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# Health policy processes in maternal health: A comparison of Vietnam, India and China

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ABSTRACT

This article reports on a comparative analysis to assess and explain the strengths and weaknesses of policy processes based on 9 case-studies of maternal health in Vietnam, India and China.

Policy processes are often slow, inadequately coordinated and opaque to outsiders. Use of evidence is variable and, in particular, could be more actively used to assess different policy options. Whilst an increasing range of actors are involved, there is scope for further opening up of the policy processes. This is likely, if appropriately managed with due regard to issues such as accountability of advocacy organisations, to lead to stronger policy development and greater subsequent ownership; it may however be a more messy process to co-ordinate. Coordination is critical where policy issues span conventional sectoral boundaries, but is also essential to ensure development of policy considers critical health system and resource issues. This, and other features related to the nature of a specific policy issue, suggests the need both to adapt processes for each particular policy issue and to monitor the progress of the policy processes themselves. The article concludes with specific questions to be considered by actors keen to enhance policy processes.



## 1. Introduction

Health policy analysis in low- and middle-income countries is attracting increasing attention. The bulk of research has focused on policy *content*, particularly evaluating technical appropriateness. However the nature of the *processes* (how policies are made, and by whom) leading to these policies affects their appropriateness and often their implementation. Researchers have only recently started to explore these processes in low- and middle-income countries [1]. A better understanding of these processes could help policy-makers to design more appropriate and effective processes and assist other policy actors in engaging with these processes.

We report on research which analysed maternal health policy processes in three Asian countries, Vietnam, India

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**Table 1**
Case studies, by study country.

| Country | Vietnam | India | China |
|---|---|---|---|
| Territorial focus | National (Vietnam) | State (Gujarat) | Region (Guangxi Autonomous Region) |
| Maternal health case study | | | |
| Skilled birth attendance | √ | √ | √ |
| Adolescent reproductive health | √ | √ | √ |
| Domestic violence | √ | | √ |
| Abortion | | √ | |

(Gujarat State) and China (Guangxi Province). This paper does not aim to fully describe the policy processes or context of each case study, which are available elsewhere [2]. Rather, this comparative analysis seeks to identify similarities and differences between these settings in order to understand better the policy processes and factors impinging on them.

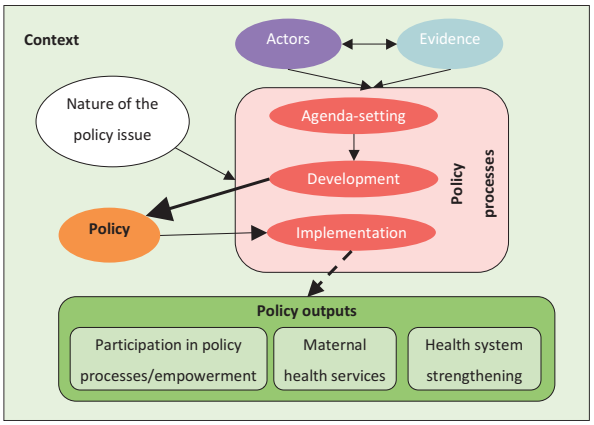
We start with an overview of the research, its methods and underpinning conceptual framework. We then present and discuss key findings and conclude with implications for strengthening health policy processes.

## 2. Methods

The HEPVIC project was interested in understanding the policy processes and particular how policy is identified, developed and implemented.

The project was a multi-method, retrospective country and comparative study. The research focused on policy processes in the field of maternal health. Four different maternal health policies were chosen as case studies (see Table 1). These were skilled birth attendance (SBA), adolescent reproductive health (ARH), abortion and domestic violence (DV). These were chosen to get a range of case-studies which involved different sectors (such as DV), policy areas that were socially sensitive (abortion, DV and ARH) and socially accepted (SBA) and those which had internationally accepted 'technical' interventions (SBA) and those where there were no clear consensus on 'technical interventions' (ARH, DV).

To enable comparisons of findings between the countries, similar research design, methods, tools and analysis procedures were used. Data collection involved review of 553 documents, 124 semi-structured interviews, 1 focus group and 5 participatory stakeholder workshops. These were conducted by the country researchers using a topic guide. Country-specific data analysis was carried out by the Asian partners supported by European partners. A framework approach to analysis was taken. The unit of analysis for the comparative analysis reported here is the study country.[2] Quality assurance checks [3] were used to strengthen the reliability and validity of findings. Ethical approval was obtained in each country and advisory committees set up to advise on the research process and assist in dissemination.



Arrows denote an influencing relationship.

**Fig. 1.** Conceptual framework for policy processes in maternal health.

A conceptual framework (see Fig. 1), which underpinned the analysis, was developed drawing on the literature. This shows, through arrows, the influencing relationships between the key components. The framework recognised that the process of identifying, developing and implementing health policy is complex and sensitive. This is due partly to the technical and political dimensions and to the number of actors involved (or not) in the processes [4–7]. The framework emanates from the Walt and Gilson *policy triangle* [5], which stems from a political economy perspective. The triangle comprises four and inter-related elements of health policy-making [6]:

- How policies are made (*processes*) with three stages: agenda-setting, policy development and policy implementation (including evaluation).
- By whom policies are made (*actors*).
- What are wider issues affecting health policies (*context*).
- What are the policy outputs (*contents*) (we identified three potential outputs, but focus here on maternal health services).

The conceptual framework distinguishes two new elements to this; the *nature of the policy issue* which is related to the context, and *evidence*. Both emerged as critical factors in the policy processes.

## 3. Findings and discussion

### 3.1. Policy process stages

Fig. 2 summarises the policy processes of the case studies in the three countries over the study period, 1999–2008. Included are national-level representations of policy (arrow boxes), and health projects and other key events (square boxes) referred to in the discussion below. Policies were represented in different forms, including national plans and programs, legislation and projects. Also

[2] The full comparative report, including details of the methodologies used both for country and international analysis is available at www.leeds.ac.uk/nuffield/hepvic.

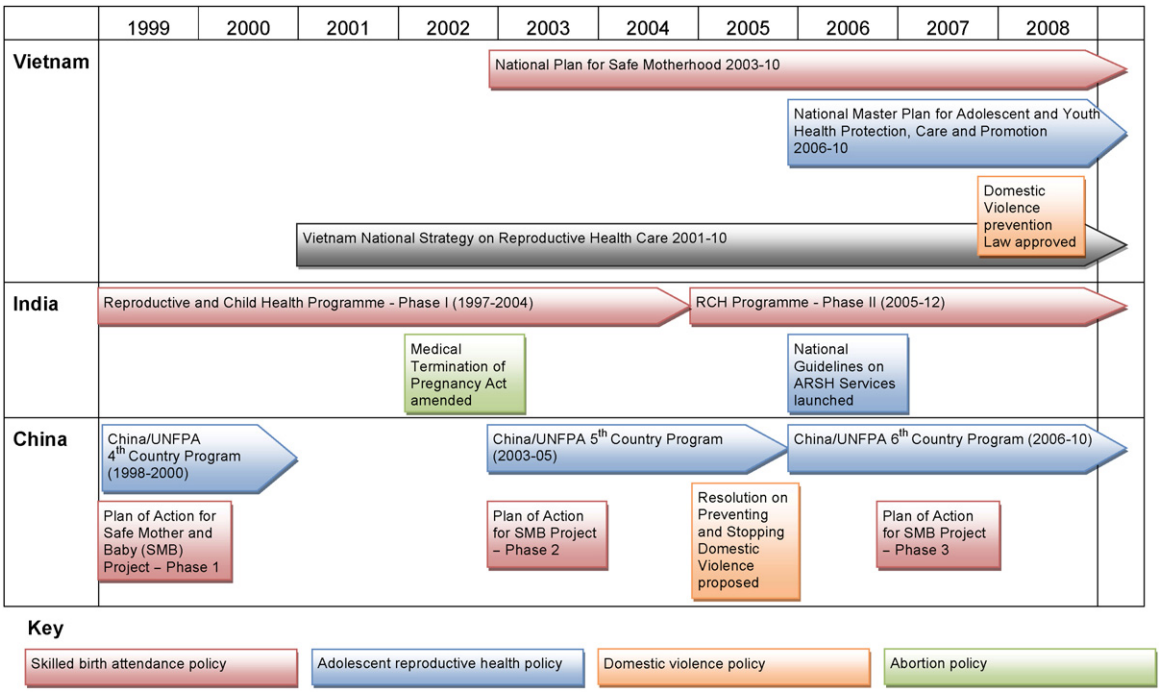



**Fig. 2.** Timelines of key events in the case study policies in Vietnam, India and China.

apparent is the cyclical nature of some case studies, with successive phases and cycles of programs/projects.

*Policy processes* are largely centralised, particularly within China and Vietnam (in India, Federal and State level policy processes exist conjointly), and the agenda-setting and development stages are often protracted over several years. They lead to different formal policy outputs (e.g. law, programme, and resolution). As such, a decision has to be made, early in the process, about the desired final policy output. This affects the locus of policy formulation, and the ability to access resources (internal and external). For example, in India, the National Rural Health Mission (a national strategic plan) was established in 2005 under the Prime Minister's chairmanship. This allowed greater access to resources and convergence with related sectors to improve service delivery for SBA. In contrast in Vietnam it was decided to formulate a lower level 'Master Plan' for ARH which was faster but with less ability to mobilise resources or other sectors.

Central government officials had a clear understanding of the processes they were expected to follow, though no explicit policy development guidelines were reported. However there was less understanding of these processes outside the inner policy circle, suggesting that greater transparency (including documentation of the policy processes) might improve participation by other actors. Mechanisms for monitoring the progress of policy development were not reported.

In the *development* of policies, alternative options for health system, service delivery and staffing approaches were rarely systematically assessed by policy-makers. Indeed there was no systematic approach to considering and testing broad policy options; instead specific policy approaches were selected (often from international initiatives) and then refined. In China, for example, the SBA policy was developed incrementally, using piloting, over successive rounds of funding. In India, the ARH programme was also piloted; however in this case the pilot results were ignored and the programme scaled up under the Ministry of Health without the necessary inter-sectoral coordination. It was unclear, however, why the specific approaches were chosen in all cases. For example, the Chiranjeevi Scheme of the Gujarat State Government, which contracted SBA delivery services to the private sector, was seen by some respondents as a pragmatic mechanism for increasing institutional deliveries and by others as a reflection of mainstream neo-liberal ideology.

Poor *implementation* of policies leads to policy 'evaporation' [8]. In India, for example, access to legal abortion services remains limited more than three decades after the formulation of the Medical Termination of Pregnancy Act. In Vietnam, the national ARH policy led to establishment of provincial structures for adolescent reproductive health, but these had no operational budgets and could not function. Our findings suggest that the implementation difficulties stem partly from insufficient consideration, at the policy development stage, of the resources required to provide services, the wider context and the operational mechanisms and management capacity for implementation.

### 3.2. Nature of the policy issue

The technical and social *nature of the policy issue* affects policy processes. For example, SBA policy processes were relatively quick and straightforward, as this issue had pop-

**Table 2**
Factors related to the policy issue which facilitate the stages of the policy process in Vietnam, India and China.

| The policy issue | Agenda-setting stage | Policy development and implementation stage |
|---|---|---|
| Fits within a context of overarching policy paradigms | √ | |
| Is seen as 'severe' or important | √ | |
| Is classed as a health rather than a social or rights issue | √ | √ |
| Appears to have clear causes and feasible solutions | √ | √ |
| Is non-controversial | √ | √ |
| Has clear and credible indicators | √ | √ |
| Has a global movement to support it, with global targets | √ | √ |
| Involves one sector | | √ |
| Is a longstanding and familiar problem | | √ |
| Fits easily within the institutional mandate | | √ |

ular support and a clear technical focus for one Ministry. In contrast, ARH processes were affected by social sensitivities and the lack of 'proven' interventions. The nature of the issue also shaped levels of public participation. Processes for SBA were closed, involving mainly Ministry of Health technical experts, whereas the DV law in Vietnam was the subject of vigorous societal media debate.

Table 2 indicates the key policy issue factors which the research identified as facilitating the policy process. Policy-makers may be unable to control all these. However, understanding them may be useful to vary their strategies for the process, and for setting achievable implementation goals and timetable.

We would also argue that policy processes need to be flexible and responsive to the particular type of issue. This suggests the need for the involvement of a range of actors and we now consider their roles in policy processes.

### 3.3. Actors in policy processes

There are many different *actors* (both individuals and institutions) with different power who are involved, or would like to be involved, in policy processes [7,9]. Our research identified a wide range of such actors. It also showed the changing roles of some policy actors. For example, in the Chinese DV case, the media role changed from advocacy to policy dissemination. In the Indian ARH case, religious leaders claimed they were initially excluded from the processes but once invited became influential actors, for example voicing effectively their disapproval of an adolescent health module in high school textbooks.

*Government bodies* dominate the policy processes in all countries though not all relevant departments or sectors are always involved. For example, human resources departments were rarely involved in policies that had staffing implications. Sub-national levels, responsible for implementation, were not involved.

Policy-making still largely occurred behind closed doors, though there are exceptions such as in India where the Medical Termination of Pregnancy (MTP) policy was discussed and debated in the Indian Parliament before passing the MTP Law. However, it appears that all countries are opening up their policy processes to wider engagement, in particular through increasing involvement of *civil society* in policy processes. For example, in India the involvement of Sewa-Rural and other NGOs by the Gujarat government in designing the Chiranjeevi Scheme acknowledged the NGOs' strength in this area. However, NGO influence on health policy processes in general in India was less than might be expected, given the social and political context.

In both China and Vietnam much 'civil society' activity was carried out through *Government-established NGOs* (*GoNGOs*) such as the Vietnam Youth Union. Such organisations had the right to involvement in some aspects of health policy and even led the policy formulation in some cases, as in the China Women's Federation leadership in DV policy-making. The independent NGO sector is still weak in China and Vietnam; however there are signs of its growth and widening role. The accountability and legitimacy of the GoNGOs or NGOs (e.g. to the groups they purport to represent or funders) was not clear, and the policy processes did not appear to consider this.

The *public*, and in particular the target groups (people expected to benefit from a policy), were rarely directly involved in policy processes. This may have led to less comprehensive and effective policy responses and their values and priorities not being considered in policy development [10].

*International organisations* often provided project funding and technical expertise in policy processes. External pressure was a key factor in agenda-setting and initiation of some policy processes. For example, UNFPA and WHO worked hard to put ARH on the agenda in each country, and a bilateral donor was influential in the DV law in Vietnam. However, where local ownership of policies, at both national and implementing levels, was insufficiently developed, there were problems with completion of the policy and its implementation. This suggests that greater involvement of actors with responsibilities for *implementation* in policy development could encourage local ownership and allow better assessment of policy feasibility.

Involvement of a range of actors (including other government departments, NGOs specialising in the area, health professionals and representatives of the target group) can strengthen the policy processes by bringing new perspectives. The involvement of NGOs appears to have led to more comprehensive policy responses, particularly where they had useful expertise in 'new' or controversial policy areas. For example the Vietnam Youth Union argued for consideration of the needs of disabled youth in the ARH policy. An Indian professional medical association influenced abortion policy by raising the conflict between women's rights to abortion services and restrictions imposed by legislation on foetal sex selection.

The changing political environment has implications for the involvement of actors in policy processes in all three countries. In particular the decentralisation of health systems with changing roles between the centre and

local levels, and growth in civil society involvement in policy, present new challenges to systems that were formerly centralised and bureaucratically controlled. This suggests that government policy-makers may need support in developing their ability to manage this changing political environment and develop new mechanisms to involve actors in policy processes. Furthermore NGOs do not always have the capacity to engage in, or understand, policy processes which implies that they may need support in developing their capacity for policy engagement. We suggest that explicit and publicly available guidelines for the policy process and mechanisms and known criteria for actor involvement might encourage and facilitate wider involvement.

Interrelations between actors are important and a growing area of research into network theory helps to understand these [11]. In this research different networks were identified. DOVIPNET (Domestic Violence Prevention Network), a loose network of NGOs, was created in Vietnam to increase the voice of NGOs to advocate for the law. In India a more formal network was set up as an association to represent the interests of traditional birth attendants; this influenced SBA policy. However, networks were not reported as major influences on policy processes and this may reflect the relative youth of NGOs, particularly in China and Vietnam.

Some policy processes experienced the emergence of a 'champion', a person or an organisation who felt strongly about an issue and had power to influence the policy process. Champions for SBA policy were found in all three countries, and for DV in China. Whilst this had advantages in moving the process along, it also had the potential disadvantage of narrowing actors' involvement and exploration of policy options. Where there was not a clear and/or powerful leader/champion there were often problems in policy processes. The need for strong coordination was particularly true in multi-sectoral issues such as DV and ARH where involvement of multiple government departments and stakeholders was critical. Furthermore, it would appear that, if policy processes become more open in the future, the need for such coordination is likely to increase.

### 3.4. Use of evidence in policy processes

Internationally there is increasing emphasis on the importance of *evidence-informed policy* [12], reinforcing the need to distinguish this as a separate component in the conceptual framework.

Various factors affect the use of evidence in health policy processes including political views, administrative feasibility, timing and nature of policies, the skills, abilities and values of the different policy actors, and decision support tools as well as contextual factors [13,14]. For example, the 'pressurised management' system in China, where the performance of managers in specific policy areas is closely assessed, meant that quarterly monitoring and reporting on maternal mortality was required by a local governor. Evidence also appears to be mostly used to confirm (or otherwise) one policy option rather than exploring alternatives.

Different types of evidence were found to be used at different stages of the policy processes. There appeared to be neither a single 'ideal' type of evidence nor a single way of effectively generating and disseminating evidence to inform health policy processes. Whilst standard scientific evidence appears to be well recognised and valued, other informal types, such as individual and institutional experiences, were also important. The potential implications of informal types of evidence on health policy processes was illustrated by the effect of a local Chinese governor's personal experiences on the political support given to the SBA policy. Different actors also had different information needs and evidence preferences which affect their views and practices of evidence generation, dissemination and use. For example, local evidence (including implementation experience from NGOs), or international evidence that has been adapted for the context, appears to be particularly appealing to policy-makers.

Perceptions of quality of evidence by our respondents showed the importance of methodology – and in particular, at the agenda-setting stage, the power of quantified information obtained through surveys. However, evidence perceived as *low-quality* may be used in an information vacuum. This was seen in the DV case in Vietnam, and in the ARH policy in India.

The perceived quality of evidence was also affected by the power and credibility of actors bringing or deploying it. Evidence brought by international agencies such as WHO was seen as particularly influential. As found elsewhere [15], it was clear that powerful actors in the three countries are able to utilise their evidence because of their reputation and credibility, and the methodological approach alone does not guarantee the successful use of evidence [15].

Lastly, the development of a policy requires a long term perspective; this suggests a need for a systematic stock of knowledge for long term policy-making through planned research and information gathering. An example of this was seen in the progressive improvement of the China SBA programme through the use of monitoring and evaluation information to design succeeding cycles.

### 3.5. Context

The above interactions between policy processes, nature of the policy issue, actors and evidence occur within a wider context, which includes the political and socio-economic environment, cultural and religious determinants, gender as well as specific aspects of the health system. The wider environment plays an inevitable role in health policy processes with policy decisions influenced by both international agendas and the national vision of priorities; hence this context needs to be considered within the development of specific policies [5]. For example, as the previous section suggested, the changing political paradigm in China and Vietnam is already opening up opportunities for civil society in policy processes, though this still remains less than in India.

The effects of the wider context on health policy processes were found to be important. Most factors identified by other authors as affecting *international* policy develop-

**Table 3**
Considerations for enhancing policy processes.

| |
|---|
| Developing and implementing policies |
| Has consideration been given to the most appropriate type of policy for the issue? |
| Is the process for developing and implementing this policy appropriate and clear to the key policy actors, at national and sub-national levels? |
| Have the resource and timing implications for policy development and implementation been considered? |
| How can the whole policy process be monitored most effectively and efficiently? |
| Have different policy alternatives been considered and what is the rationale for the selected option? |
| What resources are required for development and implementation of the policy? |
| Have the relationships between the policy, delivery of services, staffing needs and health systems been adequately considered? |
| Adapting to the policy issue |
| How can innovative and collaborative approaches be developed and tested (especially important for new and complex issues)? |
| If the issue involves several sectors, who would be the strongest coordinator to ensure all sectors are effectively involved throughout the process? |
| How sensitive or controversial is the issue and how can this be addressed? |
| If the policy area is new and unfamiliar, do the institutions involved need incentives or help to build their capacity for new roles? |
| Ensuring involvement of actors |
| Which actors could provide useful knowledge and experience and how can they be involved? |
| Do the mechanisms, such as clear guidelines, exist for ensuring input from all actors and how effective are they? |
| Do civil society organisations have enough support to be able to take part in the process? |
| The right policy for the context |
| Has consideration been given to the effects of the wider contextual factors (politics, demography) on health policy processes? |
| Have the constraints for implementation been identified and strategies to minimise them developed? |
| Have the opportunities in the context been identified, along with strategies to make use of them? |
| Making policies evidence-informed |
| What types of information do the different actors need and how these can be used in the most effective way at different stages of the policy process? |
| What support and guidance is required by different actors to generate and use this information/evidence? |
| Is evidence adapted for the national or sub-national context and used at these levels? |

Source: [17].

ment [16] applied in our research to the *national* level at which health policies are developed and implemented.

Internationally generated policy content or paradigms were adapted at the country level to make policies more locally appropriate. Key international events such as the International Conference on Population and Development (1994) were cited as important drivers of awareness and attitude change among actors. For example, in China, a locally hosted women's international conference positively affected the policy processes and content of the DV policy. Such an event may give a topic extra emphasis in policy processes and affect content. This is particularly true where the country is trying to increase and enhance its participation in international affairs – as with both China and India.

Where there is an overarching general social and economic development plan, and sufficient government capacity, resonance between this plan and the content of a specific policy can facilitate policy processes. In India, the National Planning Commission's focus on health and education for economic and social development provided scope for the development of the National Rural Health Mission. In China, the people-centred focus of general development policy meant that SBA (aiming to make more equitable access to quality services) was congruent with the overarching policy and funding allocations which were generous for underdeveloped regions. Of course, it is possible that this congruence may exclude alternative (possibly dissenting) but useful inputs on new policy directions. Other facilitating political factors include political support and flexibility in whether national or sub-national levels develop and implement policy.

Views on culturally sensitive topics were found to be dynamic and contested, and affected by the wider trends of globalisation; furthermore we suggest that such views may change quickly and the views of different generations of actors may vary. This raises questions as to how diverse views are managed, and whether/how diverse views can be accommodated in one policy. Where there is consultation on culturally sensitive topics, processes may be long, complex and involve many actors. This will need more resources, and possibly more varied involvement mechanisms. Alternatively, culturally sensitive topics may be dealt with 'behind closed doors'. Whilst the process may appear easier, there may be both more surprise and lack of ownership when the policy goes public. Such culturally sensitive topics may raise opposition from religious or political groups, such as occurred with ARH in India. This opposition can slow the process of development or implementation and raises questions as to whether involvement of such groups at earlier stages of the policy processes would reduce – or strengthen – opposition.

## 4. Conclusions and implications for strengthening policy processes

Health policies are the foundations for improving the health of a population and are the result of policy processes. This research focused on case studies of maternal health policy *processes* in three countries based on a conceptual framework developed during the research. In this article we reported on an analysis across the three countries to explore the strengths and weaknesses of policy processes. We sought to identify important areas of similarity and variance both between the different country contexts and between the case studies.

Evidence-informed, comprehensively planned policies which take account of local context, make appropriate use of financial support and expertise of international and national agencies, and are open to perspectives from a variety of stakeholders, are likely to be implemented more

successfully and to be effective in reaching their goals. However policy processes are often slow, inadequately coordinated and opaque to outsiders. Use of evidence is variable and, in particular, could be better used to inform consideration of different policy options. Whilst there is an increasing range of actors, there is scope for further opening up of the policy processes. This is likely, if appropriately managed with due regard to issues such as accountability of advocacy organisations, to lead to stronger policy development and greater subsequent ownership; it may however be a more messy process to co-ordinate. Coordination is particularly critical where there are policy issues that span conventional sectoral boundaries, but is also essential to ensure a more holistic development of policy involving consideration of critical health system and resource issues. This, and other features related to the nature of a specific policy issue, suggests the need both to adapt processes for each particular policy issue and to monitor the progress of the policy processes. Our findings clearly have implications for strengthening the policy processes and Table 3 summarises these in the form of questions for consideration by policy-makers keen to enhance policy processes.

Our research was on maternal health policy processes but, we suggest that many of the findings and implications may be relevant for other policy areas. However, contextual specificities – political, economic, social and others – clearly affect the nature of the processes. Readers therefore need to relate the findings both to their own context and to the particular policy processes in which they are interested to seek the similarities and differences for these particular settings.

Lastly we recognise that, inevitably, our research has not been able to answer a number of questions and indeed has revealed a few new ones. Further research is therefore needed of which three examples are suggested. First, further studies are needed to explore the nature of the policy processes under different contexts and with different case studies. Second, research is needed on the capacity of, and mechanisms used by, non-state actors to engage in policy processes. Third, greater understanding of the nature of champions both in terms of general policy processes is needed.

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