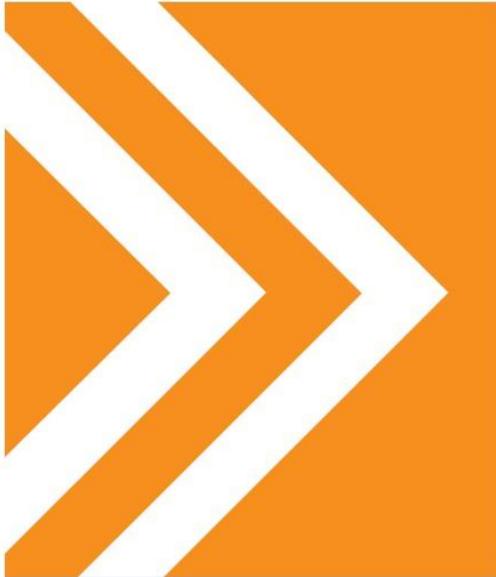




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Implementation Research for UHC in Practice

A Series of Technical Briefs Based on Lessons Learned
from the Field in Myanmar and Indonesia

Part I: Laying the Groundwork

About this Series

What is Implementation Research for Health?

If implementation research (IR) is the scientific inquiry into questions concerning implementation, then IR for health can be defined as “a type of health policy and systems research concerned with the study of clinical and public health policies, programs and practices, and aims to understand not only what is and isn’t working, but also how and why implementation is going right or wrong, and testing approaches to improve it.”¹

IR focuses on practical and actionable issues and on complex and real world—as opposed to controlled—settings. It actively involves implementers in shaping the research to meet their needs and usually relies on mixed methods to answer the research questions. IR benefits both policymakers and implementers as a way to quickly identify and respond to implementation challenges by helping to answer questions such as:

- Is the initiative being implemented as planned?
- What factors are hampering smooth implementation?
- Does the initiative translate into the expected changes in the system?
- Are there unintended consequences associated with the initiative (either positive or negative)?

¹ David H. Peters, Nhan T. Tran, Taghreed Adam. *Implementation Research in Health: A Practical Guide*. Alliance for Health Policy and Systems Research, World Health Organization, 2013, p. 27.

- What actions should be taken to improve current implementation?
- How can the initiative be scaled up or sustained?

Why IR for UHC?

Universal Health Coverage (UHC) has been gaining momentum as a global health priority for political, economic and moral reasons. As a focus of the post-MDG Sustainable Development Goals, UHC represents a commitment to ensuring all people have access to needed health services without experiencing financial hardship. Moving towards UHC is a complex and ambitious undertaking in terms of political will, political economy and systems strengthening. Thus, when implementing policies and initiatives aimed at moving towards UHC, there are inevitably processes that do work as planned, some that do not work as planned, and unintended effects that were not envisioned. IR for UHC seeks to answer questions of interest to implementers, to those who influence implementation, and to those affected by implementation of UHC. With its emphasis on actionable and prospective learning in real world and real time settings, IR for UHC can strengthen policy makers' and implementers' chances of successfully pursuing UHC.

Why this Series of Technical Briefs on IR for UHC in Practice?

While IR has been receiving growing attention in the health field, there is much confusion around what IR is and is not, and how it is distinct from other forms of research, monitoring and evaluation. Several useful guides seek to clarify what IR is and offer valuable tools, frameworks, examples, and recommended do's and don'ts. Our starting point for this series of technical briefs on IR for UHC is the 2014 WHO/AHPSR publication *Implementation Research in Health – A Practical Guide*. This series is meant to be a quasi real-time journey of USAID and HFG collaborative experiences and lessons learned in

“Without implementation research we are at best committing valuable resources in the hope that things will work out.”²

applying this guide to UHC initiatives in two countries—Myanmar and Indonesia—that are at different stages of rolling out UHC, are undergoing different political transitions, and have different competing political priorities. While the country contexts are very different, however, one feature they have in common, and share with many other low and middle-income countries, is unfamiliarity with the purpose, methods, and value of IR, especially when applied to UHC-related policies and interventions. Thus, the briefs are meant to reveal how IR for UHC works *in practice* when it is being introduced by ‘promoters’ of IR in contexts where IR—especially IR for UHC—is new to many of the stakeholders involved. Where IR is already well understood and where its value does not need to be demonstrated, the starting point and challenges faced will likely be quite different.

Our aim is to make the value of IR more tangible and accessible to a wide audience of donors, researchers, and country stakeholders implementing UHC; to sensitize this audience to the challenges of context, timing and sensitivity when laying the groundwork for IR for UHC; and to stimulate the use of IR findings to strengthen UHC policies and implementation. These technical briefs on IR for UHC support USAID priorities in both countries and embody USAID's collaborative approach to monitoring & evaluation. The series will include the following three technical briefs: 1) *Laying the Groundwork*, 2) *Defining and Designing IR*, and 3) *Implementing IR: First Cycle Lessons Learned*.

Country Contexts

As with any activity, understanding and adjusting to the local context is of paramount importance. The context will influence both the scope of IR and when and how IR can be introduced most effectively.

Myanmar: Embarking on UHC reforms

Myanmar's political leadership has expressed a strong commitment to accelerating progress toward UHC. UHC goals form an integral part of Myanmar's road to sustainable growth and poverty reduction. The

² Ibid., 61.

Minister of Health presented the country's Strategic Directions toward UHC at a special session of the 2014 World Bank Spring Meetings, which was attended by global health leaders. In line with these directions, President Thein Sein's government has already introduced several health policies that aim to improve service delivery, expand utilization and reduce out-of-pocket spending. These include, among others, the provision of free essential drugs at the township hospital level and below, and free services for pregnant women and for children under the age of five in some parts of the country. The government has also recently endorsed the Essential Health Services Access Project (EHSAP). Through this project, the Ministry of Health (MoH), with support from the World Bank, intends to strengthen planning at township level and to improve the flow of funds to frontline providers through health facility grants. More reforms can be expected to be introduced in the near future, especially in the area of health financing.

These new policies and reforms represent a remarkable and welcome shift for the country. For several decades, Myanmar's health sector received extremely low levels of public spending. In 2011-12, for example, the sector was allocated only 1.3 percent of total government expenditure, equivalent to some US\$2 per capita.³ Combined with decades of political isolation, poor economic management and internal conflicts, these limited resources have translated into low coverage of basic services and poor quality of care. They have also resulted in out-of-pocket payments for health (as a proportion of total health spending) being among the highest in the world (at almost 80 percent in 2011-12)⁴. Serious illness or a medical emergency can throw a family into (deeper) poverty. Financial barriers to access, combined with other barriers such as geographical remoteness, conflict and cultural diversity, have led to considerable inequities in the utilization of health services, with rural and hard-to-reach areas of the country being the most deprived. International sanctions, which prevented external assistance from flowing through the Government of Myanmar

(GOM), have greatly fragmented the health system. They have led to a strong presence of international and local NGOs for delivering key services. Much of the private-for-profit sector is unregulated.



The GOM is now committed to improving access to and quality of health services as part of its reform agenda. Positive changes can already be observed. Public spending on health, for example, has increased to US\$11 per capita in 2013-14 and development partners (DPs) have significantly boosted their financial support; most of the funding they provide, however, can still not flow through the government system, as sanctions have not yet fully been lifted.

Indonesia: Forging Ahead with UHC Reforms

Indonesia is a complex country that has introduced major health reforms as part of a five-year "Roadmap to Universal Health Coverage." Indonesia is an archipelago nation of more than 17,000 islands with a population of over 250 million that has been undergoing a process of decentralization since 1999. A lower-middle income country that has experienced strong economic growth in the past decade, Indonesia is now the largest economy in Southeast Asia. At the same time, the country has wide social and economic inequity, with approximately 40 percent of the population considered poor or vulnerable (living on \$2 or less) (WDI 2015, 2014 estimate). Similarly, there is wide variability in terms of health delivery and outcomes, and compared to its regional neighbors the country has weaker performance on health indicators (e.g., overall life

³ Myanmar Health Sector Public Expenditure Review, 2013.

⁴ Ibid.

expectancy; infant, child and maternal mortality; growth of HIV/AIDS, and high TB prevalence).

In January 2014, Indonesia began implementation of an ambitious national health insurance initiative aimed at moving the country toward UHC. The insurance program aims to cover the country's entire population by 2019. A single payer, called BPJS, has integrated distinct existing insurance programs for the poor, civil servants, police, military, and formal sector workers into one unified National Health Insurance Scheme, known as Jaminan Kesehatan Nasional (JKN). The vision is for the 300+ district-level insurance schemes currently active to also integrate into JKN, and for all non-poor informal sector workers to enroll by 2019. If Indonesia attains these ambitious goals, it will have the largest single-payer insurance system in the world and it will be well on its way to achieving UHC.

As with any ambitious health reform, and as experience of the first year has shown, implementation of JKN will be challenging and cause a variety of unintended effects. Challenges include ensuring adequate infrastructure and quality of service delivery, enrolling and collecting premiums from the informal sector, paying providers effectively, and communicating and clarifying how the new sets of regulations will work for government institutions, providers and beneficiaries alike.

To ensure progress toward UHC as envisioned by Indonesia's new President Joko Widodo, JKN operational processes need to be monitored and strengthened, policy decisions need to be reviewed, and roles and responsibilities need to be clarified. For this to happen effectively, policy and decision-makers at the national and district levels need to know whether JKN is being implemented as intended, whether JKN is bringing about the expected changes in the health system, and whether JKN is contributing to improving population health. Indonesia's leaders need timely, accurate and relevant information to allow them to take corrective measures that will keep them on track to achieve their goal of UHC.

Table I. Why the Start-up of Implementation Research is Different from Typical Research

Typical Research	Implementation Research
<ul style="list-style-type: none"> • The methods and the implementation arrangements can to a large extent be defined by the researchers at the onset • A one-shot exercise that ends with a formal report or one or more publications in peer-reviewed journals 	<ul style="list-style-type: none"> • An ongoing process that needs to be deeply rooted in real-world contexts and actively engage implementers and stakeholders in defining relevant questions and adopting appropriate methods • The IR process is institutionalized and turned into a routine collaborative learning activity that provides regular feedback—which can take many forms—to enhance decision making by a diverse group of stakeholders

Laying the Groundwork for IR for UHC

IR can be a particularly effective mechanism for advancing both countries' UHC agendas, whether it is building IR into UHC design and early implementation in Myanmar or using IR to inform mid-course corrections in the rollout of the UHC roadmap in Indonesia. For IR to be truly effective, however, the time and care to lay the groundwork for IR and orient government and other stakeholders unfamiliar with IR should not be underestimated. In some ways the initial phase in IR is similar to many other types of research in that clearly defining the research questions is key to determining the methodological approach and the data collection and analysis plans. Yet, getting started with IR can also be more complicated, more sensitive, more time consuming, and require different approaches and capabilities than the typical research project.

Thus, gaining buy-in, engaging stakeholders, ensuring local ownership, and narrowing the IR focus are critical to IR's ultimate relevance and use. We outline these steps below with illustrations of how we have dealt with them in Myanmar and Indonesia.

Gaining Buy-in and Trust

When introduced by ‘promoters’ of IR in contexts where IR and UHC are relatively new concepts, the buy-in and involvement of implementers and stakeholders is essential for IR to be relevant and actionable and to help strengthen implementation of UHC-related policies. Gaining stakeholders’ trust is not easy. Some of the key issues and questions that may arise include:

- How do we explain the value of IR, which is an abstract and often new concept?
- How do we deal with ‘chicken and egg’ issues, such as:
 - Needing to explain the IR focus to get stakeholders’ attention and buy-in, while needing to involve the stakeholders in shaping the IR focus
 - Needing to involve subnational implementers as key stakeholders in the IR process, while needing a clear research question prior to effectively selecting target districts
 - Needing to provide a clear price tag when approaching potential funders of the IR activity before being able to clarify the focus and scale of IR, which is an integral part of the process of IR for which funding is being sought in the first place
- If we choose an overarching research topic to get the conversation started (such as provider payment or supply chain management), do we risk imposing our own priorities and/or alienating stakeholders by selecting a topic that may be perceived as controversial or that may not be aligned with their priorities and needs?
- What are stakeholders’ priority questions? Are they looking to shape policy (decide what to do) or strengthen implementation (improve the how), or both?
- How do we facilitate a ‘top-down, bottom-up’ approach in which national and subnational stakeholders trust that their needs will be met?

- How do we address stakeholders’ concern that the IR might be used as an attempt to control or manipulate, to highlight strengths and avoid showing weaknesses in policy implementation, or to only show mistakes, weaknesses and deficiencies?



Engaging Diverse Stakeholders

Ensuring the relevance and ultimate utility of IR requires the engagement of a diverse set of stakeholders from within and across various institutions with responsibilities for effective and sustainable UHC-related policies. The process of engaging diverse stakeholders raises a whole set of challenging issues and questions:

- In a policy environment that is in flux and/or when a policy may be unclear or controversial, how do we identify the key implementers and stakeholders within multiple entities and at national and subnational levels?

- Is there a clear ‘owner’ or champion of the IR? If not, do we need to create one or more and, if so, what are the implications? Are we undermining the IR by excluding anyone?
- Who are the decision-makers around the IR? Which hierarchies need to be respected? Which stakeholders’ input is necessary to shape and support the IR? Which stakeholders will be most likely to act on the IR results?
- If we are aiming for an institutionalized IR process, which stakeholders are likely to ensure ongoing financial support?
- How do we bring together the necessary implementers and stakeholders, gain consensus on IR questions and share in an IR vision?
- How do we determine and explain the terms and processes of engagement, clarify roles of diverse stakeholder groups?
- Should individuals who will be actively involved in the IR—many of whom may be government officials—be compensated or should IR become part of their regular work
- Is there a ‘theory of change,’ or are there multiple ‘theories of change’ to guide our thinking?
- Which questions of interest can be answered through other means, such as routine information systems? Where are the gaps that require focused IR?
- How do we meet the needs and interests of the different stakeholders without making the IR unwieldy?
- How do we build consensus and identify issues and solutions when this is not necessarily a habit?
- How do we set and manage expectations for what the IR can and cannot achieve?
- How much and what type of data will central stakeholders deem sufficient to be actionable? How many IR sites need to be selected?

Narrowing the IR for UHC Focus

Moving towards UHC is a long-term process that typically involves ambitious health reforms, which translate into a complex mix of new policies. IR cannot study everything. When the initial demand for IR does not come from within the system (for example, from an external donor such as USAID, as was the case in both Indonesia and Myanmar), one of the challenges is to narrow down the focus of the IR to fit within available resources, time, and other constraints, while ensuring that the research is still meaningful. The key is to involve the stakeholders in the process to shape the scope of the IR. Important issues and questions that need to be considered include:

- What ‘prep work’ in terms of background research and outreach do we (and/or others) need to do?
- What constraints do we need to factor in as we proceed to designing the IR: time and budget constraints, limitations of the IR partners or end users, other constraints?
- What IR experience, capacity and capabilities are necessary?
- What does the identification and selection process look like?
- Which local organizations/institutions are willing and capable of carrying out the IR?
- How do we assess local organizations’ capacity and capabilities?
- How do we strengthen their capabilities?
- Can we involve more than one local organization/institution in the IR?
- How do we further the institutionalization of IR if it is contracted out?
- Considering that we are trying to institutionalize a process, how should we approach remuneration?

Ensuring Local Partner Leadership

If one of the goals of IR for UHC is to institutionalize a process of collaborative learning and decision-making, it is important to have a local partner to guide the multiple stakeholders through the process and to execute the IR strategy. Identifying and selecting the local IR partner requires answering several key questions:

Laying the Groundwork for IR for UHC in Myanmar

Introducing IR for UHC in Myanmar is facing numerous challenges, which provide real-world illustrations of some of the points raised above. These challenges relate mainly to gaining buy-in, defining the scope of IR and identifying local partner organizations.

Election distractions: It is important to note that Myanmar will be holding its first general elections in November 2015, ending nearly 50 years of military rule. Many high-level government officials have a great deal of their attention already focused on these upcoming elections. There is a clear desire to show quick wins and a certain reluctance to draw too much attention to the shortcomings of the system. This general state of mind is also felt within MoH, which complicates somewhat gaining buy-in for IR.

Introducing IR without dictating the scope: IR is a relatively new concept in Myanmar. Initially, there was considerable confusion around what IR exactly is, and what it is not. Because the scope of IR should be defined by the local stakeholders, many critical issues such as the research questions, geographical focus and institutional arrangements, are purposefully left open at the beginning. This is clearly different from traditional research where the scope, the research questions and most of the implementation arrangements are known to the researchers from the start. This iterative feature of IR has significantly complicated the initial exploration phase. Despite the government's official commitment to UHC, some of the bureaucratic procedures that are still in place hinder such a stakeholder-driven process. The requirement to obtain travel authorizations to visit many parts of the country, combined with the need for endorsement from the central level to arrange meetings with local stakeholders, for example, have led to one of those 'chicken-or-egg' situations discussed above. In order to obtain the formal approval from the central level, it is necessary to provide details about the questions that will be discussed, with whom and for what purpose. If the purpose of the visit is to conduct a general

exploration and to get local stakeholders to articulate the relevant questions, which is an important step of IR, the formal approval is unlikely to be granted, as the purpose of the visit will be considered to be too vague.

Very early on the path to UHC: Narrowing the scope of IR has also been somewhat challenging in Myanmar because the country's path towards UHC is to a large extent still uncharted. Unlike many other countries including Indonesia, there is no single, predominant UHC-related policy that would be the obvious focus of IR. A suitable entry point had to be found that is clearly linked to UHC, that is not controversial and that can generate sufficient attention and buy-in from both the central and the local levels. Eventually, stakeholders chose to focus IR on the implementation of EHSAP, the World Bank-supported project mentioned earlier. Initially the key themes will be health facility readiness, financial management, supervision, and health planning, mainly at township level and below. IR will complement the project's monitoring and evaluation (M&E) plan to better understand where the biggest implementation challenges relating to those central themes are faced and, more importantly, why. It will be overseen by the M&E working group that is to be established by MoH under the Project Steering Committee, thereby facilitating buy-in from and involvement of the central authorities. For the first cycle of learning, IR will be launched in three townships that are still to be selected based on pre-defined criteria.

Local partners within the MoH: Finally, to develop a strong partnership with a local organization that is well positioned to help introduce and institutionalize IR, important trust barriers—the legacy of decades of isolation and military rule—have had to be overcome. The Yangon University of Public Health (UoPH) is keen to collaborate. The activity fits into the University's efforts to promote evidence-based policy-making, and it offers real-world research opportunities for the University's graduate students. The Department of Medical Research (DMR), which is the MoH arm that is responsible for health-related research in the country, is also interested to contribute to the IR for UHC activity. The activity

will help with the Department's desired expansion of its health systems research. Given that both UoPH and DMR are under the authority of MoH, these partnerships require the blessing from the central level. In the meantime, key staff in both organizations have already been exposed to the fundamentals of health financing and UHC through various trainings. To most of them, these concepts were totally new.

Laying the Groundwork for IR for UHC in Indonesia

The IR for UHC activity in Indonesia was launched as three important developments coincided in 2014. First, as mentioned above, 2014 was the first year of the five-year Roadmap for JKN implementation. Many of the policy details had been worked out, but as expected, implementation was running into some significant challenges—from ensuring supply-side infrastructure and quality of service delivery, to avoiding that those with the greatest health needs are being left out, to paying providers effectively, and to communicating and clarifying for government institutions, providers and beneficiaries alike how the new sets of regulations will work. Second, President Joko Widodo was sworn in in October 2014 and prioritized UHC as an important part of his administration's commitment to increasing equity and reducing poverty in Indonesia. Third, new leadership in the health office at USAID in Jakarta renewed the Mission's strategic focus on supporting the Government of Indonesia (GOI)'s health systems strengthening efforts.



Beginning with a landscape analysis: These developments called for a need to take stock of a complex and changing environment before forging ahead with IR for UHC. With support and input from USAID, HFG undertook a comprehensive landscape analysis to ensure that the research was relevant, filled gaps in the rich inventory of previous and ongoing studies on JKN, and engaged the right stakeholders at the national and subnational levels.

Through the landscape analysis we identified previous, ongoing and upcoming studies on JKN; interviewed key GOI and academic



stakeholders, and mapped the multiple players involved in JKN implementation. Additionally, by reaching out to multiple stakeholders and sharing the resulting matrix of over 150 JKN studies, we were able to raise awareness of the planned IR for UHC activity and set a tone of sharing and collaboration.

The landscape analysis was valuable in preparing us to meet several of the key challenges in getting started with IR for UHC in Indonesia. First, it deepened our understanding of the complexities of the JKN reform process and increased our awareness of the numerous studies on JKN that were completed, ongoing and in the planning stage. Second, it helped us to identify and map the key GOI stakeholders at the national level who needed to be involved in the IR, what their main interests were, and what role they might play in the process, (e.g., convener, primary IR 'owner,' participant in a multi-stakeholder working group, etc.). Third, it helped us identify an area of focus for the activity that was broad enough to leave room for implementers to still shape the study, yet targeted enough to help us engage with stakeholders and 'sell' the IR for UHC activity as relevant to their interests and priorities.

Selecting the local partner through a

competitive process: Lastly, the landscape analysis prepared us to carry out a competitive process for selecting an Indonesian research partner with experience, capability and capacity to carry out the IR for UHC activity as envisioned. After identifying qualified institutions through a Call for Expressions of Interests, we issued a Request for Applications (RFA) that described the three goals of the activity:

1. Engage national and district-level policy and decision-makers in shaping the research and acting upon the results
2. Generate evidence and learning from cycles of research that will stimulate action and strengthen JKN implementation at the primary care level
3. Strengthen local capacity for carrying out IR

Once again, a challenge in drafting the RFA was to sufficiently define the activity parameters so that applicants understood the objectives and requirements, while at the same time giving them sufficient leeway to propose original approaches to use IR to advance UHC in Indonesia. We met this challenge by providing a hypothetical approach, which also allowed us to compare responses, and inviting applicants to propose improved approaches to engaging stakeholders, designing and implementing IR for UHC, and strengthening capacity for implementing and using IR for decision-making.

Even with the key pieces for IR in place (a research topic, primary GOI counterpart, key stakeholders to take part in a technical working group, local research partner, target provinces), the tasks of clarifying IR, engaging with stakeholders, articulating a vision for the activity, and ensuring local ownership of the process continue and are likely to do so throughout the life of the program. The process is evolving only as fast as everyone feels comfortable. The next steps are to shape the research design through consensus in a way that ensures collective learning and action.

Moving Forward while Looking Back

Looking back over the past months of setting the foundation not just for an IR project, but also for a process of learning from IR that continues to support UHC, we offer the following 10 lessons learned:

1. **Practice diplomacy** to gain the buy-in, trust and confidence of multi-stakeholders with different roles, priorities and interests
2. **Sell a stakeholder-driven process, not a research project**, to ensure the active participation of stakeholders
3. **Consider vocabulary** as not all stakeholders will understand IR terms and/or may make certain assumptions as soon as they hear the word 'research'
4. **Articulate a shared vision of success for the IR** so that goals and objectives are clear even if the context shifts
5. **Clarify how the IR process will work**, for example with a Memorandum of Understanding, so that the multiple players involved in the IR understand the when, where, why and how of their involvement, and to avoid misunderstanding and miscommunication
6. **Allow sufficient time** for all involved to understand and become comfortable with IR as a process, and for you to fully understand the political context, identify key stakeholders and gain consensus
7. **Be flexible** and allow for priorities, people and plans to shift
8. **Establish trust** by practicing open communication and sharing data and information
9. **Build in collective learning** from the get-go to enable researchers and implementers alike to get better at 'doing,' 'learning from' and 'acting upon' IR
10. **Think long term** to institutionalize IR as a locally sustainable practice. The country will benefit from routinely building IR into their policy processes

We will need to be mindful of these lessons as we proceed to the next phase of the IR for UHC activities in Myanmar and Indonesia: defining and designing IR for UHC, which is also the subject of the next brief.



ACKNOWLEDGEMENTS

The Health Finance and Governance project gratefully acknowledges the thoughtful review and comments of Joe Naimoli, Kristina Yarrow, David Peters, Rena Eichler, Catherine Connor, Chris Lovelace, William Slater, Zohra Balsara, and Edhie Rahmat.

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This publication was produced for review by the United States Agency for International Development.

It was prepared by Susan Gigli and Alex Ergo for the Health Finance and Governance Project.

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A flagship project of USAID's Office of Health Systems, the Health Finance and Governance (HFG) Project supports its partners in low- and middle-income countries to strengthen the health finance and governance functions of their health systems, expanding access to life-saving health services. The HFG project is a five-year (2012-2017), \$209 million global health project. The project builds on the achievements of the Health Systems 20/20 project. To learn more, please visit www.hfgproject.org.

The HFG project is led by Abt Associates in collaboration with Avenir Health, Broad Branch Associates, Development Alternatives Inc., Johns Hopkins Bloomberg School of Public Health, Results for Development Institute, RTI International, and Training Resources Group, Inc.



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December 2015

