

The Policy Environment Score

Measuring the Degree to Which the Policy Environment in Jamaica Supports Effective Policies and Programs for Reproductive Health: 2000 Follow-up Results

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I. Introduction

Purpose

The Policy Environment Score (PES) is intended to measure the degree to which the policy environment in a particular country supports the reproductive health of the population, with particular focus on access to high-quality family planning and reproductive health services. It is designed to reflect both the level of support and changes that take place during one to three years as a result of policy activities. This score has two major purposes:

1. To indicate the current status of the policy environment including the strongest and weakest elements.
2. To evaluate the impact of policy activities.

Definitions

For our purposes, we define policy to be actions, customs, laws, or regulations by governments or other social/civic groups that directly or indirectly and explicitly or implicitly affect fertility, family planning, or reproductive health. This extends earlier definitions (Cross, 1988; Maguire, 1990) to recognize that policies can be direct or indirect and explicit or implicit. This definition excludes population policies affecting overall mortality, migration, and spatial distribution, but includes health policies affecting all aspects of reproductive health.

II. Conceptual Framework

Local governments and international donors have a history of supporting activities designed to improve health in the developing world. Among the many lessons learned from this experience is that a supportive policy environment is a major factor in the success of most, but not all, national programs (Clinton, 1979; Freedman, 1987; Merrick, 1989). USAID and other donors have supported population and health policy activities for the past 25 years. There now exists a large and diverse literature base concerning the components of the policy environment and how the various elements interact to affect services and outcomes. In 1994, the USAID-funded EVALUATION Project addressed the issue for family planning activities with a working group on population policy indicators. A considerable amount of background research was done in preparation for that working group. Much of the following discussion expands on the report of this working group (Knowles and Stover; 1995).

The policy environment is defined as the factors affecting program performance that are beyond the complete control of national program managers. In addition to

political support and other expressions of national policy (e.g., a formal national policy), the policy environment includes those aspects of operational policy that involve decisions at a higher level than the program (i.e., the program's organizational structure, its legal/regulatory environment, the resources made available to it, and its use of provider and acceptor payments and fees).

Figure 1 presents a conceptual framework for the policy environment. The framework is organized according to the standard Input-Process-Output-Outcome schema and depicts policy activities of a single period as part of a continuous circular loop. The policy environment is the output of the policy process. It directly affects the various functional areas of programs (e.g., IEC, training, commodities and logistics, management), institutionalization, self-sufficiency, and demand for services.

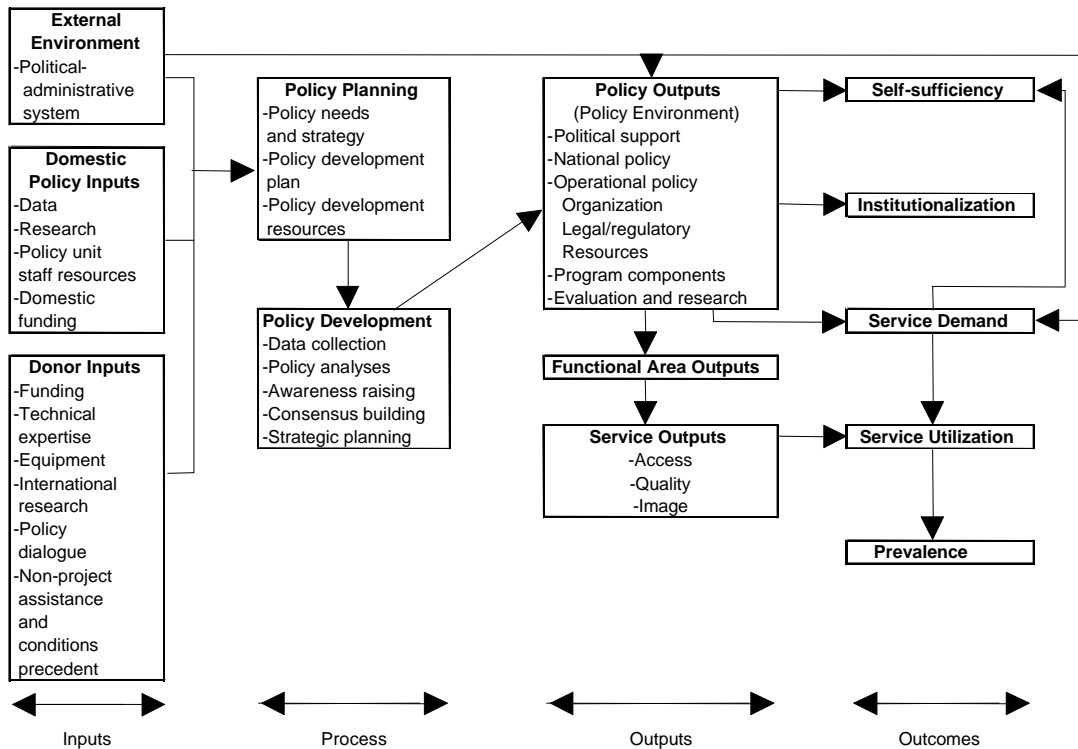
Inputs to the policy development process include

- The external environment;
- Domestic policy inputs; and
- Donor inputs.

The external environment includes a country's political-administrative system (PAS), its socioeconomic characteristics, and its sociocultural environment. Domestic policy inputs include available data, existing research, staff resources of policy units, equipment (e.g., computers, audio-visual equipment), and domestic funding. Domestic inputs are enhanced over time to the extent that the institutionalization of policy development capabilities is an effect of policy work. (Figure 1, as a single-period schema, does not explicitly show the feedback effect from institutionalization in one period to levels of domestic policy inputs in the following period, however, this should be considered as part of the conceptual framework.) Donor inputs to policy development include specialized technical expertise, equipment, funding, international research, policy dialogue, nonproject assistance, and conditions precedent to loans and grants.

The policy environment is modified over time through the planned implementation of policy activities (i.e., the process of policy planning and policy development). Policy planning is based on an assessment of the current policy environment in relation to program needs and of the inputs available for further policy development. Many policy development activities, or policy interventions, are designed to strengthen political support and/or to develop an effective national policy in support of reproductive health programs. As support for programs grows at the national level, policy interventions are usually directed to strengthening the operational policy environment.

Figure 1. Conceptual Framework for the Evaluation of the Policy Environment



As shown in Figure 1, the external environment (directly), other policy inputs (indirectly), and the process of policy development determine a national program’s policy environment. The dimensions of the program policy environment, which is the output of the policy development process, include the following:

- Political support
- National policy
- Operational policy
- Program components
- Evaluation and research

Political support at national, regional, and local levels plays a central role in a program’s policy environment, since it is an important determinant of the other dimensions of the policy environment. Political support can be both explicit and implicit. Explicit support may be indicated by statements made by high-level government officials and other leaders in support of reproductive health programs. Implicit political support is most often gauged by what the government actually does in the areas of national and operational policies.

National policy includes both formal statements of policy (e.g., national policies, national development plans) and tax and other material incentives designed to affect decisions.

Operational policy consists of three subdimensions that are directly related to the operation of national programs:

- *Organizational structure and processes*: a program's status within the government's administrative structure and its capacity to mobilize the resources of other public and private institutions.
- *Legal/regulatory environment*: taxes and other restrictions that affect the supply of commodities, particularly from the private sector, and medical barriers to service delivery and information activities.
- *Provision of resources*: financial, material, and human resources needed by programs.

Program components is intended to explicitly capture whether specific program components are included in the program by formal policy. This could be included under national policy; however, it seems better to separate it from the broader national policies.

Evaluation and research is intended to capture whether these activities are present to support the process of policy formulation.

According to Figure 1, improvements in the program policy environment should lead to stronger service delivery (access, quality, image), increased service use and behavior change, and enhanced institutionalization and self-sufficiency of programs. As noted above, institutionalization also affects levels of domestic policy inputs in the following period (a feedback loop). On the supply side, therefore, the policy environment contributes directly, both to improved service delivery in the short run and to enhanced program sustainability in the long run. On the demand side, both political support and national policy dimensions of the program policy environment (e.g., statements of leaders) affect demand for services.

This framework has been used to develop the major categories for the PES shown below.

Composition of the Policy Environment Score

All of the items in the conceptual framework could be included in the PES. However, we have chosen to limit the PES to those items that both define the policy environment and can be influenced by policy activities.

Items in the conceptual framework (Figure 1) listed under *External Environment* and *Donor Inputs* are assumed to be outside the potential influence of policy activities. Therefore, they are not included in the PES. It could be argued that they should be included, since they do help define the environment for policy; however, since they cannot be affected by policy activities, their inclusion would reduce the usefulness of the score as an evaluation device.

Items under *Domestic Policy Inputs*, *Policy Planning*, and *Policy Development* are the inputs and processes used by policy activities to affect the environment. Therefore, they do not belong in a measure of the environment itself.

Items under *Policy Outputs* represent the elements of the policy environment that policy activities attempt to influence. These items define the categories of the PES:

- Political support
- National policy (or policy formulation)
- Operational policy
 - Organization and structure
 - Resources
 - Legal/regulatory
- Program components
- Evaluation and research

A number of specific items could be included under each of these headings. Selection of items included in the PES is intended to capture the most important indicators in each category.

III. Implementation of the Policy Environment Score in Jamaica

Components of Reproductive Health

For the purposes of this application, the following four separate reproductive health programs have been included:

- *Family planning*: programs to provide high-quality family planning services to men and women who wish to plan their families.
- *Safe pregnancy*: programs to ensure that pregnancies are as safe as possible by providing good prenatal, postnatal and delivery care and by identifying and treating high-risk pregnancies.
- *STDs/AIDS*: programs to control the spread of sexually transmitted diseases (STDs), including HIV (the virus that causes AIDS) and to ensure the human rights of individuals affected by HIV/AIDS.
- *Adolescents*: programs to enhance the reproductive health of adolescents through education and services.

The PES was applied separately for each component. Specific items used in the score are the same for all programs for the components of *political support*, *policy formulation*, *organization and structure*, *program resources*, and *evaluation and research*. Items are different for the components *legal/regulatory* and *program components*, reflecting the different characteristics of each program.

To measure change in the policy environment, respondents were asked to rate each item twice—once to reflect the current status in 2000—as well as once to indicate the status in 1999. The complete instrument for all four programs is in Appendix B.

Data Collection

The PES was implemented by the POLICY Project on behalf of USAID/Kingston. A baseline assessment was conducted in 1999, and those results were presented in an earlier technical report (McClure et al., 2000). The purpose of this report is to present and discuss results of a follow-up assessment of the PES in Jamaica and compare these results with the baseline results. These results are important because progress made in the Jamaican reproductive health policy environment can be examined.

A total of 23 respondents participated in the survey between November and December 2000. Appendix A lists the respondents. Participants responded to only those programs with which they had familiarity. Thus, the number of respondents is different for each program. Furthermore, several respondents did not answer all of the questions for each program. Therefore, individual and component scores reflect on the number of responses per question. Overall scores reflect the responses of people who answered a majority of the questions. If one respondent did not answer any of the questions in one category (i.e., *political support*), the overall score will not include this person's responses.

Respondents were chosen because of their knowledge about the reproductive health program and because they represent various viewpoints. Thus, respondents included those working within the public sector programs as well as those outside the program. Respondents included staff of the Ministry of Health (MOH), the National Family Planning Board (NFPB), nongovernmental organizations (NGOs), the University Hospital of the West Indies, reproductive health programs, the private sector, and international donors. There was some overlap in respondents in the baseline survey (conducted in 1999) and follow-up survey (conducted in 2000). However, many of the largest differences in scores between the baseline and follow-up surveys can be attributed to the difference in composition of the groups of respondents in 1999 and 2000. This point is addressed later in this report.

In inviting them to participate, respondents were contacted by telephone or in person. Forms were delivered to respondents in the Kingston region and faxed to those in rural areas. Follow-up contact ensured that all respondents completed and returned the forms. Some participants failed to complete the questionnaires following review, and some referred them to colleagues who were already respondents. In some cases, assistance was provided to respondents in interpreting the questionnaire. The entire process took place from October 2000–January 2001.

Respondents were asked to provide information on the programs for 2000 as well as the same information for 1999.

Scoring

All of the items in the PES are scored on a 0–4 scale. The definition of the scale varies somewhat depending on the category (as shown in the PES questionnaire in Appendix B) in order to provide clear guidance to the scorer.

The first step in calculating the total score is to sum the individual item scores within a category. These subtotals are converted to averages by dividing by the number of items that were scored. (This procedure computes an average score per item scored; thus, items that were not scored by the respondent do not reduce the score.) These averages are converted into percentages by dividing by the maximum possible score for each category. This approach standardizes the categories in order that the number of individual items within a category does not affect its contribution to the total score.

The sum of all the weighted category scores is the total PES. The final score is adjusted to range from 0–100, with 100 indicating a perfect policy environment.

Follow-up Results

As described, this report analyses the results of the follow-up PES conducted between November and December 2000. This section analyses the results of the follow-up survey; specifically, how respondents rated programs for 2000 as compared with the same programs for 1999. Baseline and follow-up results are compared in the next section of this report.

Follow-up scores for each program are shown in Table 1. All of the program scores fall in the middle to upper-middle ranges, from a low of 54 percent of the maximum for adolescent programs to a high of 74.1 percent of the maximum for STDs/AIDS in 2000.

**Table 1: Policy Environment Scores by Program and Year:
Follow-up 2000**

Program	Year 2000 (%)	Year 1999 (%)	Change
Family planning	71.0	73.6	-2.6
Safe pregnancy	61.6	60.5	1.1
Adolescents	59.7	54.0	5.7
STDs/AIDS	74.1	73.7	0.4

Adolescents category stands out as having an improved policy environment between 2000 and 1999, with an increase of 5.7 percentage points. However, it is still rated the lowest of all of the programs with an overall score of 59.7 percent of the maximum. Slight improvements were noted for safe pregnancy and STD/AIDS. Respondents perceived that the policy environment for family planning declined between 1999 and 2000.

Table 2 compares the results of the follow-up survey by program area and dimension.

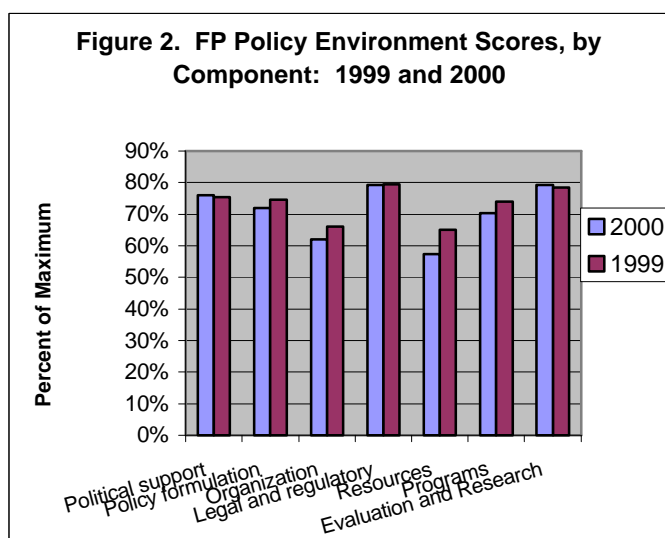
Table 2: Comparison of Policy Environment Scores by Dimension and Program

	Family Planning (%)		Safe Pregnancy (%)		Adolescents (%)		STD/AIDS (%)	
	2000	1999	2000	1999	2000	1999	2000	1999
Political Support	76	75	71	69	74	68	71	70
Policy Formulation	72	75	63	59	72	64	73	70
Organization	62	66	60	58	46	34	72	72
L/R	79	79	68	68	60	59	81	82
Resources	57	65	57	58	52	50	64	64
Programs	70	74	75	74	56	50	71	70
Eval.&Res.	79	78	69	68	62	57	74	77

Note: Values can range from 0–100.

Family Planning

Figure 2 shows the family planning scores by component for respondents' assessment of the policy environment in 2000 compared with 1999. Results indicate a statistically significant decline in the family planning policy environment. Four categories declined, two improved, and one remained the same. Results indicate that advances were perceived for *political support* and *evaluation and research*.



Decreases were perceived for *policy formulation*, *organization*, *resources*, and *programs*. No changes were noted for *legal/regulatory*. *Resources* received the lowest score (57 percent of maximum), indicating that respondents were most concerned about resources available for family planning.

Table 3 compares the changes in family planning categories as rated in 1999 and 2000.

Table 3: Family Planning Follow-up Scores

Category	Follow-up			
	Raw Score		Percent of Maximum	
	1999	2000	1999	2000
Political Support	3.02	3.04	75	76
Policy Formulation	2.98	2.88	75	72
Organization	2.64	2.48	66	62
L/R	3.18	3.17	79	79
Resources	2.60	2.30	65	57*
Programs	2.96	2.82	74	70*
Eval.&Res.	3.14	3.17	78	79

*Statistically significant: p-value .05

Legal/Regulatory (79 percent of maximum in 1999 and 2000). Along with *evaluation and research*, respondents perceived this category as the strongest in the family planning policy environment. No change was perceived in this category compared with 1999.

Evaluation and Research (78 percent in 1999 and 79 percent in 2000). As noted, this category received the highest score in the family planning PES, along with *legal/regulatory*. A 1-percentage point increase in this component is noted in 2000.

Political Support (75 percent in 1999 and 76 percent in 2000). This was the second highest rated component of 2000, with very little variation in the policy environment in comparison with 1999.

Policy Formulation (75 percent in 1999 and 72 percent in 2000). A decrease of 3-percentage points was noted. Respondents ranked almost all aspects of *policy formulation* as weaker over time. However, the existence of a national coordinating body decreased more than other scores.

Program Components (74 percent in 1999 and 70 percent in 2000). The decrease in this component is statistically significant. This score declined because of weak policies, or the lack thereof, for mass media to inform and motivate, home-visiting workers, and contraceptive social marketing.

Organization and Structure (66 percent in 1999 and 62 percent in 2000). The family planning *organization and structure* was perceived by respondents as getting weaker; this component was rated second lowest in family planning. In particular,

respondents perceived that in 1999 the service delivery program had a higher placement than in 2000.

Resources (65 percent in 1999 and 57 percent in 2000). Not only was this the lowest rated category, but respondents also noted the biggest decreases in the category over time, which was statistically significant. Inadequate funding, staffing, and resource allocation contributed to this low score.

Safe Pregnancy

Figure 3 shows the safe pregnancy scores by component for respondents' assessment of the policy environment in 2000 compared with 1999. A 1.1-percent improvement was noted between 1999 and 2000. The highest rated component in the follow-up survey is *program components*, at 75 percent of the maximum score; *political support* was also highly rated with a score of 71 percent. *Evaluation and research, legal/regulatory, policy formulation, organization and structure, and resources* received the lowest scores, between 57 and 68 percent of the maximum. No change was noted in the *legal/regulatory* environment for safe pregnancy. *Resources* declined slightly. The remaining five categories improved.

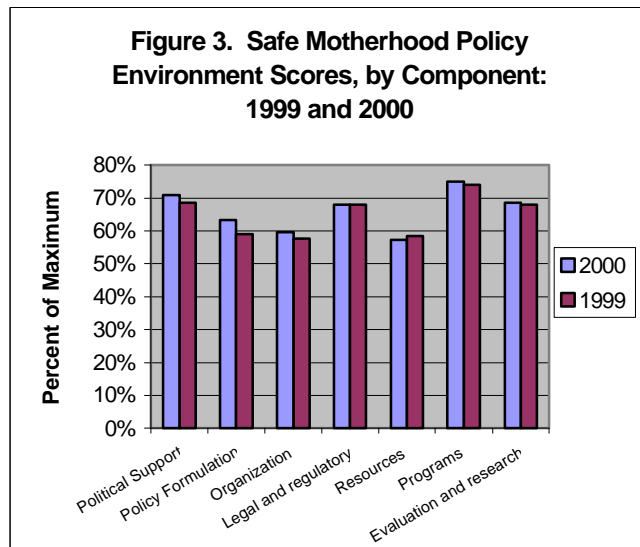


Table 4 compares the changes in safe pregnancy categories as rated in 1999 and 2000.

Table 4: Safe Pregnancy Follow-up Scores

Category	Follow-up			
	Raw Score		Percent of Maximum	
	1999	2000	1999	2000
Political Support	2.74	2.83	69	71
Policy Formulation	2.36	2.54	59	63
Organization	2.31	2.38	58	60
L/R	2.71	2.71	68	68
Resources	2.33	2.29	58	57
Programs	2.96	3.00	74	75
Eval.&Res.	2.71	2.74	68	69

Program Components (74 percent in 1999 and 75 percent in 2000). This is the highest ranked category in the safe motherhood policy environment, and the results show a slight improvement from 1999. One respondent noted improvements in service delivery norms.

Political Support (69 percent in 1999 and 71 percent in 2000). This is the second highest ranked category in safe pregnancy, with a moderate improvement noted in comparison to 1999. High-level national government support for effective safe pregnancy policies and programs was perceived as having somewhat improved over time.

Evaluation and Research (68 percent in 1999 and 69 percent in 2000). Results indicate a slight improvement in the ranking of this category. Respondents perceived improvements in the undertaking of special studies to address policy issues.

Legal/Regulatory (68 percent in 1999 and 2000). Respondents perceived no change in this score over time.

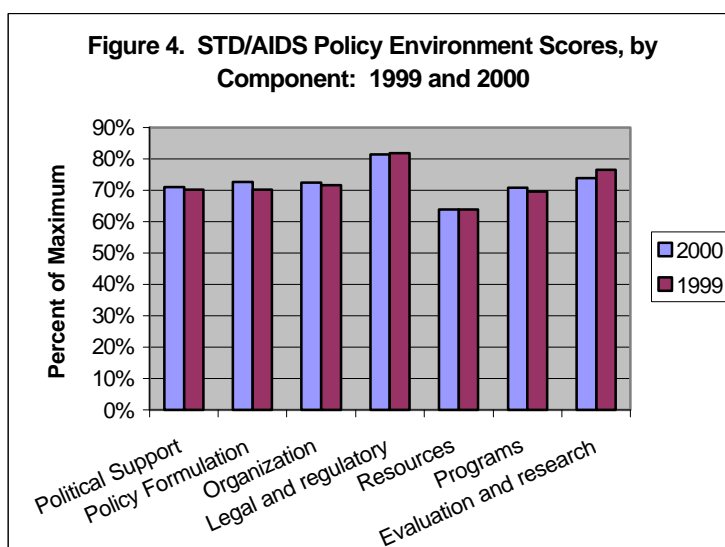
Policy Formulation (59 percent in 1999 and 63 percent in 2000). This category was rated as having moderate positive change between 1999 and 2000. Increases were noted in improved policies, programs, and strategies.

Organization and Structure (58 percent in 1999 and 60 percent in 2000). This category improved modestly over time. Increases were noted for several components of this category: the service delivery program is placed at a high level in government; the director for service delivery is full-time and reports to an influential superior officer; and NGOs as well as the private sector are formally included in policy deliberations. No change was noted in government ministries, other than the MOH, are mandated to help with program implementation.

Resources (58 percent in 1999 and 57 percent in 2000). This was the lowest ranked category in the safe pregnancy category, and the score decreased over time. Respondents noted inadequacy of government and donor funding as weaknesses in this category.

STDs/AIDS

Figure 4 shows the STDs/AIDS scores by component for respondents' assessment of the policy environment in 2000 compared with 1999. Overall, this program area improved by 0.4-percentage points. Scores increased in three categories, declined in two, and did not change in two. The highest rated component, *legal/regulatory*, scored 81 percent of the maximum



2000. Five components scored in the 70-percent range: *political support*, *policy formulation*, *organization*, *program components*, and *evaluation and research*. The component with the lowest score was *resources*, which received a score of 64 percent of the maximum in 2000. The two sets of scores were similar across categories.

Table 5 compares the changes in STD/AIDS categories as rated in 1999 and 2000.

Table 5: STD/AIDS Follow-up Scores

Category	Follow-up			
	Raw Score		Percent of Maximum	
	1999	2000	1999	2000
Political Support	2.81	2.84	70	71
Policy Formulation	2.87	2.93	72	73
Organization	2.86	2.89	72	72
L/R	3.25	3.26	82	81
Resources	2.55	2.55	64	64
Programs	2.79	2.84	70	71
Eval.&Res.	3.06	2.95	77	74

Legal/Regulatory (82 percent in 1999 and 81 percent in 2000). Respondents rate this category the highest, relative to other categories in STD/AIDS. Results over time declined by 1-percentage point.

Evaluation and Research (77 percent in 1999 and 74 percent in 2000). This component was rated the second highest within the STD/AIDS category. In each

question asked, respondents noted that programs were getting weaker in comparison to 1999.

Policy Formulation (72 percent in 1999 and 73 percent in 2000). Respondents noted slight improvements in this category. According to results, *policy formulation* has become increasing participatory, including ministries, NGOs, and other groups in the process. Improvements were also noted in the efficient functioning of a national coordinating body.

Organizational Structure (72 percent in 1999 and 2000). Respondents did not perceive any change in this category over time.

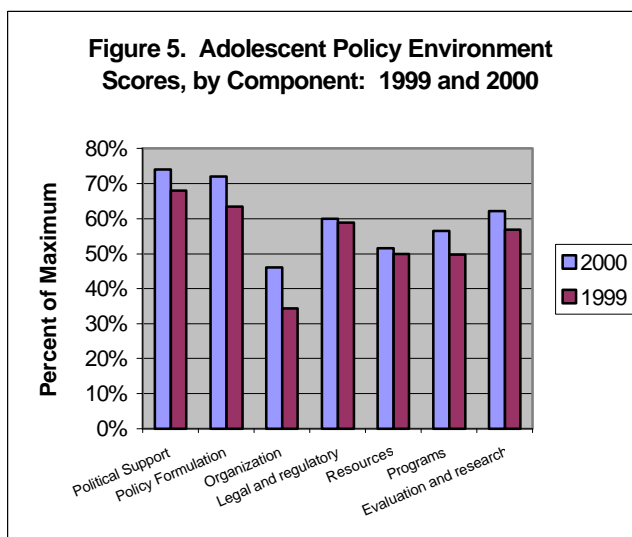
Political Support (70 percent in 1999 and 71 percent in 2000). Respondents perceived slight improvement in this category between 1999 and 2000.

Program Components (70 percent in 1999 and 71 percent in 2000). Respondents noted a slight improvement in *program components* between 1999 and 2000. The greatest improvement was the inclusion of family life education in the program.

Resources (64 percent in 1999 and 2000). This is the lowest ranked category within STD/AIDS, with no change perceived between 1999 and 2000.

Adolescents

Figure 5 shows the adolescent scores by component for both 1999 and 2000. This aspect of reproductive health was rated 5.7 percent higher in 2000 than in 1999, indicating that respondents see a positive trend in the attention given to adolescent reproductive health in Jamaica. Scores increased in all categories. In 2000, two components, *political support* and *policy formulation*, achieved scores higher than 70 percent of the maximum. Still, five of the seven components in the adolescent module received scores in the 62-percentile range or below. *Evaluation and research* and *legal/regulatory* received 62 and 60 percent, respectively. *Program components* and *resources* received 56 and 52 percent, respectively. *Organization and structure* received the lowest score with 46 percent; however, this category did show the significant improvements, with an increase of 12-percentage points



between 1999 and 2000. In each, the change in mean score by component was statistically significant (at .05), with the exception of *resources*.

Table 6 compares the changes in adolescent categories as rated in 1999 and 2000.

Table 6: Adolescents Follow-up Scores

Category	Raw Score		Percent of Maximum	
	1999	2000	1999	2000
Political Support	2.72	2.96	68	74*
Policy Formulation	2.54	2.88	64	72*
Organization	1.38	1.84	34	46*
L/R	2.36	2.40	59	60*
Resources	2.00	2.06	50	52
Programs	1.99	2.25	50	56*
Eval.&Res.	2.27	2.48	57	62*

*Statistically significant: p-value .05

Political Support (68 percent in 1999 and 74 percent in 2000). This is the highest ranked category in the adolescent program area. Respondents noted significant improvement over time, with a 6-percentage point increase. High-level national government and political party support for effective policies and programs received the highest scores, and the change over time was statistically significant.

Policy Formulation (64 percent in 1999 and 72 percent in 2000). This second highest ranked category, improving 8-percentage points between 1999 and 2000. Statistically significant improvements were noted for all aspects of *policy formulation*, with the exception of involving ministries, aside from the MOH, in policy formulation. While headway was made in this area, it was not statistically significant.

Evaluation and Research (57 percent in 1999 and 62 percent in 2000). This category jumped 5-percentage points between 1999 and 2000. Overall improvement in score is due to perceived improvements in the existence of systems to monitor secondary data sources and to bring evaluation and research results to management's attention.

Legal/Regulatory (59 percent in 1999 and 60 percent in 2000). Respondents perceived a slight change in this category.

Program Components (50 percent in 1999 and 56 percent in 2000). The 6-percentage point increase in this category can be attributed to improvements in the provision of counseling and services to adolescents in locations outside traditional service delivery points and training of health care staff. The weakest program area is the accessibility of condoms.

Resources (50 percent in 1999 and 52 percent in 2000). This category received the second lowest rating for adolescent reproductive health. All components in this category received low scores: funding from government and donor sources is generally inadequate; staffing for service provision is generally adequate; enough service points and providers exist for reasonable access by most clients; and resources are allocated according to priority guidelines.

Organization and Structure (34 percent in 1999 and 46 percent in 2000). This is the lowest ranked category for adolescent reproductive health. However, respondents noted a 12-percentage point improvement. Improvements in the inclusion of NGOs and the private sector in policy deliberations and multisectoral implementation of the program contributed to the increase in score.

Variation in Scores

Variation in scores across individual respondents could arise from a number of factors, including

- Normal differences of opinion about the correct score;
- Differences in understanding what the items mean;
- Differences between groups of respondents based on their point of view; and
- Lack of knowledge on which to base a response.

We examined responses according to whether the respondent was from the government, NGO, or donor sector and found some differences between the groups for some of the components (see Table 7). For family planning, for example, respondents affiliated with donors and government had similar overall scores. NGO affiliates rated the program a bit lower at 66.7 percent.

Table 7: Overall Score by Respondent Affiliation

	Government	NGO	Donor
Family Planning	68.5%	66.7%	69.5%
Safe Pregnancy	64.7%	54.2%	58.1%
Adolescents	63.6%	47.1%	56.9%
STD/AIDs	74.2%	79.9%	68.2%

In the *adolescents* area, government respondents perceived the program to be better than did the NGOs and donor groups. NGOs rated this area the lowest of the three groups with a 10-percent difference in overall score.

In the *safe pregnancy* area, NGO respondents perceived the program to be less advanced than the donor and government respondents, giving it the lowest overall score. Donor and NGO-respondent results were similar. The government's overall score was almost 10 percent higher than the NGO overall score. For example, there is a significant change between the baseline and follow-up survey results in the *legal/regulatory* environment (negative 10-percentage points). The difference in this component can be explained by the difference in the baseline and follow-up samples. Two service providers, who were part of the sample at the baseline survey but not at the follow-up survey (which contained no direct service providers), did not perceive any legal or regulatory restrictions placed on health care staff providing safe motherhood services. Service providers in the baseline survey also perceived a greater role of other ministries in policy formulation; again accounting for the significantly lower *policy formulation* score in the follow-up survey. Similarly, *policy formulation* decreased significantly from the baseline to follow-up survey, with an 8-percentage point decrease.

In STD/AIDS, NGO respondents had the highest overall score (80 percent). Government respondents gave a slightly lower score (74 percent), but donors gave this component the lowest score.

Some of the variation in responses is undoubtedly due to different levels of knowledge among respondents. In other instruments similar to the PES, we have experimented with the weighting of responses according to the expertise of the individual in each item. Our research to date has found little impact of weighting on improving accuracy or reducing variation.

Comparison of Baseline and Follow-up Scores

This section compares changes between the baseline and follow-up surveys. Overall, baseline and follow-up survey scores for each program are shown in Table 8. For the follow-up survey, all of the program scores fall in the middle to upper-middle range, from a low of 59.7 percent of the maximum for adolescent programs to a high of 74.1 percent of maximum for STDs/AIDS in 2000. Whereas no overall baseline scores were rated at 70 percent or higher, two categories of the follow-up survey achieved these higher scores, indicating improvements in the policy environment for these two programs.

**Table 8: Policy Environment Scores by Program and Year:
Baseline 1999 and Follow-up 2000**

Program	Baseline (%)	Follow-up (%)	Change
Family planning	67.5	71.0	3.43
Safe pregnancy	68.1	61.6	-6.44
Adolescents	56.3	59.7	3.41
STDs/AIDS	64.9	74.1	9.23

Family planning, adolescents, and STDs/AIDS showed improvements between the baseline and follow-up surveys. *Safe pregnancy* was the only program area with a declining score. *STDs/AIDS* had a dramatically improved policy environment between the surveys, with an increase of 9.23-percentage points. Although the *adolescents* program received the lowest overall score (59.7 percent of the maximum), respondents perceived that advances in this program area were achieved over time. *Safe pregnancy* showed a significant negative change since 1999, indicating that respondents perceived that the policy environment for *safe pregnancy* declined between 1999 and 2000.

Figure 6 compares overall scores for current and retrospective scores for baseline and follow-up surveys.

Figure 6: Comparison of Baseline and Follow-up Scores

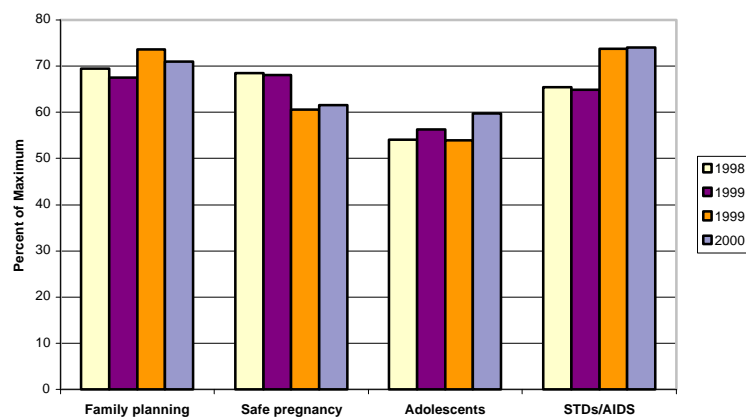


Table 9 compares the results of baseline and follow-up surveys by program area and dimension.

Table 9: Comparison of Policy Environment Scores by Dimension and Program

	Family Planning		Safe Pregnancy		Adolescents		STD/AIDS	
	Baseline*	Follow up**	Baseline	Follow up	Baseline	Follow up	Baseline	Follow up
Political Support	64	76	67	71	66	74	72	71
Policy Formulation	68	72	71	63	67	72	70	73
Organization	57	62	56	60	55	46	65	72
L/R	69	79	78	68	51	60	82	81
Resources	56	57	63	57	42	52	50	64
Programs	71	70	72	75	56	56	67	71
Eval.&Res.	69	79	70	69	50	62	63	74

Note: Values can range from 0–100. *1999 PES covering 1999/1998 **2000 PES covering 2000/1999

Table 9 compares the composite score for each program area over time.

IV. Conclusion

The PES is clearly not a perfect instrument for measuring the degree to which the policy environment is supportive of effective reproductive health policies and programs. Reliance on judgments from a small group of informed individuals leads to large variations in some responses. Nevertheless, it does provide a measure that may be useful for evaluating the current status of the policy environment and determining the amount and direction of change over time. Results reported here are consistent with other policy analyses (McLain et al., 1999; Hardee, 1998).

The findings suggest that the policy environment for *family planning* is good, although some respondents questioned the government's commitment to family planning. One government respondent said, "It appears that much less emphasis is being placed on family planning than in previous years." The role of the NFPB has been questioned during the past few years; however, in the last year, the NFPB has emerged with a renewed focus on promoting family planning, primarily through advocacy, training, and IEC. The head of the NFPB is also an integral member of the MOH senior management team on reproductive health. The significant increase in the score for family planning between the baseline and the follow-up surveys seems to imply a renewed confidence by the government to promote family planning. However, the slight increase to family planning during the follow-up survey (reflecting the perception of change in the policy environment between 1999 and 2000) shows that respondents perceive that the policy environment is changing slowly and that there is room for improvement. The weakest component of the policy environment for family planning continues to be resources.

The policy environment for *safe motherhood* is considered to have weakened from the baseline survey to the follow-up; however, the differences in the scores are largely due to differences in the samples. The baseline sample included some service providers who did not respond to the follow-up survey. Interestingly, their views on the *legal/regulatory* environment were more positive than those of other respondents. They also had more positive views than other respondents on the roles played by ministries other than health and NGOs participated in policymaking for safe motherhood. If responses of these service providers are excluded from the baseline survey, the policy environment for safe motherhood shows little change from the baseline to the follow-up. Safe motherhood enjoys strong political support and good programs; however, the organization for safe motherhood programs could be strengthened and resources remain insufficient. A nongovernment respondent noted, "There is strong support for safe pregnancy outcomes, but again shortage of staffing, and resources minimize the stated service norms."

The policy environment for *adolescents*, which received the lowest score overall in both surveys, is still considered to be improving. The *political support* and *policy formulation* are considered to be better in the follow-up survey than in the baseline. While the weakest components of policy environment for adolescents are considered to be the

programs and organization and structure, one government respondent noted, “Adolescent fertility has been recognized as a national problem, and other ministries such as Youth, Community Development and Education are included in policy dialogue. However, apart from donor support, a policy at the national level still needs to be formally disseminated.” Another government respondent remarked on the “role of donor agencies—UNFPA, USAID—in strengthening specific adolescent programmes (e.g., user-friendly clinics and more involvement of youth/adolescents in own decision-making).” Most respondents, however, indicated that adolescent reproductive health programs (services and information) need to be strengthened. Three donors are presently funding significant programs that address adolescents and youth, and all three in collaboration with the MOH. USAID is funding the Youth.now Adolescent Reproductive Health Project, UNFPA the VIP Youth Project, and UNICEF the Children and Youth at Risk Project. Given the priority that the government and donors accord to adolescent reproductive health, the policy environment for adolescent reproductive health should continue to improve in the coming years.

The most significant findings of this report are the perceived improvements in STD/AIDS, particularly viewed from the 1999 baseline and 2000 follow-up surveys. Gains in resources, program components, and evaluation and research contribute to this increase. A nongovernment respondent noted, “The HIV/AIDS programme is given high priority by government within the available resources—and involves many sectors of society.” When the baseline survey was conducted, a large donor-funded program (AIDSCAP, funded by USAID) had just finished and that reduction in funding could have affected respondents’ perceptions about the strength of the national AIDS program. In 2000, as the program enjoys high-level support in the government, a solid organizational structure in the MOH, and widespread public and community support and donor funding, perhaps respondents are more optimistic about the policy environment for combating HIV/AIDS. The policy environment still has room for improvement. One government respondent noted the “need to continue face-to-face education and to better coordinate funding to meet the overall goals of the national programme.” *The Gleaner*, one of Jamaica’s national newspapers, recently reported that the government plans to “mount a more vigorous public education and mobilization campaign to be spearheaded by public officials, including Government Ministers, aimed at stemming the spread of HIV/AIDS” (Gleaner, 2001).

Areas for improvement in each component include better coordination with other ministries, NGOs, and the private sector, for both policy dialogue and program implementation. Funding, particularly from the government, is considered inadequate, as is staffing for service delivery.

The government of Jamaica has a strong commitment to improve reproductive health. The MOH developed a *Strategic Framework for Reproductive Health within the Family Health Programme 2000–2005* (MOH, 2000). One purpose of the strategic framework is to bring the main components of reproductive health together into an integrated plan to guide strategies and activities to improve reproductive health. The

strategic framework, which lists adolescents as an important target group, includes a number of policy initiatives for family planning, safe motherhood, and STD/HIV/AIDS prevention and control. As these policy initiatives are carried out, it is likely that the policy environment for reproductive health in Jamaica will continue to improve.

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Appendix A. List of Participants

1. Dr. Alfred Brathwaite, STD Technical Adviser, Epidemiology Unit, Ministry of Health
2. Dr. Karen Lewis-Bell, Epidemiology Unit, Ministry of Health
3. Dr. Tina Hilton-Kong, Medical Officer for Health, Kingston & St. Andrew Public Health Department, Ministry of Health
4. Mrs. Eugenia McFarquahar, Health Consultant
5. Mrs. Beryl Chevannes, Health Consultant
6. Dr. Olivia McDonald, Medical Director, National Family Planning Board
7. Professor Hugh Wynter, Fertility Management Unit, University Hospital of the West Indies.
8. Mrs. Peggy Scott, Jamaican Family Planning Association
9. Dr. Richard Reid, Jamaican Family Planning Association
10. Rev. Webster Edwards, Director, Operation Friendship
11. Mrs. Ruth Jankee, Executive Director, Jamaica Foundation for Children
12. Mrs. Jennifer Knight-Johnson, USAID
13. Mr. Dervan Patrick, Health Specialist, UNFPA
14. Dr. Evon Nepaul, Senior Medical Officer – Westmoreland
15. Dr. Douglas McDonald, Senior Medical Officer, Victoria Jubilee Hospital
16. Mrs. Sheila Lutjens, USAID
17. Dr. Elizabeth Ward, Ministry of Health
18. Dr. Y. Gabre, Ministry of Health
19. Dr. Blesson Anglin-Brown, Ministry of Health
20. Pamela McNeil, The Women’s Centre of Jamaica Foundation
21. Dr. Sheila Campbell Forrester, Ministry of Health
22. Deloris Brissett, Ministry of Health
23. Sonita Abrahms, Ministry of Health

The following persons were also invited to participate but were unavailable, declined due to pressure of work, or alternatively, they passed their questionnaires to persons who were already in receipt of questionnaires:

1. Nurse Rose Scringer, MOH
2. G. Omphroy-Spencer, Victoria Jubilee Hospital
3. Dr. Peter Swaby, Hope Jamaica
4. Dr. Winston Dawes, President, MAJ
5. Dr. J. Fredericks
6. Mrs. Ellen Radlein, Director, Projects & Research, NFPB
7. Dr. Blossom Anglin Brown, University Health Centre
8. Dr. Carol Rattray, OBGYN, University Hospital
9. Dr. Wendall Guthrie, Grabham Society
10. Dr. Garth Alexander, SMO Spanish Town Hospital
11. Dr. Winston Dawes, President, MAJ
12. Dr. Barry Dixon, SMO Cornwall Regional Hospital

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13. Dr. Peter Weller, University Health Centre
 14. Mrs. Grace Allen-Young, MOH
 15. Dr. Faye Whitmore or Dr. Olive Williams

Appendix B. Policy Environment Score Questionnaire

Policy Environment Score: Family Planning

I. POLITICAL

(Scoring: 0=weak; 4 = strong)

SUPPORT **Status** **Status**
Now **1 Year**
 Ago

1. High-level national government support exists for effective policies and programmes.		
2. Public opinion supports effective policies and programmes.		
3. Media campaigns are permitted.		
4. Political parties support effective policies and programmes.		
5. The problem is recognized by top planning bureaus.		
6. Major religious organizations support effective policies and programmes.		

II. POLICY FORMULATION

1. A favorable national policy exists.		
2. Formal programme goals exist.		
3. Specific and realistic strategies to meet goals exist.		
4. A national coordinating body exists and functions effectively. (If none, enter zero.)		
5. Ministries other than Health are involved in policy formulation.		
6. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector and special interest groups.		

III. ORGANIZATIONAL STRUCTURE

1. A national coordinating body exists that engages various ministries to assist the service delivery programme. (If none, enter zero.)		
2. The service delivery programme has a high level placement in government.		
3. The director for service delivery is full-time and reports to an influential superior officer.		
4. Ministries other than Health are mandated to help with programme implementation.		
5. NGOs are formally included in policy deliberations.		
6. The private sector is formally included in policy deliberations.		

IV. LEGAL AND REGULATORY ENVIRONMENT

Status Now Status 1 Year Ago

1. Medical barriers do not exist for: (“4” means no barriers).

- a. Tubal ligation
- b. Vasectomy
- c. IUD
- d. Pill
- e. Injectable
- f. Condom
- g. Emergency Contraception
- h. Voluntary Termination of Pregnancy
- i. Other? Specify _____

2. Eligibility barriers do not exist for: (“4” means no barriers).
(Examples: age, parity, husband’s consent, etc.)

- a. Tubal ligation
- b. Vasectomy
- c. IUD
- d. Pill
- e. Injectable
- f. Condom
- g. Other? Specify _____

3. The legal age at marriage is satisfactory for:

- a. Females
- b. Males

4. A firm policy exists to enforce these ages for:

- a. Females
- b. Males

V. PROGRAMME RESOURCES

- 1. Funding from government sources is generally adequate.
- 2. Funding from donor sources is generally adequate.
- 3. Staffing for service provision is generally adequate.

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4. Enough service points exist for reasonable access by most clients.
 5. Resources are allocated by explicit priority guidelines.

VI. PROGRAMME COMPONENTS

Status Status
Now 1 Year
Ago

1. By formal policy, each of the following components is included in the programme:

- a. Use of mass media to inform and motivate
- b. Postpartum provision of family planning
- c. Contraception Social marketing (CSM)
- d. Home visiting workers
- e. Community-based distribution (CBD)

2. The private sector is deliberately encouraged through policies in which:

- a. Contraceptive advertising is permitted
- b. Import duties are minor or absent (attach amounts if available)
- c. Medical practitioners are free to provide contraception
- d. Price controls on contraceptives are minor or absent

VII. EVALUATION AND RESEARCH

1. A regular system of service statistics exists and functions adequately. (If none, enter zero.)
2. A system exists to monitor secondary data sources (surveys), censuses, local studies, etc.) for the benefit of policy guidance.
3. A system exists to bring evaluation and research results to management's attention.
4. Special studies are undertaken to address leading policy issues.

Comments:

Policy Environment Score: Safe Pregnancy

I. POLITICAL SUPPORT **Status Now** **Status 1 Year Ago**
 (Scoring: 0=weak; 4 = strong)

1. High-level national government support exists for effective policies and programmes.		
2. Public opinion supports effective policies and programmes.		
3. Media campaigns are permitted.		
4. Political parties support effective policies and programmes.		
5. The problem is recognized by top planning bureaus.		
6. Major religious organizations support effective policies and programmes.		

II. POLICY FORMULATION

1. A favorable national policy exists.		
2. Formal programme goals exist.		
3. Specific and realistic strategies to meet goals exist.		
4. Ministries other than Health are involved in policy formulation.		
5. NGOs are involved in policy formulation.		

III. ORGANIZATIONAL STRUCTURE

1. The service delivery programme has a high level placement in government.		
2. The director for service delivery is full-time and reports to an influential superior officer.		
3. Ministries other than Health are mandated to help with programme implementation.		
4. NGOs are formally included in policy deliberations.		
5. The private sector is formally included in policy deliberations.		

IV. LEGAL AND REGULATORY ENVIRONMENT

1. Providers are free from unnecessary legal and regulatory restrictions.		
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V. PROGRAMME RESOURCES

Status Now Status 1 Year Ago

1. Funding from government sources is generally adequate.
2. Funding from donor sources is generally adequate.
3. Staffing for service provision is generally adequate.
4. Enough service points exist for reasonable access by most clients.
5. Resources are allocated by explicit priority guidelines.

VI. PROGRAMME COMPONENTS

1. Safe pregnancy service norms are established to include prenatal care, nutrition advice, supervised delivery by qualified personnel, maternal tetanus toxoid and iron supplements, and detection and management of high-risk pregnancies.
2. A policy exists to identify high-risk pregnancies within local communities and to help those women reach a first-referral facility.
3. Traditional birth attendants are formally incorporated into a safe pregnancy referral system.

VII. EVALUATION AND RESEARCH

1. A regular system of service statistics exists and functions adequately. (If none, enter zero.)
2. A system exists to monitor secondary data sources (surveys, censuses, local studies, etc.)
3. A system exists to bring evaluation and research results to management's attention.
4. Special studies are undertaken to address leading policy issues.

Comments

Policy Environment Score: Adolescents

I. POLITICAL SUPPORT **Status Now** **Status 1 Year Ago**
 (Scoring: 0=weak; 4 = strong)

1. High-level national government support exists for effective policies and programmes.		
2. Public opinion supports effective policies and programmes.		
3. Media campaigns are permitted.		
4. Political parties support effective policies and programmes.		
5. The problem is recognized by top planning bureaus.		
6. Major religious organizations support effective policies and programmes.		

II. POLICY FORMULATION

1. A favorable national policy exists.		
2. Formal programme goals exist.		
3. Specific and realistic strategies to meet goals exist.		
4. Ministries other than Health are involved in policy formulation.		
5. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector and special interest groups.		
6. Government policy supports family life education and other IEC efforts for youth.		

III. ORGANIZATIONAL STRUCTURE

1. A national coordinating body exists that engages various ministries to assist with appropriate services. (If none, enter zero.)		
2. Ministries other than Health are mandated to help with programme implementation.		
3. NGOs are formally included in policy deliberations.		
4. The private sector is formally included in policy deliberations.		

IV. LEGAL AND REGULATORY ENVIRONMENT

1. There is a favorable legal and regulatory climate for ensuring that unmarried adolescents may receive services for family planning.		
2. Pregnant adolescents are allowed to continue with their education.		
3. Providers are free from unnecessary legal and regulatory restrictions (i.e., services available to adults are available to adolescents as well).		

V. PROGRAMME RESOURCES

Status Now Status 1 Year Ago

1. Funding from government sources is generally adequate.
2. Funding from donor sources is generally adequate.
3. Staffing for service provision is generally adequate.
4. Enough service points and providers exist for reasonable access by most clients.
5. Resources are allocated by explicit priority guidelines.

VI. PROGRAMME COMPONENTS

1. Contraceptives are provided for single adolescents in the usual service delivery points, as well as in schools, youth centers and other places where youth are found.
2. Counselling services in family planning for single adolescents are offered not only in the usual service delivery points, but also elsewhere, such as in schools, youth centers, or other places where youth are found.
3. STD/AIDS information is an integral part of educational efforts.
4. Condoms are easily available to youth through channels that youth have access to, e.g. pharmacies, clinics, vendors.
5. Postabortion counseling is an integral part of the youth programme.
6. Health staff are trained to counsel youth in sexuality and reproductive health matters.
7. Peer counselling is an active component of the youth programme.
8. Community-based distribution (CBD) systems exist and employ youth (male and female) distributors. (If no CBD system exists, enter zero.)

ents : _____

VII. EVALUATION AND RESEARCH

1. A regular system of service statistics exists and functions adequately.
2. A system exists to monitor secondary data sources (surveys, censuses, local studies, etc.) for the benefit of policy guidance.
3. A system exists to bring evaluation and research results to management's attention.
4. Special studies are undertaken to address leading policy issues.

Comments: _____

Policy Environment Score: STDS/AIDS

I. POLITICAL SUPPORT

(Scoring: 0=weak; 4 = strong)

**Status
Now** **Status
1 Year
Ago**

1. High level national government support exists for effective policies and programmes.
2. Public opinion supports effective policies and programmes.
3. Media campaigns are permitted.
4. The main political parties support effective policies and programmes.
5. Top planning bureaucrats recognize AIDS as a priority problem.
6. Major religious organizations support effective policies and programmes.

II. POLICY FORMULATION

1. A favorable national policy exists.
2. Formal programme goals exist.
3. Specific and realistic strategies to meet programme goals exist.
4. A national coordinating body exists and functions effectively. (If none, enter zero.)
5. Ministries other than Health are involved in policy formulation.
6. Policy dialogue and formulation involves NGOs, community leaders, and representatives of the private sector and special interest groups.

III. ORGANIZATIONAL STRUCTURE

1. The AIDS Control Programme is placed high in the government structure.
2. The ACP Director is full-time and reports to an influential superior officer.
3. Ministries other than Health are involved in programme implementation.
4. NGOs are formally included in the AIDS Control Programme.
5. The private sector is formally included in the AIDS Control Programme.

IV. LEGAL AND REGULATORY ENVIRONMENT

1. Condom advertising is allowed.
2. Anti-discrimination regulations exist.
3. There are no mandatory testing requirements.
4. Confidentiality of test results is guaranteed.

IV. LEGAL AND REGULATORY ENVIRONMENT

(continued)

(Scoring: 0=weak; 4 = strong)

Status Now Status 1 Year Ago

5. Regulations on the importation of condoms are minimal.
6. Regulations on the importation of STD drugs are minimal.
7. There are no restrictions on condom distribution.
8. There are no unethical AIDS laws (quarantine, incarceration, discrimination).
9. There is no officially condoned harassment of high risk groups (CSW, MSM, IVDU).
10. There are no restrictions on who may receive STD services.
11. Regulations on screening of blood and blood components for transfusion exist and are enforced. (If none, enter zero.)

V. PROGRAMME RESOURCES

1. Funding from government sources is generally adequate.
2. Funding from donor sources is generally adequate.
3. Staffing for service provision is generally adequate.
4. Resources are allocated according to priority guidelines.

VI. PROGRAMME COMPONENTS

1. Blood screening is universal.
2. Guidelines for medical precautions exist.
3. There is an active programme component to promote accurate reporting by the media.
4. There is a functioning logistics system for STD drugs.
5. There is a social marketing programme for condoms.
6. There is a social marketing programme for STD drugs.
7. There are national treatment guidelines for STDs.
8. There are special prevention programmes for high-risk groups.
9. There is a programme to make confidential testing available on demand.
10. Family life education for youth is included in the programme.

VII. EVALUATION AND RESEARCH

-
1. A regular system of service statistics exists and functions adequately.
 2. A system exists to monitor secondary data sources (surveys, censuses, local studies, etc.) for the benefit of policy guidance.
 3. A system exists to bring evaluation and research results to management's attention.
 4. Special studies are undertaken to address leading policy issues.

Comments: