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**Manuscript title:** Framework for assessing capacity of a health ministry to conduct health policy processes – a case study from Tajikistan

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## **ABSTRACT**

Adequate capacity of ministries of health (MOH) to develop and implement policies is essential. However, no frameworks were found assessing MOH capacity to conduct health policy processes within developing countries. This paper presents a conceptual framework for assessing MOH capacity to conduct policy processes based on a study from Tajikistan, a former Soviet republic where independence highlighted capacity challenges.

The data collection for this qualitative study included in-depth interviews, document reviews and observations of policy events. Framework approach for analysis was used. The conceptual framework was informed by existing literature, guided the data collection and analysis, and was subsequently refined following insights from the study.

The Tajik MOH capacity, while gradually improving, remains weak. There is poor recognition of wider contextual influences, ineffective leadership and governance as reflected in centralised decision-making, limited use of evidence, inadequate actors' participation and ineffective use of resources to conduct policy processes. However, the question is whether this is a reflection of lack of MOH ability or evidence of constraining environment or both.

The conceptual framework identifies five determinants of robust policy processes, each with specific capacity needs: policy context; MOH leadership and governance; involvement of policy actors; the role of evidence; and effective resource use for policy processes. Three underlying considerations are important for applying capacity to policy processes: the need for clear focus, recognise capacity levels and elements and, both ability and enabling environment. The proposed framework can be used in assessing and strengthening of capacity of different policy actors.

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## Introduction

Effective development and implementation of health policies is fundamental to health systems development (WHO, 2007; Gilson et al., 2008). Whilst research into health policy processes has often been neglected, especially in developing countries, it is growing (Gilson and Raphaely, 2008) and often reveals a weakness in these processes.

Health policy-making is the responsibility of the national government with the health ministry (MOH) typically spearheading this process (Omaswa and Boufford, 2010). Adequate public sector capacity to develop and implement health policies is therefore essential. This capacity usually includes the ability to manage policy processes in a logical and transparent way, use evidence in policy decisions, and ensure appropriate participation of key policy actors (Sutcliffe and Court, 2006; Greer, 2010).

There is increasing interest in understanding, and developing, capacity generally within health systems (LaFond et al., 2002; Green and Bennett, 2007; Potter and Brough, 2004). However 'capacity' is a complex concept; it can be seen as a process as well as an outcome; it has a dynamic nature and is multidimensional (LaFond et al., 2002). Defined as: *'...the ability of individuals, institutions and societies to perform functions, solve problems, and set and achieve objectives in a sustainable manner'* (UNDP, 2006 p.3), capacity comprises different levels (individual, organisational, system) and elements (such as skills and structures) and needs to be applied to specific tasks such as, in this context, health policy-making (Potter and Brough, 2004; LaFond et al., 2002). The importance of an enabling environment to allow the effective use of existing capacity – or 'unleashing' capacity (Development Assistance Committee, 2006) – is also recognised in the literature.

Attempts have been made to apply the notion of capacity in relation to strengthening health systems (LaFond et al., 2002; Pappaioanou et al., 2003) or conducting health systems and policy research (Bennett et al., 2010; Gonzalez Block and Mills, 2003) and to better understand the role of health ministries in health policy processes in some European contexts (Briatte, 2010; Mätzke, 2010; Greer, 2010). However, we found no frameworks that focus on capacity to conduct health policy processes in developing countries. The aim of this paper is, therefore, to contribute to filling this gap. We do so by proposing a conceptual framework for understanding and assessing MOH capacity to conduct health policy processes, informed by assessment of MOH capacity. We used a case study of Tajikistan, a post-soviet country where independence resulted in the need to develop national-level policies and hence the need for adequate capacity of the MOH.

Following an introduction to the context of Tajikistan and the methods used, we introduce the conceptual framework and summarise the key results of our assessment of the MOH capacity in Tajikistan. We then discuss the implications of our findings on strengthening MOH capacity in Tajikistan and conclude with potential future applications of the conceptual framework.

### **Setting of the context**

The Republic of Tajikistan is a former Soviet republic in Central Asia, independent since 1991. Due to neglect during the Soviet era, Tajikistan inherited many health system challenges including excessive numbers of health professionals, particularly doctors, and an oversized network of health facilities. Subsequent emigration and unequal distribution of staff and other resources contributed to many non-functioning facilities and negatively affected the health of vulnerable groups (Falkingham, 2003; Mirzoev et al., 2007; McKee et al., 2002). Economic challenges worsened during the civil war (1991-1996) and Tajikistan remains highly dependent on external aid (Mirzoev et al., 2010; Rechel et al., 2012).

Health policy development in the former Soviet Union was done centrally in Moscow with peripheral republics, such as Tajikistan, having a limited role (McKee et al., 2002). As a result, the capacity for policy development of the republics' health ministries was limited; they were primarily involved in implementing centrally-set policies. Independence meant a sudden and radical shift in the functions of the Tajik MOH from regional to national responsibilities. With the need to identify priorities and align resources, came responsibility for, and the challenge of, developing national-level health policies and guiding their implementation at lower administrative levels.

In the mid 1990s the Tajik MOH introduced a health sector reform process in the country. A health reform group was formed, with support from WHO, to support the development of a National Conception of Health Reforms in Tajikistan for 2000-2010 (MOH, 2002; Mirzoev et al., 2007). The document attracted criticism for proposing an unfeasible plan of action and not being operationalised and the health reform group was dissolved in the early 2000s. In the following decade, the country witnessed a proliferation of thematic policies focusing, for example, either on specific service delivery issues such as family medicine or on different aspects of health systems such as health financing or information systems. These policies were uncoordinated and often developed as part of conditions set within donor-funded projects, for example by the World Bank and the Asian Development Bank.

The MOH comprises thirteen divisions and units, managed either directly by the minister or by his deputies. At the time of data collection the MOH did not have a permanent policy or planning unit in its structure and these functions were performed in a rather fragmented way by different departments. The Health Policy Analysis Unit was established in the MOH- with financial support from the World Bank-funded health reform project - to support MOH capacity in policy evaluation. However, three years after establishment it was not included in the MOH statute, which raises questions with regards to sustainability of this initiative in the long-term.

## **Methods**

Data collection for this qualitative study was performed in 2008 and included in-depth interviews with key policy actors (n=37), document reviews (n=58) and observations of policy events. Data analysis was done using a framework approach assisted by qualitative data analysis software (NVivo).

The study conformed with conventional ethical principles in conducting health-related research and ethical approvals for this study were obtained both from the University of Leeds and the Tajikistan Ministry of Health.

The initial conceptual framework was informed by concepts of capacity and health policy processes found in the literature. The initial conceptual framework guided the data collection and analysis in the study and was subsequently refined following the insights from our assessment. In this paper we report the revised conceptual framework.

## **Results**

### ***Conceptual framework***

Our conceptual framework stems from a policy triangle, the most widely used framework for health policy analysis, which distinguished policy actors, context, processes and contents (Walt and Gilson, 1994; Gilson and Raphaely, 2008). Underlying the proposed framework (Figure 1) is that achievement of robust health policy processes is a result of relationships between five determinants: policy context; MOH leadership and governance; involvement of policy actors; role of evidence and, effective use of available resources for policy processes. Specific capacity needs exist in relation to each determinant; for example MOH capacity needs in relation to effective use of available resources for policy processes include capacity to: a) ensure adequate levels of resources and b) use resources effectively and in a sustainable way. Three underlying considerations aid

understanding and applying the concept of capacity to health policy processes in the framework: clear focus of capacity, recognition of different levels and elements of capacity and, understanding the need for both ability and enabling environment in the application of capacity. We discuss each component of the conceptual framework next.

*FIGURE 1 HERE*

Understanding what constitutes robust health policy processes is central to our framework. The literature refers to characteristics of effective policies such as visibility, ownership (McKee et al., 2000), evidence-informed nature and feasibility of implementation (Macintyre et al., 2001). However, no frameworks were found which identify the attributes of robust health policy *processes* and in developing our conceptual framework we propose such a set (Table 1).

*TABLE 1 HERE*

The achievement of the above attributes is determined by factors both within and outside the MOH. In our framework we identify five interrelated groups of these factors, referred to as determinants of robust health policy processes: the wider political, socio-economic and cultural context; MOH leadership and governance style; roles and involvement of policy actors; availability and use of evidence in policy processes and; effective use of available resources in support of policy processes. Each determinant is complex, as shown by the existence of frameworks to understand and assess them. Different frameworks exist relating to better understanding the role of context (Walt and Gilson, 1994; Dobrow et al., 2004; Pawson and Tilley, 1997), leadership and governance (Aarons, 2006; Siddiqi et al., 2009), policy actors, their networks and power (Perkin and Court, 2005; Tantivess and Walt, 2008; Erasmus and Gilson, 2008; Walt, 1994; Gaventa, 2005), role of evidence including characteristics of quality evidence (Lavis et al., 2009; Shaxson, 2005) and resources (Green and Collins, 2006). We acknowledge these multiple viewpoints and do not attempt to revisit these in our paper, but in Table 2 we identify capacity (needs) that ministries of health require in relation to each of these five determinants.

*TABLE 2 HERE*

Two caveats are appropriate, to help understand both the attributes and determinants of robust health policy processes and the capacity needs in relation to each determinant. First, each is complex and context-specific. For example, ‘transparency’ and ‘clarity’ of health policy processes will be different across countries and thus capacity needs in relation to MOH leadership and governance may vary. Second, these are interrelated. For example, capacity to ensure actors’ involvement in health policy processes is related to MOH leadership and governance style or capacity to recognise and use different types of evidence in policy processes is related to capacity to ensure involvement of different actors to generate different types of evidence.

Three underlying capacity considerations inform the application of the concept of capacity to health policy processes and identification of capacity needs for each determinant of robust health policy processes. First, is the need for a clear focus specifying capacity of *whom* and capacity to do *what* (Green and Gadsby, 2007). We refer to capacity of a national Ministry of Health to conduct policy processes and, specifically, capacity to: a) recognise, and ensure consistency between, different policy stages and b) manage policy processes effectively. Second, capacity includes three levels (individual, organisational, systems) (LaFond et al., 2002) and different elements (staff, structures, systems and tools) (Potter and Brough, 2004). Capacity elements cut across the three levels of capacity, as explored elsewhere (Green and Bennett, 2007; Potter and Brough, 2004). The conceptual understanding of capacity elements and levels is important in understanding and assessing the capacity needs for each determinant. Last, there is a need for both ability and an enabling environment, particularly in ‘unleashing’ capacity (Development Assistance Committee,

2006) where it may exist but is constrained. For example, the MOH staff may possess ability to involve different actors in developing a specific policy but may not be willing to do so because of the traditionally centralised decision-making.

Two changes were introduced to the initial framework following insights from our study: a) clearer identification of capacity needs in relation to each of five determinants of robust health policy processes and b) recognition of the importance of the three underlying capacity considerations in applying the concept of capacity to health policy processes.

Next we report our assessment of MOH capacity to conduct health policy processes in Tajikistan.

### **Overview of health policy processes**

Most respondents described robust health policy processes as: clear and transparent to key policy actors, participatory, evidence-informed, integrated with other health and social policies, and with a clear resource framework to ensure continuity of policy processes. A combination of all these attributes was seen as essential to ensure robust policy processes and most respondents felt that these attributes were lacking in Tajikistan.

Health policy processes in Tajikistan typically followed “...*the formal government procedure, which is written in the... Law about the Government of Tajikistan..., [the] MOH statute... [and] the statute of Executive Administration of the President*” (MOH official). Drafting of policy documents was typically led by a MOH working group established by an MOH decision with involvement of other government departments and influential international actors. The roles of powerful individuals (such as the Minister) were important in forming the views and agendas of their respective organizations in policy processes. Less importance was given to other national policy actors (for example, academia and CSOs). Although views differed, policy development was referred to as being behind closed doors with an absence of effective mechanisms for raising awareness amongst non-participating policy actors about formal government procedures.

The MOH had little influence over policy approvals, compared to other government actors such as President’s Administration, the Ministry of Justice (MOJ), and the local Hukumats (Governments). Unsurprisingly, no evidence was found of monitoring and evaluation (M&E) within the MoH of its own policy development; according to the Law this was MOJ task.

Policy implementation was seen as synonymous with service delivery with M&E being normally a component of specific projects. One specific implementation challenge identified by many respondents was a lack of clear resource commitments to implementation of adopted policies, some of which were developed as part of conditions within externally-funded projects.

### **Assessment of MOH capacity to conduct policy processes**

Most study respondents recognised the multidimensional and complex nature of the MOH’s capacity to conduct health policy processes. The statement below from a MOH officials provides a typical understanding of MOH capacity as: “...*capacity to negotiate, convening the parties in the dialogue, leading the process forward, forms of communication from proposal formulating and creating but at the same time implementing...*”. Emphasis was largely on the skills and expertise of individuals, compared to appropriate structures at the organisational level and relative roles of policy actors in policy processes.

A lack of capacity was seen to exist in relation to all five determinants of robust health policy processes (consideration of policy context, effective MOH leadership and governance, adequate involvement of policy actors, ensuring evidence informed policy processes and use of resources for policy processes), as set out further in this section. Despite the perceived lack of capacity, there was

a feeling that MOH capacity had improved since independence, though international actors were less optimistic than national ones over the degree and pace of improvements.

Although no explicit references were made to the system level of capacity, the importance of the wider *context* was recognised by all policy actors. However, most respondents, particularly international policy actors, reflected that MOH was unable to take account of these contextual implications in supporting and strengthening its capacity needs.

The country's socio-economic transition since independence posed challenges but also provided opportunities. Specific influences on MOH capacity include emigration of professionals (including policy analysts) and sharp decline in national financial resources for all public sectors, including the health sector, due to the worsening overall economic situation in the country, though the latter was counterbalanced by increased availability of external funding since independence. Different training opportunities, including study tours, are often available to the MOH staff within donor-funded projects though there appears to be no systematic identification of training needs which remain uncoordinated.

Political support from the President's Administration and other more powerful ministries (such as the Ministry of Justice) was essential in initiating and approving policies. Most respondents reflected on the limited capacity of the MOH to develop donors' trust and reconcile the short-term needs of individual projects with long-term policy priorities as part of Tajikistan's gradual transition from a relief to development stage (Akhmedov and Mirzoeva, 2000; Mirzoev et al., 2007).

The importance of appropriate MOH *leadership and governance* of health policy processes was emphasized in documents. For example, MOH leadership role was a key priority in the Health Reform Conception (MOH, 2002) and a separate MOH working group saw improvement in governance as an explicit part of its activities (Euro Health Group, 2008). Similarly, most policy actors saw effective MOH leadership and governance as an essential element of its capacity to ensure robust health policy processes.

Different respondents referred to the '*system of command and control*', '*paternalistic*' or '*hierarchical*'; all referring to the centralised governance style where other levels of the health system (oblasts and rayons) "*...might provide inputs but major decisions... are made by the ministry staff*" (Expatriate Staff, Donor Agency). The MOH leadership style was based primarily on sanctions rather than incentives. This is perhaps a post-soviet inheritance which contributes to 'behind-closed-doors' policy-making. The MOH working culture also reflected the former Soviet heritage. One specific example is the strong sense of authority of powerful individuals, typically reflected in the lack of critical appraisal of higher management levels. Another concern was the pressure to avoid mistakes by the MOH staff and the prospect of losing a job; this seems to reduce the chances for experimenting with different policy options and thus constraining the application and development of knowledge and expertise of the MOH staff.

Most respondents felt that different decision structures exist in support of health policy processes in Tajikistan, including numerous working groups, MOH collegiums and a health policy analysis unit. However, the MOH was unable to effectively utilise the available structures. The MOH collegiums (regular review, planning and management meetings) - the primary structure for making policy decisions according to MOH statute – were seen by many respondents as forums for disseminating policy decisions made earlier by the minister, thus highlighting the lack of MOH capacity to utilise these collegiums effectively in support of health policy processes.

Different national and international policy *actors* (such as national and international NGOs and civil society) felt largely excluded from the policy processes. This may reflect the limited recognition of the value of different policy actors' contribution to policy processes (such as international non-

governmental organisations or academic institutions). This may be due to the existence of a constraining environment - such as the need to produce policies rapidly within externally-funded projects. Another possible reason may be the fact that the MOH historically focused largely on routine operational issues and less on providing strategic policy direction, in contrast with respondents' perceptions of the required MOH role. Either way, this reflects the lack of MOH ability to utilise available expertise effectively.

Different actors have their own policy agendas affecting their roles in the policy processes. This was particularly evident from the documentary reviews and observations of policy events. Examples include the dominance of the World Bank in the SWAp process through their project appraisal missions and the MOH attempts to repeatedly emphasise government's role in coordinating all health reforms and projects at monthly health coordination meetings. There was, however, little evidence of the MOH capacity to recognize these different, and often competing, agendas and practices within health policy processes.

Interestingly, the existence of actors' health policy networks was not evident, suggesting either that the networks may exist but not recognised or that networking as a concept may be at rudimentary stage in a state-controlled policy environment. The absence of clearly identified networks poses the need for the MOH to deal with policy actors on an individual basis. This may be time-consuming and thus cause additional strain on the limited capacity. However, it may provide the MOH with a richer picture on the (often competing) agendas, interests and practices of different policy actors.

The limited use of *evidence* in health policy processes was criticised by many non-government actors. They perceived limited demand for evidence by the government, including the MOH. As described by one policy actor: "...research as such is not really needed and everything is initiated by and paid for by the donor[s]...The public sector says to donors 'you need research so you need to pay but we won't'." (National Staff, International NGO). Furthermore, there was little evidence of the MOH recognising the value of, and using, different types of evidence (such as research, health statistics and results of project monitoring and evaluation) in policy processes.

This culture leads to limited use of evidence derived from less powerful academia and civil society. Where evidence was used, the MOH preferred evidence with practical applicability, which is timely, accessible and originates from known policy actors such as the World Health Organization.

The international community was sceptical of the government health management information system (HMIS) and instead relied on one-off assessments thus diverting potential support for strengthening government HMIS. The MOH, despite its preference for strengthening the mainstream HMIS as a more sustainable source of evidence, appeared to lack power to influence production and use of evidence within donor-funded projects.

In relation to *resources*, the effective use of available human and financial resources for policy processes was seen as particularly important in understanding the MOH capacity. In 2008 the MOH had a total of about 60 staff with half being non-technical, hence with no role in health policy processes. The MOH technical staff appear to be overloaded with routine duties with little scope for strategic planning and policy-making. The Minister was lobbying the President's Administration for an increase in staff numbers, demonstrating his concern about this issue though many respondents were skeptical of the eventual outcome of these efforts.

Although MOH does not have a dedicated budget for supporting policy processes, different resources existed for policy development (such as those within donor-funded projects) which led to establishment of different thematic working groups to support policy processes. However, respondents referred to MOH inability to coordinate these effectively, which contributed to duplication of work, and ultimately extra workload for the MOH and other actors. The lack of clear

resource commitments to implementation of adopted policies identified earlier appears to contribute to development of unfeasible policies and is thus constraining the application and further development of MOH capacity.

## **Discussion**

From the above findings, the MOH capacity to conduct health policy processes would appear to be limited in relation to all five determinants of health policy processes. However, there is a question whether the lack of evidence of MOH capacity in Tajikistan identified in our study, is a reflection of a lack of MOH *ability* or evidence of a constraining *environment* or both. We do not attempt to answer this question in this paper but underline its importance for further research and future capacity strengthening initiatives.

Because of the pioneering nature of our study, we cannot compare our findings with similar research in developing countries. However, the complexity of applying MOH capacity to health policy processes is shown in some European contexts (Mätzke, 2010; Briatte, 2010; Greer, 2010).

The findings on the policy processes in Tajikistan provide an opportunity to strengthen the capacity of the Ministry of Health to conduct health policy development and implementation. This can be achieved by addressing the different capacity needs identified in this assessment and the focus on five determinants of robust policy processes (policy context; MOH leadership and governance; involvement of policy actors; role of evidence and, effective use of available resources for policy processes) provide a starting point. Policy-makers also need to remember the long-term nature of capacity strengthening initiatives and the need for a clear distinction between the measures in the short-term (e.g. training MOH staff to recognise the value of different actors and different types of evidence in policy processes), mid-term (e.g. addressing the issue of frequent changes in MOH staff) and long-term (e.g. addressing the issue of hierarchy within the public sector). Underlying the above distinction is the tension between the production of tangible results in the short-term (for example, as part of donor-funded projects) and the longer-term vision for a strengthened MOH.

The proposed conceptual framework is complex, but reflects the complexity of the concepts of health policy processes and capacity. Our findings suggest that the different determinants and their capacity needs are interrelated, as illustrated by multiple arrows in the conceptual framework. Ensuring, for example, timely availability of different types of evidence in policy processes can be achieved through better dialogue with policy actors involved in the production of evidence (such as researchers and civil society organisations). Researchers and policy-makers should not shy away from this complexity and recognition of complex relations in the framework could help assess and address capacity more effectively. However, knowledge and skills in the area of application of capacity (in our case health policy processes) are essential.

In constructing the conceptual framework we developed a deeper understanding of the attributes and determinants of robust health policy processes. In our study it was an important starting point for MOH capacity assessment and the proposed set of attributes can also be used for assessing, and further strengthening, health policy processes. The context-specificity of interpretations of the different attributes reduces the need for universally applicable thresholds for the proposed attributes. On the other hand, the context-specificity poses methodological challenges for comparing health policy processes across different contexts, though it is still possible as shown elsewhere (Green et al., 2011).

Capacity is a complex concept and three capacity considerations emerged from our study in the conceptual framework which in our view help understand and apply the concept of capacity to a specific area (in our case study, health policy processes). First, is the importance of a clear focus area of application of MOH capacity such as effective use of resources in support of policy processes. Similarly, understanding what constitutes robust health policy processes is important to

identify the capacity needs required within each determinant. Second, the recognition of different levels and elements of capacity emerged as an important consideration, for example, in understanding the roles of individuals (within the MOH and wider) such as in relation to leadership and governance. Third, the understanding of the need for both ability and enabling environment (such as in relation to MOH capacity to ensure involvement of actors) is important not only in assessing capacity but also in addressing identified capacity needs. We suggest that these considerations are not policy- and health-specific and may guide the conceptual applications of capacity in other areas.

In our study we set to develop a conceptual framework for understanding and assessing capacity to conduct health policy processes, informed by a developing country case study. This study, as the first of its kind, can be perceived as an initial effort to relate the concept of capacity to health policy processes in developing countries. The focus on one context is a possible limitation of our study, suggesting the need for further research to test and refine the framework in different developing countries. The coverage of all determinants and their capacity needs in our study can be seen as another possible limitation, resulting in the broad brush approach of our study, which potentially limited the scope for detailed exploration of the different attributes and determinants; further research is needed to deepen understanding of the individual determinants and their capacity needs. However, given the pioneering nature of this research, the broad nature is also a strength allowing multiple applications of the conceptual framework, as set out next.

The primary purpose of the proposed conceptual framework is to guide analyses of MOH capacity in developing countries. In the process of developing the framework, we also developed a deeper understanding of the relationship between the concepts of capacity and health policy processes, and propose that the framework can also be used – either as a whole or in relation to selected determinants - in assessing and strengthening capacity of other policy actors as well as improving health policy processes.

Our framework focuses primarily on the MOH capacity in developing countries, which are typically characterised by: a) presence of powerful international actors who, in addition to the ‘regular’ actors (such as government, civil society, private sector and professional associations), contribute to the ‘messiness’ of policy processes and b) severe resource-constrained nature, raising the importance of effective use of scarce resources. Due to its broad nature, the proposed framework may also be applicable in high-income countries though it is important to consider the above two characteristics in using the framework.

## **Conclusions**

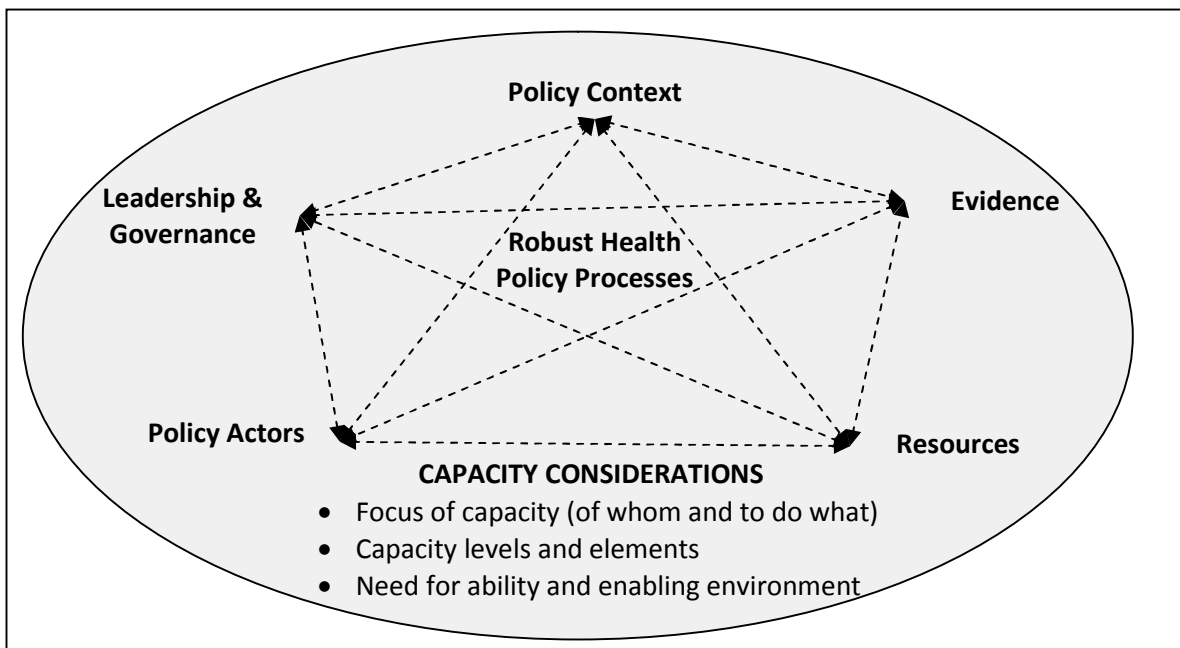
Capacity is a complex concept and needs to be applied to a specific thematic area such as health policy processes. A conceptual framework has been developed to aid understanding of capacity to conduct health policy processes, based on a case study of a developing country. Achievement of robust health policy processes is determined by policy context; MOH leadership and governance; involvement of policy actors; role of evidence and; effective use of available resources for policy processes. These five determinants are related and capacity needs exist in relation to each determinant. Three underlying considerations are important in understanding and applying the concept of capacity: clear focus in applying capacity, recognition of its different levels and elements, and need for both ability and enabling environment. The proposed conceptual framework can be used as a whole or in relation to selected determinants. The detailed understanding of the concepts of capacity and policy processes should help to apply this framework to assessing and strengthening of capacity of different policy actors, within health sectors and beyond.

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**Figure 1: Conceptual framework for understanding and assessing capacity of ministry of health to conduct health policy processes**



**Table 1: Attributes of robust health policy processes**

<b>Attribute</b>	<b>Description</b>
Clarity of policy process	Understanding of stages of policy process (agenda-setting, development, implementation, evaluation), including known conditions and mechanisms for policy actors' involvement in these stages
Transparency of decisions	Clear and known underpinning principles and mechanisms for policy decisions, including involvement of actors and use of evidence in different stages of policy processes
Continuity and consistency of process	Continuity and consistency of approaches within, and between, different stages of policy process
Integrated nature of processes	Degree of integration of processes of particular policy with other health and non-health policy processes

**Table 2: Capacity needs for each determinant of robust health policy processes**

<b>Determinant</b>	<b>Capacity (need) to...</b>
Policy context	<ul style="list-style-type: none"><li>• ...recognise implications of wider context</li><li>• ...work well within the wider context</li></ul>
Leadership and governance	<ul style="list-style-type: none"><li>• ...apply principles of good governance</li><li>• ...ensure effective leadership</li><li>• ...use decision structures effectively</li></ul>
Policy Actors	<ul style="list-style-type: none"><li>• ...ensure involvement of actors</li><li>• ...draw on other actors' capacity</li><li>• ...manage competing agendas</li></ul>
Role of evidence	<ul style="list-style-type: none"><li>• ...appreciate different evidence types</li><li>• ...ensure timely production &amp; dissemination of evidence</li><li>• ...interpret &amp; use evidence</li></ul>
Resources	<ul style="list-style-type: none"><li>• ...ensure adequate levels of resources for policy processes</li><li>• ...use such resources effectively and in a sustainable way</li></ul>