[14] Chilongozi was subsequently appointed as Country Director of POLICY's Malawi country program.
[15] Reddy, M. Ramakrishna. 2005. "Integrating Population into Development: Emergence of State Population Policies in India." Presented at International Union for the Scientific Study of Population XXV International Population Conference, Tours, France, July 18–23, 2005 (p. 16).

breastfeeding and better regulated the distribution of breastmilk substitutes. This regulation is a significant milestone in protecting breastfeeding, and signaled a major advance in the struggle to formulate policies that benefit both maternal and reproductive health.

The project was a leader in supporting the development and adoption of HIV policies and strategies by faith-based organizations. In **Southern Africa,** POLICY worked with the Anglican Communion to prepare and adopt a church HIV policy, and to design a comprehensive strategic plan that was implemented in 23 dioceses. POLICY also helped private businesses and industries establish workplace policies. Using the Workplace Policy Builder software, POLICY facilitated the formulation of workplace policies in **China**, **Ethiopia**, **Ghana**, **Mexico**, **Namibia**, **South Africa**, and **Zambia** for industrial and manufacturing firms. By establishing on-site HIV prevention programs and codes of conduct within the workplace, companies are able to reduce stigma and discrimination, encourage voluntary counseling and testing, and increase retention among employees.

In **Nigeria,** the project not only trained the military in HIV advocacy, but it also helped the Federal Ministry of Defense prepare a white paper on HIV that resulted in the adoption of an Armed Forces HIV/AIDS Policy. In September 2001, **Kenya's** Minister of Public Health signed and issued the National Condom Policy and Strategy for 2001–2005. The goal of this policy and strategy was to improve access to condoms by sexually active people, at affordable prices and through effective and responsive service delivery systems. It described the roles and responsibilities for several government entities, NGOs, the private sector, and international organizations for the provision of condoms, and also guaranteed free provision to the poor, youth, and other specified groups. POLICY supported all aspects of this multisectoral effort over the two-year period.

Governments and institutions enacted guidelines to improve programs and services

Given the considerable barriers to public sector healthcare delivery including a lack of financial, human, and infrastructure resources, good national and sectoral policies can be difficult to implement. By assisting in the development of operational policies and plans, POLICY enhanced the quality and implementation of programs through more efficient use of existing resources, ensuring adequate staff, and setting standards for care. For example, in **Kenya**, POLICY worked for two years with the National AIDS Control Council's Home-based Care Technical Working Group. The result was the *National Home-based Care Policy Guidelines* and the *National Home-based Care Programme and Service Guidelines*—which the MOH adopted in 2002.

In **Peru's** health sector, access to medicines and drugs has long been a major problem. With funding and technical assistance from POLICY, the NGO Acción Internacional para la Salud conducted extensive advocacy and policy dialogue, culminating with the passage of the *National Drug Policy*. The MOH approved the policy and its guidelines that guarantee access to medicines. The policy and guidelines have expanded access to high-quality and affordable essential medicines primarily for people living with HIV and chronic diseases.

Psychosocial support for people living with and/or affected by HIV has been identified as a crucial element to a comprehensive approach to the management of HIV and AIDS in **South Africa**. Support groups for people living with and/or affected by HIV have also been identified as an important part of a broader campaign aimed at responding to and supporting people who face the personal challenge of HIV in their homes, workplaces, and communities. In 2004, the Strategic Management Team of the National Department of Health approved and adopted the draft *Guidelines for Support Groups for People Living with and/or Affected by HIV and AIDS*. The guidelines are used as a resource in both the public health sector and within community-based organizations. The importance of providing appropriate support to

those living with HIV is particularly significant in light of scale-up of the national ARV program in South Africa.

2. Stronger high-level commitment and broad-based support for FP/RH, HIV, and maternal health policies and programs

Highlights

- ✓ 9 countries reported increased high-level political commitment to address FP/RH, HIV, and maternal health
- ✓ 101 FP/RH and HIV-related advocacy networks, coalitions, or groups formed, strengthened, or expanded
- ✓ Religious leaders in 8 countries addressed FP/RH or HIV issues within their ministries

POLICY worked with government leadership and civil society groups to strengthen commitment to effective policy responses—including raising awareness of decisionmakers, influencing community attitudes, marshalling resources, and improving understanding of FP/RH, HIV, and maternal health issues. In doing so, POLICY's work has encouraged more leaders to speak out on these issues, facilitated formation of partnerships for addressing critical policy needs, and expanded the number and types of groups involved in FP/RH, HIV, and maternal health policymaking.

Government leaders demonstrated greater commitment for reproductive health and HIV issues

Government leaders influence the development and implementation of all policies including laws, legislation, and strategic plans. They are also well placed to promote open community dialogue on sensitive issues, such as HIV stigma and gender-based violence. Commitment from across the spectrum of government and political leaders is essential for ensuring long-term local capacity and sustainability of policy development. POLICY collaborated with a range of political government leaders, including heads of state, ministry officials, district representatives, parliamentarians, and political parties. In 2005, in the face of waning political support for FP/RH, **Uganda's** Minister of State for Health (General Duties) launched the *Family Planning Advocacy Strategy*, for which the MOH adopted a five-year strategy and one-year workplan. To implement the strategy locally, district population officers successfully advocated for increased resources for reproductive and maternal health activities in their districts. In **Madagascar**, greater commitment by the national government led to the inclusion of a budget line item for family planning and restructuring of the MOH. In 2004, the ministry was renamed as the Ministry of Health and Family Planning, with two new General Directorates. In other countries, stakeholders within government, supported by POLICY, mobilized to influence their peers—resulting, for example, in the creation of the Parliamentary Network on Repositioning of FP/RH in **Kenya** and the **Tanzania** Parliamentarians AIDS Coalition.

Groups joined together to promote policy change

Through networks and coalitions, POLICY has helped civil society groups increase their collective influence and target a range of issues, including HIV, adolescent reproductive health, improved access for the poor, and safe motherhood. Examples include reproductive health advocacy networks in **Peru, Russia, Uganda,** and **Ukraine**, and the multisectoral citizens groups for combating HIV in **Mexico**. Civil society groups can encourage increased political commitment and achieve greater policy results by working together with government than by operating in isolation. Government-civil society interactions

led to significant policy breakthroughs, including the adoption of the *National Adolescent Health Policy* by **Uganda's** Ministry of Health in 2004 (see Box 10).

Box 10. UGANDA | Advocacy network facilitates adoption of Adolescent Health Policy

With assistance from POLICY, civil society organizations formed the Uganda Reproductive Health Advocacy Network (URHAN) in 2000/01. The network identified the lack of youth-friendly reproductive health services as its advocacy issue and developed a plan to make this issue a government priority. URHAN members met continuously with health officials and maintained pressure through many face-to-face advocacy efforts. In January 2004, a key ally in the ministry's reproductive health unit formed a committee, which included representatives from URHAN, to review and revise a new draft policy. To strengthen its advocacy efforts, URHAN surveyed middle managers in key ministries to determine how the lack of an approved national adolescent health policy was affecting the public sector's ability to carry out youth-focused programs. Following URHAN advocacy, Uganda approved its first comprehensive National Adolescent Health Policy in October 2004.

New and diverse voices became integral partners in policymaking

The project expanded policy development in many countries to include groups and individuals who have not traditionally been involved in reproductive health and HIV policymaking. By strengthening the skills of HIV-positive networks, women's groups, and youth advocates, POLICY has helped those affected by policies participate in policy dialogue. POLICY was especially effective at bringing faith-based organizations into the policy dialogue process in many countries. Religious leaders can encourage increasing age at marriage, delay of sexual debut, and birth spacing, and can promote girls' education as well as support compassionate care for people living with HIV (see Box 11). POLICY also expanded policy work with other sectors. Business organizations such as the Confederation of Trade Unions in **Ethiopia** and the *Consejo Nacional Empresarial sobre SIDA* in **Mexico** are adopting HIV policies and implementing campaigns to reduce HIV-related discrimination in the workplace, while media watchdog groups, such as the *Alianza de Portavoces* in **Honduras**, are challenging stereotypes surrounding HIV.

In the **Ukraine,** the Ukrainian Reproductive Health Network (URHN) plays an active role in the country's FP/RH program. POLICY was instrumental in the founding of this network and in supporting its development and growth to become a self-sustaining organization. The member organizations and agencies of the URHN include 26 diverse groups, such as NGOs and agencies representing and advocating for children, women, physicians, persons living with HIV, injecting drug users, voters, equal opportunity for women, better health, and safe motherhood. Since its founding in 2000, URHN has been involved in all major deliberations and policymaking affecting reproductive health in the country. Thanks to URHN and its position today in Ukrainian policymaking, there is real multisectoral engagement around reproductive health.

Box 11. MALI | Islamic leaders tackle FP/RH and HIV issues

Prior to 2005, there had been no organized, structured, and planned effort by Islamic leaders in Mali to meet the FP/RH or HIV needs of their communities. As a result of POLICY's technical assistance, the Muslim Supreme Council created two national networks of Islamic leaders and issued policy documents on Islam's position on various FP/RH and HIV issues. For example, the FP/RH policy document specifies that religious leaders favor birth spacing among couples, using modern contraceptive methods, and promoting girls' education. In response, Islamic leaders have organized public meetings on FP/RH using a presentation on Islam and family planning produced with POLICY support. The policy document for the National Islamic Network on the Fight Against AIDS outlines the network's vision on care for people living with HIV and guidance on other HIV issues. The network has also adopted a three-year action plan that includes care and support activities.

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3. More resources devoted to services and resource decisions based on principles of efficiency and equity

Highlights

- ✓ 22 countries mobilize $100 million in increased funding for FP/RH, HIV, and maternal health programs[16]
- ✓ 3 countries introduce innovative new financing mechanisms for FP/RH services
- ✓ 4 countries develop guidelines or mechanisms for efficient and/or equitable resource allocation
- ✓ 7 countries adopt measures that encourage efficient and/or equitable resource allocation
- ✓ 5 countries reduce or eliminate barriers to private sector participation in FP/RH services

POLICY worked with a range of ministries (e.g., health, finance, education, women's affairs, and defense, among others), and civil society groups to ensure the availability of funding for FP/RH, HIV, and maternal health services and commodities. POLICY's programs helped decisionmakers understand the far-reaching benefits of basic health services for women's health, poverty alleviation, and economic development. Advocacy efforts backed by these arguments, sound information on financial realities and requirements, and clear articulations of funding options encouraged governments to not only increase public sector budget allocations to FP/RH, HIV, and maternal health but also to introduce diverse financing mechanisms that alleviate the burden on the poor and on the public sector. POLICY's assistance in strategic planning and data analysis facilitated resource mobilization, improved resource allocation toward more cost-effective interventions, and ensured that public sector programs serve the neediest clients.

National governments increased budgets for FP/RH, HIV, and maternal health

Confronted with competing demands, both within and outside the health sector, governments are often hesitant to commit the monies necessary to fund reproductive health and HIV programs, whose links to economic development are not immediately obvious. However, given that donor support is only supplemental to national budgets, governments remain an essential funding source for FP/RH, HIV, and maternal health services. Without ever-increasing government financing and good targeting strategies, the prospects for serving the poor are diminished. To convince government leaders to increase allocation of resources for these services, strong quantifiable evidence on the health and economic impacts of FP/RH, HIV, and maternal health services is necessary.

POLICY stimulated increased public sector funding for FP/RH in several countries as a result of both direct technical assistance to government leaders and advocacy support to civil society groups. The latter used new-found skills to argue for additional funds for reproductive healthcare programs. In **Jordan**, the Higher Population Council formulated its *Reproductive Health Action Plan* (RHAP) 2003–2007, giving priority to low-cost, high-impact activities for implementation during the first year. The Ministry of Planning immediately allocated JD200,000 (close to US$300,000) for the implementation of these interventions, thereby ensuring successful implementation of RHAP's initial phase. POLICY was intimately involved in supporting development of the action plan and the financial decisionmaking. In **Egypt**, support from the project led to the Ministry of Finance committing over US$4 million for contraceptive procurement in 2005 (see Box 12).

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[16] This amount does not include the $912 million dollar commitment of the Jharkhand government over eight years for construction of rural health centers.

The resources available for HIV have increased dramatically over the past five years. At the outset of POLICY II, little was known about the global and country-specific magnitude of resource needs. POLICY's work in estimating financial requirements globally and nationally played a major role in the formulation of the plan of action for the President's Emergency Plan for AIDS Relief. Project staff participated in an influential study estimating that US$9.2 billion would be needed annually by 2005 for an adequate response to the HIV epidemic in developing countries. These estimates were also used to support the successful call for the Global Fund to fight AIDS, Tuberculosis and Malaria.

Governments introduced and implemented new financing mechanisms for FP/RH

POLICY helped a number of countries identify, test, and implement new and innovative financing mechanisms for FP/RH services. For years, **Romania** depended on erratic and insufficient donor supplies or high-cost pharmacy products to meet its population's family planning needs. In order to reduce uncertainty in supplies and prepare for donor phaseout, POLICY worked closely with the Ministry of Health and Family (MOHF) to identify alternative means to finance the provision of commodities. Advocates and policy champions within the MOHF carried out policy dialogue and advocacy activities in favor of one such option—coverage of contraceptives through the national health insurance system. As a result of these concerted efforts, which were backed in part by cost and cost-effectiveness analyses, the National Health Insurance House approved the inclusion of generic formularies for oral contraceptives and injectables in the Compensated Drugs List (February 2002).

In **India**, POLICY provided technical assistance to the Uttaranchal state government to draft, disseminate, and encourage the implementation of a government order that addresses budget limitations in government hospitals by promoting the use of alternative financing mechanisms. The order, issued in March 2004, created autonomous hospital committees that are authorized to raise money from a range of different sources, including user fees and donations, to be used for quality improvements in FP/RH and ob-gyn services. These cost-recovery and donation mechanisms are in place today.

Strategic planning enabled governments to allocate resources to achieve the greatest impact for their investment

POLICY's GOALS Model has helped countries to understand and set priorities for effective resource use. In **Lesotho**, GOALS helped the government determine the most cost-effective means to achieve the best combination of results for the seven main objectives in the HIV/AIDS national strategic plan. Using the model's projections, the government formulated a lower and more practical budget. The model allowed

officials to see that they had allocated excessive funding to certain interventions and not enough to others. Donors accepted the resultant balanced budget and thus made a more realistic funding allocation to Lesotho on this basis.

POLICY has assisted five other national governments in estimating the resource requirements for implementing their national HIV strategic plans (**Cambodia, Honduras** (see Box13)**, India, South Africa,** and **Vietnam**). For example, in **Vietnam**, staff from the AIDS Division of Vietnam's Ministry of Health applied the Goals Model to inform the National HIV/AIDS Strategy and the accompanying budget for 2004. The use of the model was critical in helping the Vietnamese allocate their resources to the service areas most in need. Previous budgets had overly focused on low-risk populations. Subsequently, the ministry recommended a 33 percent increase in the HIV budget to the National Assembly and recommended channeling greater resources to more vulnerable groups. In **South Africa**, the national Department of Health (DOH) used Goals to analyze the national program during the Mid-term Expenditure Framework review. The review indicated severe gaps in condom supply, prevention services for prostitutes and men who have sex with men, and care and support services. As a result, the government not only increased its HIV budget but also allocated more resources to the areas identified as underserved by the Goals Model. The DOH increased resources for HIV from US$76 million in 2002/3 to $153 million 2003/4, and to $254 million for 2004/5.

Box 13. HONDURAS | Goals modeling justifies national GFATM proposal and funding

The Global Fund represents the single largest donor of HIV funds in Honduras, financing $4 out of every $10 spent on HIV. POLICY contributed to a government-commissioned independent review of Honduras' achievements with GFATM Phase I funding that identified errors in the local funding agent's initial assessment. The team's report, "Assessment of the HIV/AIDS Grant Performance of the Global Fund Project in Honduras," used data obtained from the Goals Model to demonstrate the implications of withdrawing Phase II funds. The report made specific linkages between the HIV program and impacts and showed how the financial allocation in the rejected proposal was in fact necessary both in amounts and distribution. The Honduran government successfully used the report to advocate for reinstating the $15 million Phase II funding in Honduras. Moreover, this exercise led to internal Global Fund reform to include an early warning system and more extensive technical assistance to countries.

In **Ukraine**, POLICY used the PMTCT Model with the MOH and PMTCT Working Group in planning and budgeting for the country's prevention of mother-to-child transmission (PMTCT) program by doing a Budget Requirement Analysis resulting in several resource allocation scenarios. Ukrainian planners were able to discuss and analyze the multiple funding scenarios and make determinations on the most effective distribution of government funding. After the end of the project, the follow-on Health Policy Initiative continued this activity and a PMTCT budget was submitted to the MOH in June 2006. It is highly likely that it will be approved.

Resources were directed to programs for those most in need by removing barriers to access

There is growing evidence that with sufficient political support, "pro-poor" health policies can result in substantial reductions in health inequalities by improving access to services for the poor. To support pro-poor policy development, the project helped identify and remove financial and operational barriers to improve access among low-income clients and, at the same time, helped clarify the roles and capacity of NGO and commercial providers for delivering services to those who are better off.

With POLICY technical assistance, countries such as **Bangladesh, Egypt, El Salvador, Jordan,** and **Peru** have used in-depth market segmentation analyses to identify roles and responsibilities for different providers, and developed a "whole market" approach to contraceptive provision. For example, in **El Salvador**, the National Contraceptive Security Committee prepared a market strategy that outlines distinct roles for the MOH, the IPPF-affiliated NGO, and the commercial sector. The strategy mandates that the MOH concentrate its contraception provision to the two lowest socioeconomic quintiles. The government of **Peru** issued a decree in 2004 mandating that health services provided within the Maternal and Infant Integrated Health Insurance (SUMI) program, which includes maternal health services and family planning for women in the postpartum period, be provided to women most in need. Since few women use family planning in the postpartum period, MOH is considering changing the law to include family planning for all women insured under SUMI. Different strategies for implementing the health insurance program are scheduled to be pilot-tested and scaled up.

In May 2000, a POLICY analysis revealed that the high level of duties, tariffs, and sales taxes imposed by the government of **Jordan** on imported contraceptives pushed high-income clients to access free public sector services, thus both avoiding taxes imposed at private services and consuming resources that would be more equitably spent on the poor. Accordingly, in 2001, two revenue-related policy barriers were removed through coordinated follow-up and advocacy efforts by POLICY, the National Population Council, and the Commercial Market Strategies Project. The Minister of Finance, Minister of Industry and Commerce, and the General Director of Customs exempted all modern contraceptives from duties and tariffs. At the same time, the Council of Ministers exempted all modern contraceptives from sales taxes. With the resultant significant reduction in the procurement cost of modern contraceptives to private service providers, clients with even minimal resources are now better able to afford private sector services which, in turn, freed up government resources to respond to the needs of the poor.

In **Romania**, the government adopted a system of self-certification of poverty to make free contraceptives available to the neediest populations. In 2003, "Government Order 248" approved self-certification of poverty status as a requirement to access free contraceptives. The order revised earlier guidelines specifying that a client must provide official documentation proving eligibility to receive free contraceptives. In 2000 and 2001, eligible categories included students, unemployed, people with low or no income, and families receiving social protection allowance. A POLICY study on the implementation of the policies found that service providers were often more likely to provide free contraceptives to students with valid school or university identification cards. A client claiming eligibility but bearing no official documentation or proof of poverty status, however, was not given free contraceptives. Another POLICY-supported study made representatives of the Ministry of Health and Family, Ministry of Finance, NGOs, and private commercial firms aware of the cost and difficulty of obtaining contraceptives, particularly official certification of poverty status. POLICY assistance was instrumental in getting the government to develop an operational policy that allowed for the poor to self-declare poverty status, thus allowing many low-income women to obtain contraceptives without bureaucratic barriers.

4. Policymakers better able to integrate gender in policy and program decisions

Highlights

- ✓ 3 countries adopted national policies or plans paying specific attention to gender issues
- ✓ 36 gender training workshops conducted with over 750 USAID and CA staff
- ✓ 8 curricula designed for workshops on a range of gender issues

Recent evidence suggests that accounting for gender in policymaking and program design improves women's and men's reproductive health and HIV services. However, how to integrate gender across countries, sectors, and programs was not well understood. POLICY shared its expertise with government, civil society, implementing agencies, and donors through training and materials to impart a better understanding of the impact of gender issues on reproductive healthcare and links between gender and HIV.

Governments and partners gained improved understanding of the impact of gender issues on reproductive healthcare and HIV

POLICY provided needed leadership in helping others understand the importance of addressing gender. Through USAID's **Interagency Gender Working Group**, POLICY designed eight modules and provided training workshops for donors and other CAs on topics such as gender and HIV, gender-based violence, and integration of gender into RH/HIV projects. These workshops reached over 750 donor and CA staff. Another significant contribution was research on women and HIV, resulting in a research compendium and framework for linking HIV and gender.

Additionally, POLICY collaborated with local NGOs to build their capacity to address gender issues, thereby enabling them to effectively participate in the policy process. For example, collaboration with the **International Community of Women Living with HIV/AIDS** resulted in greater involvement of HIV-positive women in policy dialogue on multiple levels, particularly in their own communities. These women have begun to engage local decisionmakers to support issues such as provision of high-quality reproductive healthcare in local clinics. Similarly, POLICY provided support in **Kenya** for a project focused on women's inheritance rights. By undertaking advocacy training and increasing women's capacity, more NGOs have an improved ability to make links between gender and health.

Policymakers addressed gender inequalities in policies and programs

POLICY's work with policymakers often raised the need for integrating gender equality into policies and programs. For example, POLICY assisted the **Cambodian** Ministry of Women's and Veteran's Affairs in revising the *Policy on Women, the Girl Child, and STI/HIV/AIDS*, which was adopted by the ministry in October 2002. Among other changes, the revised policy drew specific attention to HIV as a gender-based epidemic and included relevant measures, such as male involvement. In **Ukraine**, results from POLICY's study on availability, accessibility, and affordability of reproductive healthcare for HIV-positive women informed the *National VCT Protocol* and *National PMTCT Program*. POLICY co-founded and co-led the national Gender and HIV/AIDS Technical Subcommittee of **Kenya's** National AIDS Control Council (NACC), which produced *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan, 2000–2005*. NACC used the document to review the *National AIDS Strategic Plan* for gender sensitivity.

There is growing recognition that there are important benefits, both to men and women, in involving men in reproductive health decisions and services. POLICY has been a leader in advancing policy dialogue and the development of policies to foster men's involvement in transforming gender norms of masculinity and femininity, increasing male involvement in their own health, and building men's understanding and support for their partners' health and rights. As a result of civil society involvement in **Cambodia**, male involvement is now firmly on the policy agenda (see Box 14).

> **Box 14. CAMBODIA | Civil society collaborates on draft male involvement guidelines**
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> In early 2004, the Cambodian Reproductive Health Promotion Working Group (RHPWG) undertook an advocacy initiative to encourage the MOH to develop guidelines for male involvement. Research indicated that successful pilot programs had been undertaken and that no explicit policy barriers existed, but little attention had been paid to creating practical policies and guidelines to ensure systematic scale-up of male involvement activities. With POLICY assistance, RHPWG held a series of meetings with senior officials of relevant ministries and NGOs. In December 2004, the MOH asked the RHPWG to spearhead an initiative to devise draft guidelines. An assessment of gaps and opportunities in Cambodia's policy responses provided crucial inputs into a multisectoral effort to draft the guidelines during the spring and summer of 2005. The RHPWG submitted the guidelines to MOH for consideration. The MOH held several broad consultative meetings to finalize its draft *Strategic Plan for RH in Cambodia (2006–2010)*, which included male involvement as a guiding principle.

5. Human rights advanced and stigma and discrimination reduced

HIGHLIGHTS

- ✓ 18 laws and policies incorporated human rights and anti-discrimination language
- ✓ Leaders from various sectors mobilized to speak out against HIV-related stigma
- ✓ 6 tools designed to measure and assess stigma, discrimination, and compliance with human rights principles

POLICY worked to create policy environments that recognize and embrace the fundamental health needs of people in developing countries—especially the poor and disadvantaged. This meant supporting activities that encouraged inspired leadership in combating stigma and discrimination and integrating human rights-based approaches into HIV policies and programs. Those working in the health field are increasingly recognizing the importance of ensuring equity and equality as key components in the quest for improved FP/RH programs and services. POLICY built the capacity of vulnerable groups and people living with HIV to overcome stigma and discrimination; mobilized leaders from various sectors to speak out against stigma and discrimination; and established mechanisms to enact, assess, and monitor human rights.

Vulnerable groups and people living with HIV began to overcome stigma and discrimination

A fundamental aspect of POLICY's approach to stigma, discrimination, and human rights has been to involve and empower people living with HIV and other vulnerable groups. The project's early work in this area focused on building specific skills, such as advocacy, working with the media, and overcoming internal stigma. POLICY's work soon moved beyond simply including people living with HIV as recipients of training to involve them as facilitators, planners, and program implementers. For example, *Red Mexicana de Personas que Viven con VIH/SIDA* was a key partner in POLICY's effort to design indicators and guidelines for measuring and addressing stigma and discrimination in **Mexico**. Furthermore, POLICY has assisted HIV-positive people and vulnerable groups to be involved in a range of policy issues, including national policy development, women's inheritance rights, and treatment access. This has resulted in the needs of people living with HIV being integrated into HIV laws and policies in countries such as **Malawi, Peru,** and **Vietnam**. In **Kenya**, POLICY has continued to break new ground

by mobilizing HIV-positive people from different sectors, including teachers and religious leaders (see Box 15).

Box 15. KENYA | HIV-positive religious leaders break the silence surrounding HIV

Religious leaders can play a significant role in reducing HIV-related stigma and discrimination. POLICY, in collaboration with World Vision, assisted with setting up the Kenya Network of Religious Leaders Infected and Affected by HIV/AIDS (KENERELA) in February 2004. KENERELA was born out of the African Network of African Religious Leaders Infected and Affected by HIV/AIDS (ANERELA), based on the pioneering work done by the Canon Byamugisha. By accepting and acknowledging the presence of positive clergy in their own churches, religious communities can extend a hand of healing to their members and provide leadership in tackling HIV-related stigma. Kenya was the first country in East/Central and Southern Africa to set up such a network. Representatives from 20 denominations participate in KENERELA. Originally, KENERELA had 44 registered individual members. After the strategic planning meeting sponsored by POLICY/Kenya in April 2004, there were more intensive recruitment efforts, resulting in an increase in the number of members by 40 in Nairobi (28 that are HIV positive and 12 that are willing to get tested) and by 30 in Homa-bay (10 that are HIV positive).

Government, civil society, and private sector leaders came to understand and speak out against stigma and discrimination

Many of the factors that influence public health—including HIV-related stigma and discrimination or rights violations based on gender, sex, age, economic class, and HIV status—cannot be addressed by the health system alone. When leaders speak out on HIV, it can help give those most affected by the epidemic the courage to come forward and can facilitate community dialogue on issues surrounding HIV. POLICY assisted organizations, such as the **Zambia** Interfaith Networking Group on HIV/AIDS, in training their members specifically in addressing stigma and discrimination.

POLICY was instrumental in the **ANE** region in strengthening leadership to speak out publicly against stigma and discrimination. The project collaborated with the Asia Pacific Leadership Forum on HIV/AIDS and Development to enlist high-level commitments from influential leaders in an effort to inspire stronger country leadership to stop the spread of HIV before it expands even further in the region. The resulting publication, *Act Now*, was used throughout the region as a springboard for high-level policy dialogue.

Leaders must also speak out on issues that affect reproductive health, such as discriminatory practices that limit the poor's access to healthcare and services or worsen gender inequalities. In **Guatemala**, in 2004, advocacy from POLICY-supported civil society groups ensured that leaders in the new government reaffirmed support for the National Reproductive Health Program and principles such as universal access to healthcare.

Mechanisms and tools created to assess and monitor human rights

POLICY supported approaches such as conducting legislative and human rights audits, building civil society advocacy capacity, researching and raising awareness of the needs of vulnerable groups, and supporting citizen surveillance of policy and program implementation. For example, POLICY assisted the **Tanzania** Women Lawyers Association in conducting a review and providing recommendations to improve the country's HIV law, and worked with a multisectoral community advisory board in **Ukraine** to analyze HIV-positive women's barriers to accessing reproductive healthcare. POLICY also helped establish and strengthen mechanisms for redressing grievances—for example, by strengthening the

Cambodian Human Rights and HIV/AIDS Network, supporting the Human Rights Referral Center of the **Zambian** Network of People Living with HIV/AIDS, and facilitating formation of patients' rights conflict resolution centers in **Peru** (see Box 16).

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Box 16. PERU | Patients' rights enhanced through improved negotiation, conflict resolution, and operational policies

Women seeking reproductive healthcare historically had little recourse in correcting inequities in the Peruvian health system. To address this issue, beginning in 2003, POLICY supported the formation of Centers for the Prevention and Resolution of Conflicts in Health (CEPRECs). These specialized pilot centers have been established in five areas in collaboration with the Peruvian Association of Public Health Law. The goal of the centers is to promote patients' rights and to address patients' complaints through negotiation and conflict resolution. Since their inception, the centers have come into their own as effective mediators. As a result of CEPRECs' actions, university and regional health facilities have instituted various mechanisms to streamline complaint resolution and improve operational guidelines and service implementation. For example, in January 2004, intervention by the Ayacucho CEPREC enabled individuals covered under the social insurance system to receive the free medications to which they were entitled. In March 2005, the Junin CEPREC requested that health personnel be properly identified with nameplates, that the health law be disseminated among health providers, and that the facilities publicly show the type of services covered by public insurance. The Regional Health Directorates are now implementing these changes.

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6. Policies and programs met the needs of youth and OVC

Highlights

- ✓ 10 national and local adolescent/youth RH policies, plans, and programs adopted in 7 countries
- ✓ 2 OVC policies, plans, and strategies adopted
- ✓ More than 3,000 youth policy champions in Egypt active in youth reproductive health advocacy
- ✓ Online youth policy database created and accessed by 17,000 users
- ✓ Youth reproductive health advocacy training manual created

Young people face a range of reproductive health and HIV-related issues. Too often, young people lack access to youth-friendly information and services, and governments and communities have been slow to change the cultural and societal norms that could improve the health and opportunities of young people. In many POLICY countries, existing policies ignored the needs of young people or lacked consistent definitions of youth. As a first step, POLICY raised awareness of the issues facing youth and OVC. Next, POLICY strengthened the capacity of government and civil society to assess the needs of youth and plan appropriate policy responses. As a final step, POLICY built the capacity of youth to engage policymakers and media on issues affecting their lives and health.

Policymakers implemented youth reproductive health and OVC policies and plans

POLICY's programs with governments and civil society led to the adoption of 12 national policies, strategic plans, and guidelines focusing on youth and/or OVC. For example, POLICY provided technical and financial support in preparing the National Plan of Action for **Kenya's** first-ever Policy on Adolescent Reproductive Health and Development, approved in June 2005. Advocacy efforts by Nigerian NGOs resulted in a state-level Youth Reproductive Health Strategic Plan (see Box 17). In **Nigeria**, POLICY also helped draft and gain approval for the *Plan of Action on Orphans and Vulnerable Children*,

which the Director for Child Development endorsed in September 2002 on behalf of the Federal Ministry of Women's Affairs and Youth Development. This marked the first time that the ministry recognized the impact of HIV on children and that this issue deserved special attention.

Box 17. NIGERIA | State government approves Youth Reproductive Health Strategic Plan

In 2002, POLICY identified Nigeria's Edo State as a high-potential jurisdiction for devising a state-level strategic plan to operationalize the National Youth Reproductive Health Policy. POLICY assisted local groups in Edo State to carry our research that revealed high rates of unintended pregnancies and induced abortions. The project also provided technical assistance to form the Young Adult and Adolescent Reproductive Health Network. POLICY then worked with the network and government leaders to prepare a strategic plan. In April 2004, the Governor of Edo State approved the final version of the Young Adult Reproductive Health Strategic Plan with an annual budget of $1.7 million. The activity sparked a donor's interest in extending the project to another state, with POLICY's assistance. With multiple states recognizing the importance of adopting youth reproductive health plans, Nigerian youth have improved opportunities for accessing healthcare and services at local levels.

Youth are increasingly involved in the policy decisions that affect their health

With appropriate capacity building and assistance, youth can work effectively to inform and support youth reproductive health policies. During **Jamaica's** process of revising the National Youth Policy in 2004 and preparing a national strategic plan, POLICY mentored young people at the National Center for Youth Development and provided them with the necessary technical support and leadership skills to take an active role in the policy planning process.

Youth involvement goes beyond the policy process, as youth are often effective in facilitating discussions with their peers. To expand the scope of youth advocates in **Egypt**, POLICY identified and trained 3,000 youth to serve as policy champions to raise their peers' awareness of health issues. In 2002, POLICY initiated the Youth Policy Champions Program to promote small family sizes, gain a youth perspective in FP/RH issues, and create links for policy action at the executive/national level. The program resulted in a partnership between POLICY/Egypt and the Ministry of Youth to expand youth-to-youth advocacy activities, including creating Youth Policy Champion groups in 15 additional governorates. The concept of youth policy champions has been successfully integrated into the cultural program of youth centers in three Upper Egypt governorates, as youth champions there have conducted over 70 advocacy events, using the youth-to-youth methodology and data provided by POLICY. Mobilization of youth policy champions has been instrumental in enabling young people to communicate their pressing reproductive health needs so that they resonate with policymakers and program managers.

THE PROJECT'S LEGACY

The examples of results presented above and the discussion of the POLICY Project model demonstrated the many ways that the project contributed to improving the policy environment for FP/RH, HIV, and maternal health. Over the past decade, POLICY's work has led to greater commitment to action by public and private leaders, countless policies being adopted or reformed, and increased and better use of resources. POLICY's legacy is not only evident in *what* it accomplished, but in *how* it achieved its objectives. POLICY sought to bring new partners into policy processes and strengthen their capacity to develop and implement policies. Working with partners, the project addressed a range of policy issues with numerous government and private policymaking entities. At the same time, POLICY put in place an innovative organizational approach based on decentralization, building local capacity, and effective working relations between U.S.-based and overseas staff. In many cases, POLICY has seen its efforts lead to sustainable policy processes and replicable approaches within countries and communities. In other cases, the project's work has broken new ground and planted the seeds for future policy work. The following points articulate some of the project's lasting legacies.

POLICY improved the enabling policy environment for FP/RH, HIV, and maternal health

When POLICY started in 1995, much of the program's attention centered on national population and FP/RH policies. HIV policy issues were not yet in the forefront of the project's work. Over the years, POLICY devised increasingly responsive and flexible approaches to policy assistance and made special efforts to extend these approaches to its HIV programs. In recognizing the need to consider both policy outputs and policy processes as well as to link policies to implementation, the project has also expanded understanding of what the "policy environment" encompasses. This expanded understanding permeated the project's work and improved the quality of its results. As a result, POLICY worked at multiple levels, across diverse sectors, and on varied policy issues to bring about more comprehensive enabling environments to improve FP/RH, HIV, and maternal health programs.

The project's approach has led to a deeper understanding of and capacity for policy work. A policy response will not be effective, for example, if it is not based on solid evidence. A policy may be adopted, yet it will be difficult to implement without proper resource allocation or multisectoral support for implementation. A policy that does not consider the needs and views of clients, women, the poor, or people living with HIV may miss the mark in terms of delivering services to those in need. Policies will have limited impact on people's health if they remain vague principles at the national level and are not supported by operational guidelines or policies at district and local levels. These kinds of policy processes and issues must be addressed continuously in any country, and therefore, it is critical that there be a sustainable local capacity for policy work. All of these components must come together to strengthen the policy response. If any aspect is neglected, the integrity of the policy environment is compromised. POLICY staff and its partners ensured that these components did come together to stimulate profound improvements in the policy environment in many countries.

Previously, we examined the case of Nigeria. It is a powerful example of how the POLICY Project addressed the breadth and depth of policy needs, and how the project employed all of its main components to achieve a transformation of the policy environment (see Box 19).

POLICY institutionalized multisectoral engagement in policymaking

Laws and policies are designed, adopted, and implemented every day, and many people are often left with the feeling that those policies make no difference in their lives. The POLICY Project came to view policy development both as an *output* and as a *process*. It is the process through which policies are developed and the extent to which stakeholders are involved that makes them relevant for and responsive to the realities of people's daily lives.

POLICY's approach to participation is one of its most significant legacies. POLICY put key principles of participatory approaches to work in its FP/RH, HIV, and maternal health work. The project extended these approaches throughout its programs by helping to broaden the numbers and types of government sectors participating in policy development, and by supporting NGOs, NGO networks, and private entities with the tools and training to become effective advocates. Promoting meaningful participation and multisectoral engagement underlay everything that POLICY accomplished—whether it involves supporting women, youth, or HIV-positive people to serve as policy champions; assisting government and NGOs to use tools and models to improve program planning; or building the capacity of the project's in-country staff and partners. The project's approaches and achievements showed that meaningful participation is not only possible, but that it also improves policy responses. Whether taking part in advocacy, planning, or SPECTRUM modeling activities, thousands of people in POLICY countries had the chance to contribute to real policy development affecting the lives of families and fellow citizens. The project has strengthened global capacity for policy development and implementation, and the impacts will be felt well into the future.

Better policy models and analysis have improved the quality of policymaking

POLICY's computer models remain an enduring aspect of the project's legacy as they continue to play an important role in supporting policy activities at organizational, national, and global levels. POLICY has created new models and modified existing ones to meet the changing needs for policy development. Whether estimating resource requirements to fight the HIV epidemic, highlighting the demographic dividend in population projections, or incorporating the latest research results on the effectiveness of various treatment regimes on mother-to-child transmission of HIV rates in the PMTCT Model, these analytic tools are state-of-the-art. They continue to be used around the world in awareness raising, policy analysis, strategic planning, policy formulation, and program design. Capacity building underlies POLICY's modeling work and is geared toward ensuring that counterparts thoroughly understand the data and analysis techniques and can use the models independently. Since the beginning of POLICY II in July

2000, external users have downloaded 15,000 copies of the SPECTRUM software. In addition, we have distributed 3,000 hard-copy manuals. Besides being one of the key methodological approaches used with government officials and agencies, the models are used widely by donors such as UNAIDS to produce global estimates of HIV prevalence, by professors in universities around the world to teach population dynamics, and by businesses to formulate workplace policies. Simulation models, pioneered by USAID's Policy Division over 30 years ago, continue to be one of the pillars upon which countries improve their policies and programs around FP/RH, HIV, and maternal health.

POLICY's strategic framework and monitoring plan broke new ground in quantifying policy objectives

POLICY's strategic framework and monitoring system broke new ground by defining and clarifying how specific policy objectives can be measured. In turn, the POLICY strategic framework and performance monitoring plan helped staff and partners to design more effective programs and contributed to the hundreds of results eventually achieved by the project. POLICY's strategic framework also provided a useful mechanism for specifically linking USAID Mission and Bureau for Global Health objectives. The project institutionalized its strategic framework within the project through the "Project Design, Evaluation, and Quality Assurance Manual," which gave clear guidance on the results framework, defined indicators, data sources, and provided guidelines for writing up and documenting results. POLICY shared information of the project's monitoring and evaluation system, database, and documentation widely within USAID and with other CAs. For example, MEASURE Evaluation borrowed heavily from POLICY's documentation binder in designing and setting up its own internal performance monitoring plan. Moreover, POLICY drafted the policy chapter in MEASURE Evaluation's *Compendium of Indicators for Evaluating Reproductive Health Programs*. One of POLICY's program assessment indices, the AIDS Program Effort Index, is included in USAID's *Handbook of Indicators for HIV/AIDS/STI Programs* and has been adopted as one of the program output indicators in the President's Emergency Plan for AIDS Relief. Donors such as UNAIDS, WHO, and UNICEF also use the index to measure progress in the HIV/AIDS policy environment.

The project's organizational model changed the way policy work is carried out

Building on the foundation of two decades of policy development programs mostly based in the United States, POLICY embarked in 1995 on a path that radically shifted the majority of program work to local country staff. At the same time, the project put resources into hiring and training competent local staff at all levels, and strengthened the centralized management and operations systems needed to support a highly decentralized project. Global technical leadership remained in the United States for the most part through the project's core-funded programs, while project management promoted the linkages between U.S. staff and local POLICY staff in the execution of both core-funded and field-supported activities. In this environment, local technical and management staff excelled while technical innovations and accomplishments multiplied in POLICY countries.

One of the most significant results of this approach was that the project's senior local staff were continuously involved in monitoring a country's policy needs (as opposed to the previous model of having most staff based in the United States and making periodic trips). According to their own technical and strategic strengths, Country Directors and their staff took the POLICY Project in some new and highly effective directions. Without this organizational model, many POLICY country programs would have remained at the levels that existed in the project's first years. Instead, locally driven programs resulted in major and innovative improvements in policymaking in a number of countries. In India, district action planning has become a hallmark of the country's basic health system, while in Vietnam, the

hitherto ignored but most vulnerable groups are now a main focus of the government's HIV program. Similarly in Peru, partnerships and capacity development with local civil society groups have appreciably raised the levels of accountability in the public health system, especially with respect to FP/RH. These kinds of innovative local approaches enabled the project to be more responsive to the unique policy needs of each country. Thus, the project's local responsiveness and capacity played a major role in the expansion of country programs and the technical breadth of the results.

POLICY's organizational structure contributed to the achievement of hundreds of results, dramatically increased capacity in USAID-assisted countries, generated huge cost savings over the U.S.-based model, and produced technical advances and adaptations that have greatly improved the policy environment for FP/RH, HIV, and maternal health. The model and its implementation also raised the demand for policy programs in countries. POLICY established a worldwide reputation for high-quality programs, and this effectiveness—demonstrated many times in the project's activities and results—has, in turn, raised the profile of policy work on government and donor agendas. The project's decision to decentralize and shift technical and managerial responsibility to country offices was well-supported by its strong emphasis on capacity development (which was mandated through IR4 in the POLICY II design by USAID). POLICY's decentralized organizational model changed the way policy work is carried out and in many countries has left behind an established local capacity to carry out policy programs well into the future.

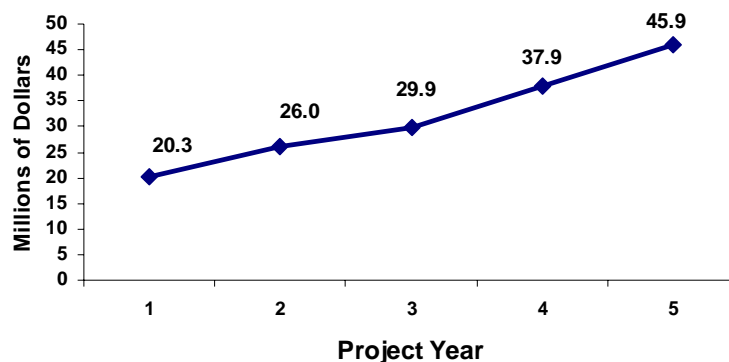### POLICY succeeded in getting sensitive socio-cultural issues on the policy agenda

One of POLICY's most notable successes was getting sensitive socio-cultural issues such as stigma, discrimination, gender bias, and inequitable access to services squarely on the policy agenda. POLICY helped raise awareness and build capacity among government, private sector, and religious and community leaders so that they have the knowledge, skills, and confidence to promote open dialogue and policy solutions to entrenched socioeconomic and cultural factors that degrade or endanger public health. A congresswoman speaking out against gender-based violence—which is often seen as a private, domestic issue between a husband and wife—and an imam calling for birth spacing and compassionate care for HIV-positive people are significant breakthroughs that happen more and more each day. In countries such as Turkey, Jordan, Guatemala and Ukraine, women and men in NGO networks and in government raised the issues of family planning and contraceptive security to the national level in acceptable and convincing ways. POLICY has also worked to help those most affected by policies, particularly women and HIV-positive people, to speak out on their own behalf and become leaders in the policy response.

Missions devoted more emphasis to policy development and implementation

Many studies and evaluations make the point that development will not occur without the existence of a supportive policy environment. In the area of family planning, the Office of Population and Reproductive Health has supported policy work for the past 34 years. In the 1970s and 1980s, most policy work was driven from the United States and involved research, surveys, and awareness-raising activities. The funding levels were low relative to other technical areas in USAID's population program. When the "field support" mechanism was introduced 15 years ago, Mission funding of policy activities was not large. POLICY I's initial country obligations were in the range of $100,000–$200,000 per country. With the advent of POLICY, this picture changed and the policy element became a more important part of Missions' portfolios.

Funding levels for the POLICY Project tell a story of continuously increasing demand for policy work and increasing commitment by Missions to policy programs (see Figure 8).[17] In fact, during the POLICY decade, policy development and implementation programs became ingrained in many USAID country strategies and portfolios at significant levels of effort. Not only have Missions continued to buy into the successor policy project— the USAID | Health Policy Initiative—but some Missions have awarded bilateral projects that emerged in part from POLICY's experience (e.g.,

Figure 8.
POLICY Project Annual Funding, 2000-2005

Nigeria, India, Bangladesh, Nepal, Ukraine, and the USAID Regional Development Mission/Asia). Further, POLICY's work played a role in other donors' programs in developing countries, such as the Gates Foundation Essential Advocacy Project in India. This legacy of increasing commitment and attention to the policy environment by USAID and other donors fits well with the Agency's objective of promoting sustainable local FP/RH, HIV, and maternal health programs.

POLICY staff and partners produced a prodigious number of results

The combination of the collective factors discussed in this report, together with the "legacies" above, led to a project that exceeded expectations. In particular, the staff and the project partners produced a prodigious number of results over the decade. The project's Performance Evaluation Boards, convened by USAID to periodically and independently evaluate POLICY's work, consistently gave the project high scores and praise under the "Results" criteria. We conclude this report with the words of the Performance Evaluation Board in March 2006, which succinctly summarizes the project's performance.

"I*n the Results category, POLICY has clearly exceeded expectations. The documentation shows the broad reach and depth of the project and brings into focus the significance of its accomplishments not only in creating policy change but also in building strong foundations at the country level for sustainable FP/RH and HIV/AIDS programs....*

Over the course of the project, 256 SO level results have been achieved, far exceeding the number required. This is very impressive, particularly since the policy process takes time and involves considerable capacity building in country. Many of the results...show the convergence of work on different levels and the culmination of the support provided to advocacy groups, combined with information and other policy and advocacy efforts over time.

...the [Performance Evaluation Board] would like to commend the Contractor for exceptional performance throughout the life of the project. The number, breadth, and significance of the project's results greatly exceeded the targets we set for the POLICY Project in 2000. But the project's accomplishments go beyond numbers of results. The approach to policy and advocacy work that was developed and refined over the 10+ years of POLICY I and POLICY II clearly show that this kind of work can be undertaken successfully in varied circumstances, that it can be measured and documented, and that it can be done in a way that will leave a lasting legacy in dozens of developing countries."

—GH/PRH/PEC Performance Evaluation Board, March 21, 2006

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[17] Note that Year 5 in Figure 8 is mostly FY04 funding but includes some FY05 money to cover activities undertaken during the project's extension to June 2006.

APPENDIX A.
PUTTING IT TOGETHER
COUNTRY CASE STUDIES

Technical assistance to improve reproductive health and HIV programs is more effective and has a greater likelihood of achieving desired results when all the factors of the POLICY model described previously—country-focused programs, strong local capacity, multisectoral engagement, good evidence, and solid operational systems—come together.

Reproductive health was not a priority on Ukraine's policy agenda in the mid-1990s despite poor maternal health, a high number of induced abortions, and indications of a rapidly growing HIV epidemic. POLICY's comprehensive, multi-year program of assistance not only resulted in the adoption and implementation of a new National Reproductive Health Program (NRHP), it also changed the way in which policies are formulated in the country.

Creating the National Reproductive Health Program, 2001–2005

While conditions in the late 1990s were favorable for strengthening the reproductive health policy environment, several critical elements were missing. Among the most important were the lack of involvement of key sectors and a limited understanding of Ukraine's reproductive health issues and resource needs among policymakers. To remedy this situation, the POLICY team used data from its key informant study, the 1999 national reproductive health survey, and a legal and regulatory analysis to increase stakeholder understanding of and commitment to addressing reproductive health issues. In addition, with POLICY support, the MOH formed the Policy Development Group (PDG) to bring together representatives from ministries, local and national government bodies, private and NGO sectors, and donors. The PDG held its first meeting in March 1999 and identified its mission as developing, coordinating, and monitoring reproductive health policy, including the creation of a program to succeed the National Family Planning Program.

After a year-long process of policy analysis, priority setting, indicator development, and budget analysis, the MOH sent the draft *National Reproductive Health Program 2001–2005* to the Cabinet of Ministers for approval. Heralded by local experts as a model for other national programs, the Ministry of Economics noted that it "*differs from its precursors by concretely determined objectives and accurately identified indicators.*" President Kuchma formally adopted the NRHP and budget in March 2001.

Reducing Barriers to Program Implementation

Following the adoption of the NRHP, the next challenge centered on devising mechanisms to implement the new national program. What would be the operational barriers to implementation? How would the national program be implemented by local health administrations? How could civil society be more involved in policy and policy implementation processes? Finding answers to these questions formed the basis of POLICY's subsequent work in Ukraine.

The PDG took the lead in addressing barriers to effective implementation. Having identified 26 crucial operational barriers, the group began to develop responses to them with POLICY's assistance. Since 1999, the MOH has approved the PDG's recommended new outpatient and inpatient reproductive healthcare orders; a reproductive health guide for healthcare practitioners; and a monitoring and evaluation plan for the NRHP, which was the first of its kind for a national health program.

To facilitate implementation of the national program by local authorities, the PDG and the mayor of Kamianets-Podilsky City took on the sensitive issue of inefficiencies in the healthcare system that had remained from Soviet times. With POLICY technical support, local researchers studied inefficiencies at the facility level, inflexibility in city budget allocations, the "shadow economy" in the health sector, and outlined recommendations. The performance-based local reproductive health program that emerged and

other changes to human and material resource allocation were significant achievements. The fact that the reform process was comprehensive, well-informed, and inclusive helped bring about these changes. The process was data driven, accompanied by a carefully-costed budget, and vetted through extensive policy dialogue with concerned stakeholders.

Giving Voice to Civil Society Policy Champions

Changes to the policy formulation process were not just taking place within high-level national policy circles or select local initiatives. In September 2000, POLICY facilitated the creation and training of the Ukrainian Reproductive Health Network (URHN), the first NGO advocacy network in Ukraine. URHN now includes 26 NGOs from 14 oblasts working in reproductive health, youth, education, HIV, journalism, drug addiction, and women's rights. URHN shaped the policy agenda affecting communities and supported local program development and implementation. Network members now sit on four Coordinating Boards overseeing local reproductive health programs; three cities have youth-friendly clinics; 19 industrial companies have issued maternal health policy changes; and the national health education curriculum doubled the time devoted to reproductive healthcare issues in the classroom. As veteran advocates and experienced trainers, URHN members transfer their knowledge and skills to other civil society actors in health and other sectors.

A New Program, A New Approach

By late 2004, it was time to begin formulating the follow-on NRHP 2006–2015. The PDG submitted the draft program to the MOH in December 2005. While equally rigorous and evidenced-based, two differences stood out about the process. First, owing to POLICY's commitment to build local capacity, U.S.-based assistance was dramatically reduced. Under the leadership of Country Director Dr. Andriy Huk, POLICY's local team and consultants provided technical backstopping to the PDG. U.S. technical assistance was limited primarily to the introduction of newly developed approaches and tools for policy formulation: the SPARHCS framework to address contraceptive security and the Allocate Model to understand the cost implications of potential interventions. Second, civil society was a full partner in the process. The URHN now has two members on the PDG and local authorities view the network as a highly-valued and essential partner. To kick off the development of the new program, the URHN sponsored a national roundtable to gather feedback on the first program—turnout was substantial and productive. Dr. Nadiya Zhylka, Head of Mother and Child Healthcare at the MOH, noted that the ministry alone could not have attracted such broad and fruitful participation.

POLICY achieved significant, long-lasting results in Ukraine through a multi-year program of assistance that combined key technical approaches along with an emphasis on building local capacity to formulate and put policies into practice. POLICY and its partners changed reproductive health policy formulation and implementation patterns in the following ways:

- ✓ Backed by the Cabinet of Ministers, the PDG has become a government-wide model for policy dialogue and formulation.
- ✓ Civil society advocates ensure policies are informed by and meet community needs.
- ✓ Strategic planning, financial analyses, and monitoring and evaluation underpin new programs.
- ✓ Information-based decisionmaking—supported by computer models, research, and other policy formulation tools—is standard practice.
- ✓ Scores of committed stakeholders have the skills to drive the process and ensure sustainability.

GUATEMALA	*Overcoming political, operational, and resource barriers to improved reproductive healthcare*

In Guatemala, the 1980s and 1990s marked a period of government hostility and organized opposition to FP/RH. The public mention of the term "reproductive health" was sufficient to provoke censure from organized opponents, while expanding basic services was literally unthinkable. In 2000, a new administration, led by President Alfonso Portillo, transformed Guatemala's reproductive health policy environment. The new Minister of Health publicly aligned himself with reproductive health advocates and officially launched the National Reproductive Health Program (NRHP). Proponents of FP/RH and women's health rallied quickly to take advantage of this new opportunity to improve the policy environment in Guatemala.

Establishing a Legal Framework for the National Reproductive Health Program

The creation of the NRHP demonstrated unprecedented political will on the part of the government. However, the program lacked teeth—it had no legal base, no formal organizational structure, and no funding. The first step toward making it a bona-fide government program was to provide it with legal legitimacy. In 2001, POLICY worked closely with a multisectoral group to formulate and advocate for a law that addressed the population's social and development needs, including those related to reproductive health. The group analyzed the draft law; identified reforms that would make it more responsive to local needs; organized workshops to obtain input from a broader group of civil society organizations; and advocated with Congressional representatives for its approval. In September 2001, Congress approved the law and suggested amendments and changes submitted by the multisectoral group. In October 2001, Guatemala saw the official enactment of the *Law of Social Development and Population*, the first of its kind in the country. The law sets clear objectives for the NRHP, identifies services to be provided under its auspices, and assigns responsibility for its coordination and implementation to the MOH, Social Security Institute (IGSS), and Ministry of Education.

Ensuring Effective Implementation and Sustainability

Removing barriers at the national level. Operational barriers at different levels in the health system hindered the implementation of the NRHP. Following a rigorous process to identify these barriers, and drawing on information from POLICY-supported research and discussions, ministry officials, including the Minister of Health, and NGOs concluded that the main barrier to effective implementation was that the NRHP had an insufficient political and organizational base to guarantee its continuity in Guatemala's mercurial political climate. Workshop participants submitted a proposal to the MOH recommending a series of actions to address this problem and subsequently advocated with high-level MOH officials to ensure their implementation.

In 2004, the government raised the standing of the NRHP by making it an official MOH program through Ministerial Resolution SP-M-239-2004. The resolution established the NRHP as one of several key programs intended to care for individuals, which falls under the MOH's General Directorate for Health Regulation, Oversight, and Control, and authorizes it to negotiate its budgetary allocations with the MOH and governmental and nongovernmental entities. This change strengthened the legal framework for reproductive health by ensuring that the NRHP will continue regardless of changes in government leadership. It also constituted the first step toward securing specific resources for interventions related to reproductive health.

Addressing barriers at the service delivery level. In 2003, POLICY spearheaded a survey to identify barriers in the three major service provider organizations—the MOH, IGSS, and the NGO APROFAM. Barriers identified in the study included inappropriate eligibility criteria and restrictions on access to services (e.g., minimum age and parity for voluntary sterilization). The service delivery organizations have relied heavily on the study findings to draft operational policies that reduce barriers to services. Specifically, the NRHP used the findings in preparing its "Action Plan for the Elimination of Medical Barriers Related to Adolescent Reproductive Health." The action plan focuses on issues such as youth-friendly clinic schedules and unbiased counseling on contraceptive methods.

Mobilizing Funding for Reproductive Health Programs

By 2004, Guatemala's reproductive health program was firmly ensconced within the MOH's organizational structure and backed by a strong legal framework. However, it relied solely on USAID for funding. Both the Social Development Law and the Ministerial Resolution provided the legal framework for budgetary allocations, but the NRHP lacked public sector funding. Two civil society networks created and strengthened with POLICY support—INSTANCIA/Salud Mujer and REMUPAZ—played a key role in securing government funding for the NRHP. Acting as liaison, POLICY organized and facilitated 10 meetings between these two NGO networks and Congressional Commissions on Health, Women, and Human Rights, as well as the Inter-Parliamentary Women's Coalition in Congress. During these meetings, INSTANCIA and REMUPAZ presented information on the status of women's health and the lack of funding for the reproductive health program. POLICY also worked closely with INSTANCIA and REMUPAZ to formulate a budget proposal for the NRHP. As a result, in June 2004, Congress approved a Legislative Decree that mandates that 15 percent of the tax on alcoholic beverages (approximately US$3.4 million) will be used for reproductive health, family planning, and alcoholism prevention and treatment programs. In addition, in November 2004, the Congressional Health Commission amended the 2005 National Budget to include a US$2.5 million allocation to the NRHP.

Ensuring Long-term Access to Services

POLICY played a pivotal role in creating a sustainable reproductive health policy environment in Guatemala. Through a multi-year program of assistance that combined advocacy, research, data-based decisionmaking, and multisectoral participation, POLICY helped Guatemala achieve significant, long-lasting results. By providing a legal base, institutional structure, and resources for Guatemala's NRHP, future generations are ensured access to high-quality FP/RH services.

Kenya has experienced a devastating HIV epidemic since its first case was diagnosed in 1984. By 1999, national adult HIV prevalence was 13 percent, prompting President Moi to declare HIV a national disaster. Moi created the National AIDS Control Council (NACC) to coordinate a multisectoral response and provide leadership on all matters pertaining to HIV and AIDS. One of NACC's first tasks was the formulation of the *Kenya National HIV/AIDS Strategic Plan (KNASP) for 2000–2005*. With little prior experience, the development of the KNASP was marked by limited engagement of stakeholders from other ministries, civil society, and the private sector. Consequently, there were two major concerns about the strategic plan: 1) it did not recognize the gender dimensions of the epidemic, given higher and disproportionate new infections occurring in younger women aged 15–24 than their male peers; and 2) program managers and implementers found the document hard to read and use for reference.

In response, POLICY embarked on a multi-year program of assistance that was designed to address gender gaps in the national plan; build the capacity of civil society policy champions; and facilitate effective program planning and implementation, particularly in terms of understanding resource needs.

Addressing Gaps in the HIV Response: The Gender Perspective

POLICY worked to address the intersection of gender and HIV at both the national policy and community practice levels. At the national level, POLICY and the University of Nairobi founded and managed a technical subcommittee that identified gaps in the KNASP and created a framework through which gender concerns could be integrated into the strategy. The subcommittee brought together representatives from nearly 40 organizations, including the Society of Women with AIDS in Kenya, the Kenya AIDS NGOs Consortium, and UNIFEM. POLICY/Kenya staff brought to the agenda their interest, knowledge, and skills around gender issues. NACC approved and adopted *Mainstreaming Gender into the Kenya National HIV/AIDS Strategic Plan, 2000–2005* in November 2002 as an integral part of the strategic plan. As a result, program managers now have ready access to gender-sensitive programming.

POLICY also sought to ameliorate gender inequalities at the community level. For example, women in Kenya who have lost their husbands, due to AIDS or other causes, have often been denied inheritance rights. To address this issue, POLICY's inheritance rights project has been implemented in four phases: 1) situational assessment; 2) community-based field work; 3) development of an advocacy strategy; and 4) implementation of advocacy campaigns. Collaborating partners in the project included groups such as the Kenya Human Rights Commission, Jaramogi Oginga Odinga Foundation, and the Orongo Widows and Orphans Group. Among the groups targeted by the advocacy efforts are family court judges and magistrates, chiefs, village elders, district commissioners, and women themselves. With support from POLICY, local groups have been able to reclaim land for widows and have inspired community and traditional leaders to publicly state their support for women's inheritance and property rights. These are important first steps in breaking the cycle of gender inequality, poverty, and increasing vulnerability to HIV brought about by the epidemic.

Empowering Policy Champions from Civil Society Groups

POLICY worked with various civil society groups to increase their leadership capacity in the fight against HIV. Involvement is critical to ensure that the needs of those most affected by the epidemic are met; that community leaders break the silence and stigma that hinders HIV prevention and treatment; and that resources for implementation are mobilized across all sectors. In Kenya, POLICY has strengthened the

HIV-related policy and advocacy skills of faith-based organizations, networks of people living with HIV, and other civil society groups. These groups include the Kenya Network of HIV-positive Teachers, Kenya Network of Religious Leaders Infected and Affected by HIV/AIDS, National Muslim Council of Kenya Women's Network, Network of People Living with HIV/AIDS in Kenya, and Seventh Day Adventist East Africa Union, among others. POLICY also worked with new and emerging initiatives, such as the Kenya Treatment Access Movement, for policy advocacy on access to comprehensive HIV treatment.

Facilitating Data Use and Resource Mobilization for Effective Policies and Plans

POLICY worked closely with NACC, civil society, and the private sector throughout the implementation and review of the KNASP. For example, POLICY provided technical and financial support to NACC to produce a concise and simplified, reader-friendly version of the strategic plan. This document served as the main reference point for programmers and implementers, and for carrying out NACC's Joint HIV/AIDS Program Reviews conducted in 2002 and 2005.

During the 2002 program review—a national forum for evaluating achievements and setting priorities for the remainder of the plan's duration—POLICY assisted NACC in assessing progress made toward reaching national goals. The Goals Model projections demonstrated the resources required to achieve the objectives outlined in the strategic plan. Findings showed that an additional $60 million would be needed to meet the prevention goals and $76 million for the treatment access goals. The analysis facilitated resource mobilization and helped to improve resource allocation toward more cost-effective interventions.

When NACC embarked on the development of the second strategic plan for 2005–2010, little attention was given to intervention costs or resource requirements for a credible response to the HIV epidemic. It was also difficult to determine the coverage targets and level of scaling-up that could realistically be achieved with the available resources. What then was the best way to allocate resources given the changing scenario? POLICY filled these needs by collecting data on the unit costs of various services and using the Resource Needs Model (RNM) to estimate total resources required. The process of applying the model encouraged dialogue and consensus around priority issues in the development of the new plan. Additionally, POLICY facilitated NACC's production of RNM preliminary results, which were used to cost the entire 2005–2010 strategic plan. The estimates of resource needs are being used to mobilize government, donor, and private sector resources to support the plan's implementation.

Laying the Foundation for Future Policy Work

POLICY achieved significant and long-lasting impact on the HIV strategic planning process in Kenya in the following ways:

- ✓ Costing, priority setting in resource allocation, and data collection and use will underpin future national strategy development.
- ✓ NACC has increased capacity for planning and implementation of the KNASP.
- ✓ Policy champions actively advocate for attention to gender and other HIV-related matters.
- ✓ People living with HIV are now represented in all of NACC's key committees and task forces.

Nepal is experiencing "concentrated epidemics" with an HIV prevalence rate greater than 5 percent among certain vulnerable groups. Without effective prevention and treatment, HIV could become more prevalent and AIDS could cause the deaths of up to 20,000 Nepalese annually in the near future. Prior to 2004, the battle against HIV was not a priority for the Nepal Police, but the vulnerability of uniformed services could not be ignored. Some studies show that more than one-third of the clients of prostitutes are from the uniformed services, including the police and armed forces. Furthermore, ill treatment of prostitutes is widespread, including arbitrary arrests, violence, and forced sex. Other vulnerable groups, such as injecting drug users (IDUs) and men who have sex with men (MSM), also report harassment by police, including arrests for carrying condoms. The police recognize this antagonistic relationship and struggle with their mandate to keep order and maintain public safety within an environment of contradictory and confusing laws, policies, and practices among agencies dealing with HIV. Although prevalence among the police force is unknown, the leadership assumes that HIV could affect a considerable number of its personnel, based on a 5 percent STI prevalence rate among officers visiting the Birendra Police Hospital.

Owning the Problem—and Addressing It From Within the Police Force

Early in 2004, POLICY engaged in extensive discussions with high-level police officials to sensitize leadership about crucial issues facing the police. After initial resistance, the police recognized the need for their own comprehensive approach to addressing HIV. In March 2004, the Nepal Police asked for POLICY assistance to form an HIV/AIDS Steering Committee—a multidisciplinary group representing senior police, the National Center for AIDS and STD Control (NCASC), and POLICY. As Deputy Inspector General Kumar Koirala said, "*We wanted to institutionalize the HIV prevention activities within our system...the Nepal Police should be accountable for all these activities.*" With Koirala as coordinator, the Steering Committee's mandate was to coordinate the HIV programs and initiatives of the Nepal Police with the *National HIV/AIDS Strategy* (2002–2006).

"Uniformed services personnel, and particularly police officers, must understand the impact that policing practices can have on the effectiveness of HIV prevention initiatives, and in perpetuating HIV/AIDS-related stigma and discrimination."

—Excerpted from *HIV/AIDS Strategy and Workplan, Nepal Police, March 2005*

The Nepal Police became the first branch of the uniformed services to endorse a five-year *HIV/AIDS Strategy and Workplan* in March 2005. This seminal document provides a framework and systematic approach for the police to protect themselves and their families from HIV, to sensitize them to the rights of the most at-risk populations, and to ensure that policing practices do not impede HIV prevention initiatives. While the top police hierarchy decided to create a strategy, the final product was based on broad and extensive consultation. As Koirala explains, "*They [vulnerable groups] have to be involved in the process of development of strategy and workplan... We interacted with our higher level officers, our middle-level officers, trainers, and training institutions. We interacted with our fresh police intake, our serving police officials, NCASC, and other development partners... Now we can say this is your document, it is not only that the police did it ... so we have to work together.*"

Moving Ahead with Training—Changing the System One Officer at a Time

By March 2005, Nepal Police had designed and launched its own HIV/AIDS Training Curriculum, now incorporated into its basic training program. The Steering Committee designed curricula for senior officers, mid-level officers, entry-level officers, and peace keepers, and sensitization materials for senior officials. The materials provide police with basic information on STIs and HIV, including risk factors and prevention measures, voluntary counseling and testing, care and support, human rights, and stigma and discrimination. Like the strategy itself, a participatory curricula development process led to widespread ownership of the training program.

To initiate the training program, POLICY trained 13 police master trainers, who in turn trained 130 regional police officers. Now, with 143 trained personnel, 13 of whom are women, the Nepal Police uses the curricula for training new recruits and for in-service awareness raising. The curricula also include interactive sessions with vulnerable groups. For trainees, these interactions have brought to life the reality of those affected and infected by HIV.

> "I have been in the service for 11 years and I had never imagined that we would have to talk about HIV, let alone be the ones training other officers on HIV."
>
> —*Inspector Samir Kharel*

Making a Difference—and Serving as a Model for Others

According to master trainer Inspector Samir Kharel, the training program is working. "*In one of our first trainings, our department had invited all the vulnerable groups—prostitutes, MSM, IDUs—to the police training center. None of them agreed to come for the training. They were scared of us.*" In a short period, he has seen his colleagues become more sensitive to HIV and toward vulnerable groups. Kharel still invites the vulnerable groups to share their stories. "*Now, they are comfortable with us. Wherever we have the trainings, they come and share their problems. This exchange has been very good both for us and for them.*"

> "I will not say the behavior [of the police] has been changed totally, but it is in the process of changing… We cannot change the behavior of 47,000 police officers overnight. But it's a very good start I would say."
>
> —*Deputy Inspector General Kumar Koirala*

Representatives of vulnerable groups share this sentiment. As Sunil Babu Pant of the Blue Diamond Society observes, "*After working with POLICY, the police are willing to learn, and stigma and discrimination is being gradually reduced.*" Both sides feel comfortable listening to each other's concerns and issues.

The efforts of the Nepal Police are extending beyond the communities they serve. Other branches of the uniformed services have expressed interested in replicating the training program. After hearing Koirala's presentation at the 2005 International Congress on AIDS in Asia and the Pacific, a UNFPA/Bangladesh delegation visited Nepal to learn more. UNFPA was so impressed with the program, it invited Koirala to Bangladesh to help design an HIV program for the police force under the Ministry of Home Affairs.

POLICY's work with the police highlights how, when taken together, policy dialogue and formulation, planning, meaningful participation of vulnerable groups, and capacity building can foster an enabling policy environment for HIV prevention and control.

With a population of 170 million, only five countries in the world (including India) are larger than the state of Uttar Pradesh. About 80 percent of the state's population lives in rural areas and nearly one-third (31%) lives below the poverty line. In 1992/93, about 30 percent of currently married women had an unmet need for family planning. Maternal mortality, especially among the state's predominantly rural population, is abysmally high. In some districts, 10 percent of all children die before their fifth birthday.

Given the need to revitalize and reorient the reproductive health program in Uttar Pradesh, USAID and the government of India (GOI) sponsored the Innovations in Family Planning Services (IFPS) Project. The 12-year initiative (1992–2004) had the goal of reducing the total fertility rate and improving reproductive and child health (RCH) services. An autonomous agency, called the State Innovations in Family Planning Services Agency (SIFPSA), was created to manage and implement the project.

Achieving Greater Impact through Decentralized Planning

In the early years of the IFPS Project, funds were programmed over the vast expanse of the state, which limited the potential for district-wide impacts—much less statewide impacts. To address this, SIFPSA and USAID designated "focus" districts for concentrated activities. Despite designating focus districts, the approach lacked coordination, participation by all stakeholders, and buy-in by local government and NGOs. Thus, the initial focus district approach had little impact on improving RCH indicators.

Recognizing that IFPS needed to focus efforts and concentrate resources to achieve broad-based impacts, POLICY opened a dialogue with SIFPSA and USAID on the feasibility of designing and implementing District Action Plans (DAPs) as a means of enlisting the full commitment of district leaders in the RCH effort. The approach called for mobilizing local resources in a coordinated manner, and outlined specific roles and timetables for the various partners, including government health facilities, NGOs, religious groups, employers and cooperatives, private practitioners, and district and village leaders. SIFPSA and USAID fully accepted the approach in 1998, and the DAP approach has since become one of the keys to achieving the central objectives of the IFPS Project.

Scaling Up Action Plans Across Districts

In 1997, POLICY and SIFPSA provided assistance to conceptualize and design a pilot action plan in Rampur. The Rampur DAP was a full-fledged, integrated, and funded plan based on local population and facilities survey data. The approach emphasized fostering participatory approaches to designing and programming the DAP. Thus, for the first time in the history of the national RCH program, a locally designed plan of action evolved from the collective thinking of local leadership. The Rampur pilot was a success, and SIFPSA and USAID approved the DAP model for replication in other districts. From 1998 to 2003/04, local leaders devised and adopted DAPs in all 33 IFPS districts.

Key components for ensuring that DAPs responded to and met local needs included: baseline surveys of district-specific data on family planning and RCH needs and available resources and infrastructure; district-level planning workshops with multisectoral participation to devise appropriate strategies; use of computer models to explore various policy options and impacts; preparation of detailed district profiles with proposed strategies and resource and training requirements; review by SIFPSA's Project Appraisal Committee and preparation of the budget; establishment of a District Innovations in Family Planning

Services Project Agency (or "DIFPSA") and a Project Management Unit to coordinate and monitor activities in each district; and formulation of monthly operational plans to guide activities.

Improving RCH Services for Rural and Underserved Populations

Millions of women, men, and children enjoyed direct benefits from the successful implementation of DAPs. Some of the main interventions included providing lady doctors at primary health centers, dramatically increasing the supply and demand for iron and folic acid tablets for pregnant women, and organizing integrated RCH camps that offered various services in one location on a pre-announced day. The RCH camps were pivotal in reaching rural villagers and attendance rose to record levels in 2003. From May 1998–March 2005, the camps provided family planning counseling to more than 1.7 million clients, spacing methods to more than 1.1 million clients, sterilization services to about 770,000 clients, antenatal checkups to more than 475,000 pregnant women, and immunizations to nearly 525,000 children.

The figures below demonstrate achievements in two critical areas. By 2003, only 38 percent of births were attended by trained medical personnel in non-DAP districts. In the DAP districts, about one-third (32%) *more* women, or about 50 percent of all births, had a trained attendant present. Until the DAP concept was put into place, it had been a challenge to meet demand for family planning services in Uttar Pradesh. Using a variety of approaches to reach rural populations, within a few years, contraceptive prevalence for modern methods increased dramatically in DAP districts. By 2003, it had reached 27 percent in DAP districts, six percentage points higher than the non-DAP districts.

2003 Maternal Health Performance: DAP and Non-DAP Districts

2003 Modern CPR: DAP and Non-DAP Districts
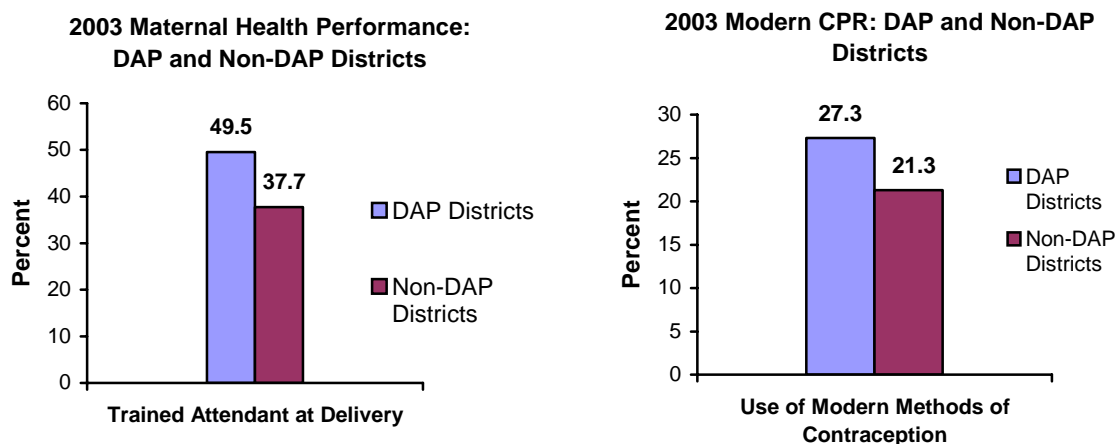
Achieving Long-term Impact

Besides the direct RCH-related benefits in Uttar Pradesh mentioned above, the GOI has adopted the DAP approach in several of its key health and development programs. In 2004, DAPs were formulated in an additional seven districts in Uttar Pradesh as part of the national government's Empowered Action Group scheme. These are known as the Decentralized Participatory Planning districts. In addition, in 2005, the GOI launched the National Rural Health Mission (NRHM), a massive effort to rapidly scale up a range of healthcare services for rural populations in the country's poorest 18 states, including Uttar Pradesh. District action planning and decentralized health management are central components of the NRHM and the program requires that every state submit two sample DAPs with the State Project Implementation Plan. POLICY created a DAP manual that serves as the official guidance to states and districts on how to create, carry out, and monitor district health action plans.

APPENDIX B.
FURTHER READING

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