7
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Reforming Operational Policies:

A Pathway to Improving Reproductive Health Programs

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December 2001

POLICY

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Acknowledgments

POLICY Occasional Papers are intended to promote policy dialogue on family planning, reproductive health, and HIV/AIDS issues and to present timely analysis of issues that will inform policy decision making. The papers are disseminated to a variety of audiences worldwide, including public and private sector decision makers, technical advisors, researchers, and representatives of donor organizations. An up-to-date listing of POLICY publications is available on the web at www.policyproject.com. Copies of these publications are available at no charge.

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Executive Summary

Many countries around the world have made great progress in improving reproductive health programs that now reflect the principles of the 1994 ICPD *Programme of Action*. Governments and donors have pursued two main routes to improving reproductive health. First, they have enacted national policies and laws aimed at expanding services and raising the quality of available services. Second, they have implemented a wide range of service projects and demonstrations to show how services can be enhanced and client education improved. Too often, however, national policies and laws are not translated into systemwide programs and improved reproductive health services, especially for the poor. Because these doctrines are necessarily broad and encompassing, they neglect the structures and systems that serve as a bridge between national policies and local programs. Projects and demonstrations are often not replicable because they are not financially sustainable in the long run. More important, they generally do not systematically address the underlying policy constraints in the structures and systems that affect the service delivery environment. This paper focuses on the vast arena between national policies and the point of service delivery, which is the domain of operational policies.

Operational policies are the rules, regulations, codes, guidelines, and administrative norms that governments use to translate national laws and policies into programs and services. While national policies provide necessary leadership and guidance, operational policies are the means for implementing those policies. In many cases, program deficiencies, such as a lack of trained service providers and other resources, can be traced to operational policies that are inadequate, inappropriate, or outdated. Poor operational policies result in wastage and inefficiency that pervade every clinic, health post, and hospital and adversely affect health personnel and every client. When drafted or modified appropriately, operational policies can help enhance the quality of reproductive health programs by making more efficient use of existing resources.

The paper discusses the nature of operational policies, stresses the important role they play in the continuum from national decrees to local services, and provides a framework for operational policy reform. The operational policy reform process calls for

- understanding the public sector, which gives rise to the policies that shape the service environment;
- setting up a collaborative system with managers and providers for identifying

operational barriers to high-quality reproductive health care;
- conducting analyses to determine the operational policy roots of those barriers; and
- adopting recommendations and strategies to remove the operational policy barriers.

The process of analyzing operational policies and devising reform strategies is most effective as a participatory endeavor that draws on the insights and perspectives of those who manage and provide reproductive health care services and those who set policies.

The paper also provides evidenced-based examples of how operational policy analyses have illuminated the debilitating effects of outdated or nonexistent policies on reproductive services in a number of countries, including Guatemala, Haiti, India, Jordan, the Philippines, Romania, and Ukraine. The analyses led to reform initiatives that helped governments at all levels. Analyzing operational policies and supporting policy reform is a highly effective tool for improving the delivery of much-needed reproductive health care services in developing countries.

Introduction: Impact of Operational Policies on Reproductive Health

The purpose of this paper is to develop an increased understanding of an area of public sector policies that must be addressed in order to improve reproductive health services. No matter how they are defined, operational policies can be found almost everywhere in the health systems literature, and their consequences are apparent in every clinic, health post, and hospital. In simple terms, operational policies are the rules, regulations, codes, guidelines, plans, budgets, procedures, and administrative norms that governments use to translate national laws and policies into programs and services[1] (Cross, 2000). Operational policies govern the "operating system" for public sector programs. To use a computer analogy, operational policies are the "language" that governs the relationships between health system inputs and outputs. If the "language" does not govern efficiently, the operating system is bound to fail. The symptoms of failure are not unlike the computer crash where the machine simply stops functioning as intended.

Operational policies also have a critical economic aspect. Operational policies are one of the determinants of how inputs to the health care system (e.g., resources such as personnel, equipment, and transportation) are deployed once health care priorities have been determined. Poor operational policies can limit the production of high-quality health care outputs and lead to inefficiency[2] and wastage in health care programs.

Governments Remain Pivotal to Reproductive Health Services

Despite growth in the private sector provision of health care in developing countries, the public sector still plays a critical role in the delivery of reproductive health services. In many countries, the poor rely exclusively on government programs for family planning. In almost 70 percent of the countries surveyed in the past five years, the public sector

[1] The policy working group of the USAID-funded Evaluation Project defined four components of operational policies directly related to the operation of national family planning programs: organizational structure and process; the legal and regulatory environment; provision of resources; and pricing (Bertrand, Magnani, and Knowles, n.d.). This definition did not include the rules that govern how systems operate, which are the vital "glue" that holds systems together.

[2] Microeconomic efficiency refers to the scope for achieving greater efficiency from existing patterns of resource use. Wastage and inefficiency occur in all health systems. Allocative inefficiency occurs when resources are devoted to the wrong activities while technical inefficiency occurs when too many resources are used to achieve a given health intervention or outcome (WHO, 1999).

accounts for 50 percent or more of family planning services (DHS, 2001). Similarly, for maternal and child health services, poorer groups depend heavily on government services. Not only do governments provide a large share of the services thought to be most effective in preventing deaths and illness, but they also pass and enforce the laws, regulations, and codes that greatly influence the provision of these same services by commercial providers and other nongovernmental organizations (NGOs).

Although the public sector plays an important role in providing reproductive health services, most efforts to improve family planning and reproductive health (FP/RH) programs have addressed only national public sector policies and focus on service delivery performance and the private sector (Seidman and Horn, 1991; Ross and Frankenberg, 1993; Population Council, 1998a, 1998b; Shane and Chalky, 1998; Miller et al., 1997; MSH, 2000). The gap between national policy and improved service delivery performance has been the lack of attention to operational policies.

Consequences of Faulty Operational Policies: Inefficiency and Wastage

The past 50 years have witnessed tremendous expansion of government-run health care systems accompanied by burgeoning bureaucracies that have become rigid and inefficient (WHO, 2000). Initially responsible for financing and operating public hospital and primary care systems, ministries of health are now large, hierarchical bureaucracies characterized by unwieldy administrative rules and a permanent staff protected by civil service regulations (Bossert et al., 1998). The problems faced by ministries of health are exacerbated by inefficiently run government systems on which ministry operations depend, including civil service regulations and public works and transportation norms, among others. As a result, policies and procedures that may be burdensome, conflicting, obscure, outmoded, and difficult to change often govern quality, access, and working conditions at the point of service provision. Many of these operational policies create conditions that act as disincentives for health workers to perform their duties, or even show up for work.

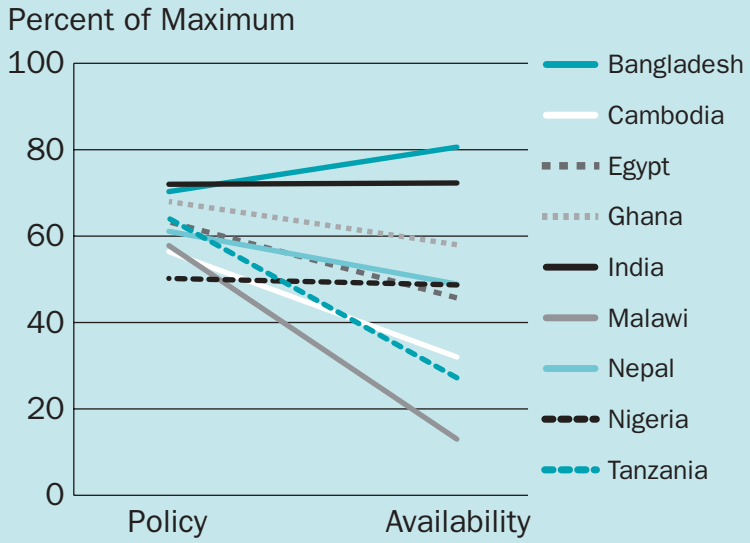
The consequences of flawed operational policies are well documented. In Kenya, Owino and Korir (1997) estimated an average inefficiency level of 30 percent in the public health sector as a consequence of factors such as a shortage of professional staff, a poor combination of inputs, irregular or nonfunctioning operating theaters and laboratories, transport problems, lack of or poor distribution of drugs and medical supplies, frequent breakdown of equipment, and/or poor servicing of machines and equipment. In Bungoma District, Kenya, district health management boards are responsible for supervising the health system in the district. However, the boards lack a budget, transportation, and the authority to discipline any medical personnel (BDMI, 2000). Nurses who run health posts in Kenya have to travel to the district hospital to receive their monthly pay; some travel as much as one day each way, thus losing 10 percent of their potential work time (Sharif, 2001).

In Uganda, an expenditure tracking exercise revealed that a significant portion of funds allocated to basic social services never reached the intended health clinics or schools, particularly in rural areas (Ablo and Reinikka, 1998). In Ghana in the early 1990s, 70 percent of Ministry of Health (MOH) vehicles were reported to be waiting for repair in government workshops. Reorganization of maintenance and repair arrangements and budget practice led to rapid improvement, but Ghana's recent experience is widespread (WHO, 2000). A study of the management information system in Uttar Pradesh, India, found that too much information is collected on too many forms, and most of it is never used. At the subcenter level, auxiliary nurse midwives had to fill in 13 registers and four forms each month (POLICY Project, 1998a).

Operational Policies Are Neglected

Over the past 30 years, governments and donors have overwhelmingly focused on national policies and general program directions as well as on community-level service delivery performance and demand. Efforts to improve national policies have included follow-up strategic planning and, in some cases, program planning and budgeting. As illustrated in Figure 1, these efforts have not extended to analysis and correction of operational policy barriers that might impede the implementation of a national policy or strategic plan. Program effort scores[3] (Ross and Stover, 2000) demonstrate that national policies do not necessarily translate into program action, such as family planning method availability—an important proxy for access and one indicator of quality. Figure 1 also shows that in the "policy" category of the 1999 program effort survey, all nine countries score between 50 and 70 points out of a possible 100. In contrast, the "method availability" category shows scores ranging from 13 to 80 points—a huge deviation from the patterns in the policy category. This deviation illustrates that the mere existence of laws, policies, national population councils, and official program documents does not guarantee family planning access and use.

Figure 1. Program Effort Scores by Country



[3] *The Program Effort Score (PES) study has a 30-year history (Ross and Mauldin, 1996). The PES contains a component on operational policy that measures three subdimensions that are directly related to the operation of the national program. The three subdimensions include organizational structure and processes, the legal and regulatory environment, and the provision of resources.*

There are significant operational policy barriers to ensuring sustainable access to high-quality reproductive health services. Hardee et al. (1999) identified the following difficulties in implementation of the 1994 ICPD *Programme of Action:* (1) prioritization of reproductive health interventions to provide program guidance, (2) initiation of FP/RH program expansion, and (3) mobilization of financial resources. Others have made similar observations (Ashford and Makinson, 1999; Forman and Ghosh, 2000; Tantchou and Wilson, 2000). While developing countries need national policies to provide leadership and direction at the national level, they also must have the political will and the means to implement them. They need money, other resources, and operational policies to make implementation possible.

Similarly, investments in service delivery have focused on certain inputs such as training of staff or procurement of commodities. Much of the time, an investment is made without examining the relevant operational policy environment to make sure that the health system uses the investments productively. Jordan provides an instructive example. A major donor has trained some midwives to insert intrauterine devices (IUDs), but the interpretation of the public health law governing the medical professions allows only physicians to insert IUDs (JNPC and POLICY Project, 2000). At a minimum, the training program should not have been undertaken without some indication from government policymakers that the operational policy barrier would be addressed.

Governments and especially donors have attempted to overcome implementation problems by carrying out demonstration projects and operational research in specific areas, such as a district. In these costly interventions, demonstrations often attempt to overcome operational barriers not by changing the policies that create them but rather by "financing" around them, as shown in Box 1. As an example, instead of addressing operational policies that keep vehicles in perpetual states of disrepair, a demonstration project purchased new vehicles. Not surprisingly, many such interventions are successful for the duration of the demonstration or research. However, if the demonstration's design does not address underlying operational policy barriers, there is a high likelihood that the health system will return to its original state as soon as the financial assistance is withdrawn.

In sum, until recently, governments and donors seem to have focused on policy at the highest level and performance at the service level. They implicitly assumed that

Box 1. Operational Policies: A Key to Scaling Up Pilot Projects

"To address a basic breakdown in the primary health system as a result of decentralization, USAID funded a pilot project in Cameroon to introduce a new approach to financing and delivering health services. Thanks to the provision of a steady drug supply, a system of revolving funding, and an upgrade of free primary health care, the project was a major success when it concluded in 1994. However, it has not been scaled up. The new aspects of this pilot [project] required obtaining temporary waivers of normal procedures. These temporary waivers were not translated into the operational policy reforms necessary for the project to be replicated."

(World Bank, 1998)

implementation automatically follows policy reform and that technical interventions lead to permanent systemwide improvements absent any other changes. These assumptions were often erroneous and highlight the need for greater awareness of operational policy barriers and their consequences in all stages of policy and program design and at all levels of management.

Undermining Investments in Health Sector Reform

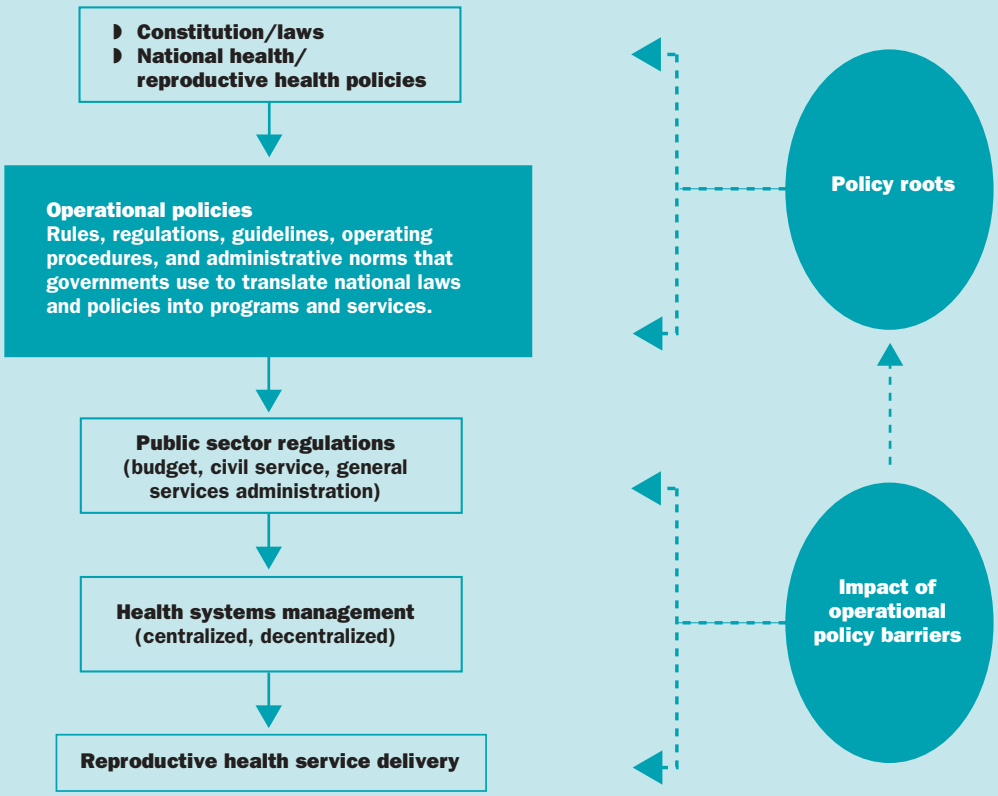
Increasingly, experts in the field are reaching the conclusion that the neglect of policies and procedures that are responsible for inefficient practices undermines the investments of ever-scarce resources needed to expand services to meet rising demand for health care. Health sector reform initiatives tend to focus on the macroeconomic context, on financing issues, and on the use of incentives and disincentives to motivate health care managers and staff (Cassels, 1995; Berman, 1995; WHO, 2000). Experts have determined, however, that more needs to be known about the health systems environment in which staff work (Berman, 1999; Shaw, 1999; WHO, 2000; Manning, Mukherjee, and Gokcekus, 2000). Indeed, operational policies are central to understanding the health systems environment.

It is vital that governments work to improve operational policy efficiency as an integral element of health reform. The challenge is daunting not only because of the complexities of operational policies and bureaucratic inertia but also because some policies preserve longstanding patterns of improbity. However, the central role of the public health sector and the impact of its policies on the nongovernmental sector make it imperative that reform initiatives focus on the "nuts and bolts" of those cumbersome and detailed administrative rules that hinder the operation of health systems and the ability of health care managers and providers to perform their jobs. Therefore, health reform initiatives, especially those affecting reproductive health, must explicitly understand the policy roots of operational barriers and find workable ways of resolving them. Without such understanding and actions, it will be difficult to implement health reforms successfully, and it will be almost impossible to improve public sector reproductive health services.

The Policy Roots of Operational Barriers

National policies, such as reproductive health policies, provide the broad vision and framework for government action. To succeed, national policies must be translated into programs that will achieve the goals set forth at the national level. Such goals include, for example, a reduction in maternal mortality or the incidence of HIV/AIDS or expanded access to family planning. Moving from national policies to local programs requires the design and implementation of operational policies that, in turn, have a determining influence on health management and services (see Figure 2).

Figure 2. Conceptual Framework for Operational Policies



Box 2. Levels of Policies Governing Public Sector Health Programs and Examples of Operational Policies

Constitution/Laws/National Policies

- National laws affecting reproductive health
- National reproductive health-related policies
- Human rights guarantees

Operational Policies

Public Sector Regulations

- Budget (process for determining annual funding, level and allocation, flexibility)
- Taxes and duties (excise, import, value-added tax (VAT), exemptions)
- Personnel (rules for hiring, firing, transfer)
- Buildings and grounds (utilities, building and maintaining the physical infrastructure)
- Transportation/vehicles (resources and rules for obtaining and maintaining vehicles, fuel)

Health Systems Management

- Policy, planning, and evaluation (process and procedures)
- Organization (centralized and decentralized responsibilities)
- Facility-based services organization (location, distribution, lines of authority)
- Community-based service organization (location, distribution, lines of authority)
- Standards and accreditations (personnel, facilities)
- Fees for service (levels, exemptions)
- Procurement/logistics (procedures, regulations)
- Management information systems, monitoring (regulations, circulars, procedures)
- Referral systems (guidelines, circulars)
- Client rights (regulations, norms)
- Regulation of the private health sector

Service Delivery (including reproductive health)

- Organizational structure (lines of authority)
- Personnel (clinic and community-based: job descriptions, allocation of time, recruitment, deployment, professional development, training, supervision, performance appraisal)
- Tangibles (equipment, materials/supplies, procurement and maintenance of pharmaceuticals)
- Logistics management (transport, warehousing, inventory, cold chain, ordering)
- Facilities maintenance (circulars, regulations, guidelines)
- Financial management (guidelines on retention of fees, management of funds, facility budgeting, local procurement)
- Clinic organization/patient flow (hours of operation, availability of medical personnel)
- Clinic records, management information systems, including service statistics (guidelines, circulars on compiling and reporting information)
- Service delivery guidelines/protocols/norms/standards (medical, counseling, education services, informed choice/consent)
- Quality assurance system
- Client outreach/follow-up

Levels of Operational Policies

Box 2 shows the hierarchy and range of laws, regulations, and policies that affect the provision of reproductive health services as organized by governmental level. Laws, regulations, codes, and policies affecting the operations of a health system range from those governing import duties and budget allocations, tenders, and purchases of contraceptives at ministerial levels to those influencing how health personnel at the primary care level spend their time and the quality of treatment clients receive at the facility level.

Operational policies derive from all levels of the governmental system—from the constitution and laws to the service delivery point—and are within the purview of several ministries and executive agencies. Addressing operational policy barriers may require attention to one or more levels of government; to one or more laws, regulations, or policies; and to one or more agencies or ministries.

Categories of Operational Policies

In addition to understanding the different *levels* at which operational policies function, it is useful to *categorize* operational policies according to the component of the health care delivery system they govern. With a barrier to services identified at the operations level, the categories of policies can be used as a checklist to determine which policies most likely create the barrier.

For example, assume that beneficiaries in community X are not receiving the attention they expect from health workers because the health workers are not visiting villages as often as they should. To understand the operational policy roots of the problem, it would be important to first ask why the workers are not showing up. Depending on the answers, the next step would be to look for possible operational policy roots in the categories of personnel, transportation, training, and supplies. Inevitably, one would expect to find one or more operational policies that are behind a workers' failure to visit the community and hence are affecting the worker's performance.

Figure 3 shows the categories of operational policies that might be found in a governmental health system.

Box 3 shows examples of operational barriers for the various categories of operational policies in Figure 3.

Determining the Policy Roots of Operational Barriers

Problems with operational policies can manifest themselves in different ways. The cause of some operational barriers is inappropriately attributed to operational policies that are only presumed to exist. For example, providers may impose conditions of spousal consent or age limitations on certain contraceptive methods in the mistaken belief that laws or regulations specify such conditions.

Operational policies may interfere with service delivery as a result of misguided

policy design as, for example, in the case of lack of clarity in the law. In Jordan, the MOH and the medical profession interpret a provision of the public health law to mean that only licensed doctors of medicine may insert an IUD, although no explicit prohibition exists on insertion by nurses and midwives.

In other cases, there is a policy vacuum such that policymakers must develop operational policies where none existed previously. With India's target-free approach implemented during the 1990s, the country failed to develop operational policies to guide program implementation. A policy vacuum may also exist when health sector reform is introducing major changes to a country's health system (POLICY Project, 1998b; 2001b).

An operational policy vacuum continues to exist in many countries as they embark on expanded national HIV/AIDS programs. Owing to its completeness and adherence to international HIV/AIDS principles and agreements, the Philippines's national HIV/AIDS policy and strategic plan provides a model that other Asian nations have followed. Yet, the plan's operational policies actually foster an environment that is contradictory to the Philippines's national policy. For example, while the Sanitation Code of 1975 requires all female sex workers to be regularly tested, it places an age restriction on clients of government health clinics responsible for detecting and treating STDs and HIV/AIDS (Government of the Philippines, 1975). Thus, female sex workers under the age of 18 (who are the majority of sex workers in some places)

Figure 3. Categories of Operational Policies

Box 3. Examples of Operational Barriers by Category of Operational Policies

Barrier	Category of Policy
Frequent absence and turnover of personnel	Personnel, financing
Disproportionate urban-rural or regional distribution of doctors and nurses	Organizational structures, personnel, financing, resource allocation
Medical barriers such as restrictions on the personnel permitted to distribute given contraceptives or to administer drug treatment and the requirement for spousal consent for services	Medical norms
Limited choice of contraceptives	Medical norms, financing, taxes
Stock-outs of contraceptives, drugs, and supplies	Supplies, financing, vehicle/transport
Wastage of commodities	Supplies, information, financing
Inadequate pre- and in-service training	Training, personnel, organizational structures
Lack of transportation for emergency obstetric cases	Vehicle/transport, resource allocation
Weak referral systems	Organizational structures, training
Burdensome reports for management information systems (and lack of understanding of how the information from service statistics can be used)	Information
Long delay in new directives from the central level reaching local levels	Organizational structures, communications

have little if any access to preventive and treatment services (POLICY Project, 2001a).

Cambodia has promulgated a national policy and a corollary policy statement specifically protecting the human rights of its citizens with HIV/AIDS. Yet, the country has no labor policy for the treatment of workers with respect to HIV/AIDS. Employers can dismiss with impunity workers with HIV/AIDS. A similar situation exists in the Philippines, where the Department of Labor has no workplace policy for businesses with respect to HIV/AIDS.

Other operational policies are inappropriate because they are out of date. In India, for example, midwives continue to fill out forms with information that is no longer even used. Once introduced, registers are never withdrawn, resulting in a misuse of labor by the most essential health worker (POLICY Project, 1998a).

Some operational policies are sound, but their implementation is slowed by the lag between the time that the policies are developed and the time they are communicated to relevant levels of the health system. For example, in the Philippines, a World Bank assessment in

the late 1980s noted that eight months elapsed for a directive to go from the Department of Health to the local level (Feranil, 2001). The process of communicating a policy or directive is in itself an important operational policy.

It is also important to identify which operational barriers may not have policy roots. Some barriers, for example, can be resolved by delivering training or tools to improve knowledge, skills, and practice (e.g., contraceptive technology updates or training on existing norms and standards or improving management practices). Other barriers are the product of sociocultural attitudes or result from inadequate resources (e.g., resource allocation policies are sound, but the limits in funding prevent acquisition of needed equipment, supplies, or maintenance). Barriers associated with inadequate resources must be eliminated by setting appropriate priorities or increasing resources. Still, numerous problems that occur at the operational level result from policy barriers.

Operational barriers often seem formidable and intractable; yet, there are proven ways to identify and address the policy roots of operational barriers. The following section outlines methods for addressing operational policy barriers.

Methods for Addressing Operational Policies

Addressing operational barriers and their links to operational policies requires four broad steps as follows:

- understanding the public sector;
- setting up a collaborative system for identifying barriers;
- conducting analyses to identify the policy roots of the barriers; and
- following through with the recommendations of the analysis to remove the policy barriers.

The sections below describe each of these steps in more detail.

Understand the Public Sector

An assessment of operational policies must begin with a thorough understanding of the public sector. We are interested in what Donabedian termed the "structure" of care,[4] "the relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and of the physical and organizational settings in which they work" (Donabedian, 1980: 81). The first step is to obtain a clear picture of the policy environment of the public sector within which a health care system operates—and how health service operational policies relate to national laws and policies, public sector regulations, health systems management, and reproductive health service delivery (see Figure 2 and Box 2). Operational barriers can be traced to these four levels, and many barriers are affected by policies at multiple levels. As shown in Box 4, a range of agencies is involved in setting operational policies.

The second part of understanding the public sector is to include the perspectives of the managers and staff most knowledgeable about operational problems and their impact on access and quality. Often, managers and staff within a health care system do not know or do not explore the underlying policy causes of the operational problems they encounter; however, when asked the right questions, they can provide invaluable insights into the workings of the public sector.

Not all policy barriers have the same impact on access, quality, and efficiency; not all policy barriers require the same resources for their elimination. Box 5 presents an example checklist that can be used for setting priorities for addressing

[4] Donabedian's (1980) classic framework for assessing quality in health care served as the basis for the Bruce/Jain family planning quality of care framework (Bruce, 1990). Donabedian included three components in his framework: the structure of the system, the process of care, and the outcome of care.

Box 4. Levels of Operational Policies and Responsible Agencies

Policy	Agency or Ministry
Public Sector Regulations	
Taxes, duties, patents, approval for manufacture, import, sale of pharmaceuticals	Legislative and executive branch, ministries of finance and commerce
Appropriation, resource allocation	Legislature, ministry of finance
Financial management	Treasury, ministry of finance
Regulations to implement laws in fields of health (including insurance), finance, human rights	Ministries of health, finance, administration, labor, food and drug administration, agencies with judicial oversight
Personnel	Civil service authority
Public facilities and equipment (planning, use, construction, maintenance)	Public works
Executive orders	Chief of state
Health Systems Management	
Public health system executive orders and management policies (manuals, circulars, directives)	Minister of health, secretary general/principal secretary, bureau/division chiefs (of medical services, primary health care, procurement, pharmacy, training, IEC), regional/ departmental medical directors
Licensure, accreditation, government medical/ pharmaceutical professions, standards of care medical/pharmaceutical professions	Government accreditation boards, professional associations of physicians, nurses, midwives, pharmacists
Admissions, curricula, standards in facilities/ schools of medicine, nursing, midwifery auxiliaries	Faculty/school staff, professional associations
Insurance norms	Minister of health, regulatory commissions
Service delivery guidelines/protocols/ norms/standards	Bureau/division responsible for norms and standards
Types of services to be provided by various health care personnel	Professional associations of physicians, nurses, midwives and pharmacists, ministry of health
Service Delivery (including reproductive health)	
Personnel deployment within a jurisdiction, scheduling, assignments, budgeting, performance monitoring, collection of fees	District chief medical officer, district hospital supervisor, director of nurses, supervisor of health workers, clinic medical officer, chief nurse, manpower/personnel officers, politicians
Planning workloads, equipment, supplies, commodities	District chief medical officer, district hospital supervisor, director of nurses, supervisor of health workers, clinic medical officer, chief nurse
Clinical procedures	Regional/departmental medical directors, clinic managers, chief nurse

operational policy barriers. The checklist can be used throughout the process of identifying and analyzing operational barriers and their policy roots. Information on the checklist can be filled in as it becomes available in the process. Figure 3 and Box 3 can be used to identify the type, scope, and impact of the operational barriers (the barrier; potential impact on access, quality, and efficiency of the barrier to be removed; and complexity of the barrier). Other information useful to determining which operational barriers to address includes potential support or opposition to addressing the barrier, the time and resources required to make a change, what needs to be changed about the operational policy (policy vacuum, policy presumed to exist, policy exists but implementation is slow, policy is out of date), and the ease of the decision to change the operational policy (e.g., an executive order or an act of parliament). With this information, operational barriers can be ranked by priority.

Take a Collaborative Approach

Collaboration is one of the most productive strategies for ensuring that all government policymakers, local institutions, and donor agencies focus on complementary approaches to solving operational problems. Most of these individuals and organizations neither have the mandate to address policies beyond

Box 5. Checklist for Determining Priority Operational Barriers to Be Addressed

Barrier *(Use Figure 3 and Box 3 to classify and describe barrier)*	**Potential impact on access, quality, efficiency in reproductive health programs** *(Strong, medium, low)*	**Complexity of the barrier** *(High, medium, low)*	**Potential support or opposition** *(Describe)*	**Time required to change** *(Short, medium, long)*	**Resources required to change** *(Financial, human)*	**What needs to be changed?** *(Policy presumed to exist, policy based on lack of clarity in the law, policy vacuum, slow implementation, out of date)*	**Ease of decision to change operational policy (e.g., executive order rather than act of parliament)** *(Difficult, medium, easy)*	**Priority rank** *(High, medium, low)*

their immediate operational setting nor often look at policies in other sectors that might affect health. Nonetheless, organizations—whether local or international—that work on policy issues can address all levels of policymaking, from the president and parliament down to the decentralized level. They can work on policy issues beyond the reach of the operational-level staff and, in collaboration with service delivery organizations, ensure sound problem analysis and appropriate, practical reforms.

For example, the Maximizing Access and Quality (MAQ) Initiative focuses mainly on the reproductive health service delivery level by seeking interventions[5] that will improve the care received by clients. However, commitment of leadership is envisioned as the first of many MAQ interventions needed to ensure support for change. Therefore, organizations with policy expertise should be included in the design and support for MAQ activities. Otherwise, these activities might not elicit support from the requisite level of decision makers and may be stalled, as demonstrated in some of the Francophone region MAQ efforts.

In a Francophone MAQ conference (Dakar, March 1999), participants reported on progress with development of protocols, norms, and procedures (PNPs). Despite the high quality of both the content of and process for developing many of the PNPs, nearly all participants agreed that there was little evidence that the PNPs were being effectively implemented at the operations level. Reasons included "lack of resources" and "lack of training." In other words, an important component of operational policies existed but remained "on the shelf" because commitment to PNPs seldom went higher than a division or bureau chief or the staff responsible for the national family planning program. Policies that have an impact on the implementation of PNPs include personnel deployment, changes in job descriptions and working conditions, training needs assessments, resource allocation, and preservice training. Those with control over such policies include high-level ministry officials, professional boards and associations, and faculties of medicine and nursing. In most cases, these decision makers were not engaged from the outset of the PNP process; therefore, they had yet to be persuaded of the need for policy reform in their respective areas.

As a precursor to the MAQ Initiative, several studies looked at the "medical barriers" to family planning services (Hardee et al., 1998; Bertrand et al., 1995; Galway, 1992; and MSPAS, OPTIONS, and USAID, 1993). Shelton, Angle, and Jacobstein (1992) listed seven types of medical barriers: inappropriate contraindications, eligibility requirements, process or scheduling barriers, provider bias, regulatory hurdles, limits on who can provide services, and inappropriate management of side effects. A number of these barriers have policy implications. In Guatemala, for example, an organization

[5] *The 12 areas of intervention in the MAQ Synergy of Interventions framework include (1) leadership; (2) client engagement; (3) community engagement; (4) provider rewards/environment; (5) standards/guidelines; (6) organization of work; (7) training; (8) job aids; (9) supplies/logistics; (10) supportive supervision; (11) indicators/certification; and (12) problem solving.*

working on policy issues teamed with other partners in a study of medical barriers among providers (Jewell, 2000). By bringing a policy perspective to the study, the team identified the policy issues underlying the identified barriers. The providers are now addressing the policies as they work toward making permanent and long-term improvements to access and quality of services (MSPAS et al., 2000). In a complementary activity carried out by the same policy organization, a report on Guatemala's reproductive health laws and policies clearly set out the legal and policy basis for the right to family planning information and services. Consequently, advocates are using the report as a tool in their campaign to work with the Minister of Health, who is known as a strong family planning supporter, to promote the elimination of medical barriers identified in the study.

As a complementary initiative to the MAQ Initiative, international reproductive health organizations are undertaking another quality improvement initiative in the area of performance improvement that focuses on human resources and branches out to institutional factors when such factors are determined to impede the performance of a health care worker. For example, if a worker is not doing his or her job, one "root cause" may be inadequate facilities, equipment, or supplies. Inadequate facilities, equipment, and so forth have their causes in management systems but also in the operational policies that govern those systems. To date, performance improvement has focused primarily on the service delivery level. Adding a policy approach can extend the focus to all levels of the public sector system.

Situation analysis studies can uncover a problem with particular subsystems in a family planning or reproductive health program but do not necessarily identify the operational policy issues perpetuating the problem. Furthermore, the organizations conducting the operations research are often not the organizations charged with making the necessary changes to programs or policies.

Situation analyses that show changes over time (e.g., Burkino Faso, Kenya, Senegal, and Zimbabwe) provide an opportunity to identify areas where improvements over a long period have not been significant and to determine whether underlying policies impede progress. For example, one study in Kenya found that, while more education materials were available in clinics over a six-year period, there was no improvement in health talks provided to waiting clients and no improvement in the frequency of supervision—despite similar findings and recommendations in earlier studies (Ndhlovu et al., 1997). The findings could be further examined for policy roots that may prevent personnel from taking action. Do personnel policies block efforts to ensure that job descriptions, working conditions, training, and placement for clinic staff accommodate the need for more health talks, more supervision visits? Do vehicle maintenance, repair, and use policies support more frequent supervision visits?

Analyze the Operational Policy Barriers

In view of the wide array of possible problems and causes and the range of

opportunities for intervention, many methods are available for studying operational policies. The selected method should, however, adhere to certain principles that are likely to lead to successful outcomes. First, all methodological approaches should be based on two integral components of total quality management: the principles of mapping or diagramming operational processes and root-cause analysis, which identifies a problem and follows it to its primary cause (or causes) (Juran and Gyrna, 1988; Ishikawa, 1982; Omachonu, 1991). Second, analysts need to collect accurate and thorough information about the barriers or inefficiencies, including data about the extent of the problem, its impacts, and the operating policies that cause the barriers. The information must include the exact operational policy document (decree, joint circular, regulations) and information about who is responsible for and can change the operational policy.

Third, a participatory process is critical. In addressing operational barriers and their policy causes, the involvement of managers and staff from appropriate levels is crucial for accurately identifying the most important and the most wasteful barriers. However, it is equally crucial to engage high-level decision makers to secure their commitment from the outset to tracing the barriers back to their root causes and seriously considering the resulting data. Once data have been analyzed, field staff should assist, first, in identifying and ranking operational policy barriers that need to be addressed and, second, in offering solutions for eliminating the barriers. Researchers need to help design the studies, collect the data, and perform the analyses required to address operational policy barriers. Policymakers need to be included to ensure appropriate changes in the larger policy environment that lead to implementation of policy reforms.

Methodologies that have been used to study the operational barriers and their operational policy roots include the following:

- Collaborative studies of operational problems that focus on a particular perspective (e.g., medical barriers, maximizing access and quality, situation analyses) in which a policy organization has joined with counterpart institutions for the express purpose of identifying and addressing the policy-related causes whose resolution is beyond the reach of operations staff (Galway, 1992).
- Legal-regulatory studies that inventory relevant legal and policy texts and examine their impact at the operational level through key information interviews (JNPC and POLICY Project, 2000; Iknane et al., 2000; Rudiy, 1999; Ravenholt, 1999; Ministère de la Santé Publique, 1994).
- Direct studies of specific operational problems that link problems to their policy roots (POLICY Project, 1998a; Bailey et al., 1994; Adé, Eustache, and Guengant, 1996; Huk, 2001).
- Financial, budget, and administrative analyses that show where resource allocation policies, financing practices, and administrative procedures cause operational inefficiencies (Olave, 2000; IIHMR and POLICY Project, 2000).
- Policy environment and program effort studies in reproductive health (including family planning, safe motherhood, and

HIV/AIDS) that identify operational policies needing correction (Ross and Stover, 1997; Stover, 1999; Bulatao and Ross, 2000).

Follow Through with Recommendations to Reduce Operational Policy Barriers

Identifying and analyzing operational policy barriers are only half of the process. Taking steps to reduce or eliminate the barriers is equally important.

An extensive analysis of operational policy issues in Uttar Pradesh, India, followed a systems analysis approach to identifying numerous policy-related barriers (POLICY Project, 1998a). The researchers started at the facility level of the public health system by compiling a list of operational conditions at primary health centers and subcenters. Conditions included the presence of adequate supplies and commodities, functioning equipment, available personnel, status of maintenance, vehicle availability, and so forth. They then collected all circulars and memorandums issued on relevant subjects such as transport, logistics, and staff transfers, among other topics, over a set period of time. They also analyzed data from available registers and reports. Finally, the researchers interviewed key individuals at each level to understand how they interpreted the operational problems and to identify which operational policies caused which adverse impacts on system performance.

Throughout the process of identifying the operational barriers, analyzing the policy roots, and recommending solutions, the research team briefed the appropriate policymakers. As a result, the 2000 Uttar Pradesh State Population Policy addressed all the major operational policy issues revealed in the Uttar Pradesh studies (Government of Uttar Pradesh, 2000). The steps to revise the policies were included in the state's detailed plan for operationalizing the policy, and the implementation plan was formally adopted in 2001.

In Haiti, the mapping of facilities and personnel graphically illustrated the disproportionate allocation of resources in the national health service delivery system as described in a widely distributed report (Adé, Eustache, and Guengant, 1996). The information from the mapping project is now serving as a data source for policy analysis and as the basis for reform, including the proposed expansion of mobile clinics by the MOH and the development of the first national population policy.

In Jordan, as a follow-up to the study on policy, legal, and regulatory barriers that identified exclusive provision of IUDs by physicians as a barrier to access to IUDs, advocacy activities have included a workshop and discussions between a policy organization and the MOH (Almasarweh, 2001; JNPC and POLICY Project, 2000). The national task force charged with drafting the Reproductive Health Action Plan (RHAP) has recognized the importance of this barrier and has included its elimination among the activities to be implemented during the next three years.

In Romania, a legal and regulatory analysis that identified gaps in insurance

coverage formed the basis for recommendations to fill the gaps. In 1997, Romania passed a social health insurance law that provided a general framework for insurance. The MOH, the Health Insurance House, and the College of Physicians were responsible for specifying which services would be included. Among other advocacy activities, a study of the cost-effectiveness of contraception (Jensen and Stanescu, 1998) convinced the government to include FP/RH in the health insurance basic benefits package. Health reform made the social health insurance system primarily responsible for service delivery while the MOH's focus shifted toward operational policy development and management of national programs. In 2000, Romania approved three broad contraceptive security policies that together lay out a framework for contraceptive targeting and financing. Now the government is developing clear criteria and implementation guidelines for identifying and verifying who should benefit from government subsidies (Feranil, Clyde, and Cross, 2001).

In Ukraine, the president's administration adopted the National Reproductive Health Program 2001–2005 (NRHP) in 2001. A workshop on operational policy barriers brought together a wider group of stakeholders, including members of the MOH's Policy Development Group, to begin addressing the development of clinical standards and operational plans for successful implementation of the NRHP. A paper identifying some operational policy issues in the context of health reform provided the background for discussions (Huk, 2001). Some of the operational policy barriers identified at the workshop had well-known root causes and were addressed in a draft order of Ukraine's MOH, which was submitted to the cabinet of ministers for approval in mid-2001. For the operational policy barriers for which root causes were unknown, studies are currently underway and focus on the inefficient use of resources—financial, human, capital, and material. A future round of recommendations submitted to the cabinet of ministers will address these barriers.

As described in the preceding country experiences, it was crucial to engage high-level decision makers in following through on recommendations to ensure decision makers' commitment from the outset to tracing the barriers back to their root causes and to considering seriously the resulting data. Once the data were analyzed, the perspective of field staff became important for identifying and assigning priority to operational policy barriers that needed to be addressed and for offering solutions for eliminating the barriers. However, only policymakers can ensure appropriate changes in the larger policy environment that lead to implementation of reforms in operational policies.

Summary of Steps for Addressing Operational Policy Barriers

Box 6 provides a more detailed list of activities associated with the steps for addressing operational policy barriers.

Box 6. Steps to Addressing Operational Barriers in Reproductive Health Through Policy Analysis

Step	Description
1. Understand the public sector	
◗ Identify issues with likely operational policy roots	◗ Engage managers, staff, researchers, and others as appropriate ◗ Use checklist (see Box 5) to determine which operational barriers to address ◗ Review existing information on reproductive health programs and health systems
◗ Obtain commitment from policymakers to address policy obstacles at the operations level	◗ Engage policymakers, program managers, major stakeholders, and donors ◗ Agree on methodology for identifying operational barriers ◗ Agree on a plan to follow up findings
◗ Identify operational barriers and their policy level	◗ Engage managers and staff and others, as appropriate ◗ Conduct or use existing studies such as situation analysis, medical barriers, or other MAQ initiatives ◗ Make findings, draw conclusions regarding barriers at the operational level
2. Take a collaborative approach	
◗ Identify priority barriers to be addressed	◗ Use checklist (see Box 5) to help determine priority operational barriers to be addressed (for each barrier, list the potential impact, complexity, time required, resources required, and whether eliminating the barrier is a one-time decision)
◗ Explore root causes	◗ Assemble staff from appropriate levels of the organization ◗ Collaborate with other organizations addressing operational barriers to ensure that a policy perspective is included ◗ Use Figure 3 (categories of operational policies) and Box 3 (barriers by category of policy) as guides ◗ Identify and classify root causes resolvable through training, behavior change, resources, policies, and so forth ◗ Continue the process with those barriers that are rooted in policies at any level of the public health system

Box 6. Steps to Addressing Operational Barriers in Reproductive Health Through Policy Analysis (continued)

Step	Description
3. Analyze the operational policy barriers	
◗ Collect and analyze additional data to identify policy impact at the operations level in areas of highest priority	◗ Review texts of policies (e.g., policy statements, circulars, service records, and so forth) ◗ Review existing data (e.g., financial data and service statistics, management information system records, supply and commodity records, and DHS information) ◗ Interview key informants at all levels of the system under study ◗ Use a "case study" approach for a sample of districts, health care centers, and so forth to detail policy impacts ◗ Provide appropriate physical evidence, such as photography, to document physical infrastructure problems ◗ Conduct study or draw from existing economic analysis
4. Follow through with recommendations to reduce operational policy barriers	
◗ Recommend and advocate for changes	◗ Present the findings of the policy analysis to policymakers in an understandable way ◗ Conduct policy dialogue ◗ Disseminate findings to support advocacy through wide participation of stakeholders
◗ Help with drafting or redrafting relevant operational policies	◗ Identify appropriate mechanisms and decision maker(s) responsible for change
◗ Monitor policy change and implementation of new or revised operational policies and their impact on the operational barriers	◗ Conduct follow-up study to measure changes from baseline

Conclusion

According to *World Health Report 2000,* "[S]ervice quality falls when the required inputs (physical and human) are lacking, and when proper procedures are not used. Common symptoms in the public sector are a lack of essential drugs, inaccessible health facilities or absent staff, nonfunctioning vehicles and equipment, and dilapidated premises. Where these symptoms occur, health outcomes suffer" (WHO, 1999: 34–35). This description of public sector programs applies to many reproductive health programs around the world. As resources become increasingly scarce, the conditions in public sector health programs worsen. Donabedian (1980: 81) noted 20 years ago, "I believe that good structure, that is, sufficiency of resources and proper system design, is probably the most important means of protecting and promoting the quality of care."

Operational policies are an integral part of this "good structure" and make themselves apparent every day in their impacts throughout the health care system. To the extent that operational polices are inefficient, they cause further strain on scarce resources. Operational policies are therefore not only central to current health system performance, but they are also critical to successful health care reform. They occupy that vast "middle ground" of the policy world that is largely hidden from observers and participants alike. Studies worldwide show that policymakers, bureaucrats, doctors, nurses, and midwives are largely unaware of many of the most critical operational policies affecting the delivery of reproductive health services. It is easy for them to see the symptoms of operational policy breakdowns (e.g., lack of supplies, drugs, maintenance, transportation, and the misallocation of staff), but few have knowledge of the underlying policies and therefore little idea about how they might be changed.

The problems that constrain reproductive health services as described in this paper are not confined to selected components of the health system but rather pervade all areas, such as supplies, personnel, transport, and budget. Therefore, given that operational policies govern all parts of the health care system, a comprehensive understanding of such policies provides a critical pathway and a clear advantage in improving performance anywhere in the health system through a systematic policy process.

Addressing operational policies that affect reproductive health programs is clearly a challenge. It means delving into the details of the operations of government agencies or ministries in an effort to streamline operating procedures and make resource use more efficient. The

work is painstaking—all the more so because policymakers and bureaucrats have a vested interest in maintaining the status quo. Rather than dealing with interest groups to revise or remove unnecessary or outdated operational policies, government agencies or ministries often impose new operational policies on top of old operational policies. As a result, health systems have become sluggish and increasingly inefficient. But, by following the steps outlined in this paper to adopt a policy perspective in redressing the operational barriers to the service delivery aspects of high-quality reproductive health care, policy initiatives—particularly collaborative initiatives—can contribute to improving program efficiency and strengthening reproductive health programs worldwide.

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