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Editorial

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Policy analysis—important for improving iCCM implementation; essential for success of global health efforts

In the introductory paper of this supplement on policy analyses of integrated community case management of childhood illness (iCCM), we argue that 'the continued neglect of policy analysis in policy design, implementation and evaluation contributes to inappropriate decisions, ineffective programmes and inequitable consequences hindering our ability to reach widely endorsed global health goals' (George *et al*. 2015). The manuscripts contained in this issue provide important insights not only into how iCCM programmes can be better designed and implemented but also on how national and global health actors can take local context and policy considerations into greater account to improve the chance of their efforts being successful, regardless of the intervention.

Along with our co-funders, UNICEF's primary interest in supporting this work was to identify (in a few key countries) factors that have hindered or supported policy and programme development regarding iCCM, including identifying facilitators or barriers to policy and programme change, the relative roles of different actors, the role of evidence in policy development and the specific expressions of policy that support and inhibit iCCM implementation, including which elements of the overall policy are critical to implementation success. iCCM has been widely recognized as a key strategy to improve coverage of essential child health interventions, and in sub-Saharan Africa, most countries now have some written policy to enable iCCM services to be delivered (Rasanathan *et al*. 2014a). However, this success has been mixed and much remains to be done to realize the potential of iCCM, particularly in scaling up services within countries and increasing utilization (Young *et al*. 2014).

A key finding of this work is the extent to which iCCM policy development and implementation has been influenced by the existing context of health systems in each country, and the history of primary health care and the role of community health workers. iCCM, while supported by the existence of joint statements and normative guidelines, is not enacted in a vacuum. Its implementation is affected by the nature of existing health worker cadres, and how iCCM services are delivered is negotiated in terms of the domains and services these cadres already provide. Unintended consequences are commonly seen from this interaction and need to be addressed. The status of community health workers in existing systems and their integration- or not- into national health systems are key determinants of the acceptability and success of iCCM within countries, as seen by the factors favouring early adoption in Malawi (Rodriguez *et al*. 2015a) and the continuing challenges to implementation in Kenya (Juma *et al*. 2015).

Beyond the context for policy, the manuscripts collected in this supplement also shed light on the dynamic processes and actors that determine the uptake—or not—of health policy. While the role of available financing, which is foregrounded in all the case studies, is a well-recognized influence on policy uptake, the role of policy entrepreneurs (Shearer, 2015) and epistemic communities (Dalglish *et al*. 2015a) and the importance of power analyses (Dalglish *et al*. 2015b) are often omitted in policy development and implementation plans for health programmes and interventions. In global health, the importance of evidence is often emphasized but here too the case studies demonstrate how evidence is brokered by international agencies and national champions, and specific evidence to justify interventions is also filtered through policy entrepreneurs and epistemic communities (Rodriguez *et al*. 2015b). The function and flow of power is a paramount, and woefully under-considered, determinant of policy and implementation success. It is no coincidence that many of the countries with the greatest progress and impact of iCCM have seen its championing by charismatic and powerful political executive leaders, beyond the sphere of senior technical advisers in Ministries of Health (Rasanathan *et al*. 2014b).

As we leave the Millennium Development Goal era and the influence, also described in these papers, of its goals and targets, and move to the challenge of the broader and more ambitious targets of the Sustainable Development Goal agenda, there are many lessons from the body of knowledge collected in this supplement. For those of us in global agencies, there is further stimulus to prioritize policy and power analysis, in addition to greater focus on context, in supporting and advocating for key interventions for child health. And also to consider how we broker evidence, and balance the demands of our mandated roles, which sometimes have the potential to conflict (Bennett *et al*. 2015).

But for all of us committed to ending preventable child deaths in this generation, or involved in public health generally, whether at community, district, provincial, national or global levels, these papers should provoke deep reflection on our policy and implementation efforts. Too many interventions and programmes in global health ignore the policy and political context, often in favour of technocratic science which essentializes 'gold-standard' experimental evidence and generalizable findings. While such evidence is important and useful, we also need to be less afraid of embracing diversity, power, politics and specificity. Policy analysis is one key prong to address this gap, along with political economy analyses and implementation research—which need greater support from

global health actors and from national decision makers and domestic resources alike.

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