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How to study the implementation of health policy interventions with integrative frameworks?

Valéry Ridde, Manuela De Allegri, Marie-Brigitte Dukuze, Julia Lohmann, Joy Mauti, Zoé Richard, Emilie Robert, Tony Zitti, Lara Gautier

Abstract

Given the biomedical and epidemiological history of health research, it is still too often the question of effectiveness and efficiency that attracts evaluational attention. Yet, what is the point of explaining the achievement of health policy objectives if we need to account for how this was achieved? The study of health policy implementation is, therefore, essential. But there are many ways to study the implementation of health policy. Thus, in this chapter, we have brought together several (single and multiple) case studies from around the world (Burkina Faso, Kenya, France, Mali, Senegal) to show how it is often relevant to use integrative analytical frameworks from rigorous conceptual *bricolage* to study the implementation. Students of health policy will thus find a source of inspiration from several lessons learned from international contexts rarely highlighted in the scientific literature.

Keywords: implementation, process, framework, integration, bricolage, Africa

Introduction

While the effectiveness of health interventions has monopolized scientific attention for decades, the state of knowledge on the analysis of their implementation is beginning to develop and catch up, even if it's very unevenly, across the world. Implementation can be defined simply as the process of organizing activities within a setting or organization, with some suggesting that the choice of these actions be based on evidence or sound theory (Damschroder et al., 2009), thus "*getting science into practice and policy*" (Fixsen et al., 2011).

In this chapter, we will not revisit the history of the study of policy implementation, which essentially shows that the field is still under construction. There is a large body of literature on this subject since and well before the famous book *Implementation* by Pressman and Wildavsky (1984), which has significantly influenced the field. In addition, Saetren's reviews (2005; 2014) and Hill, M., & Hupe, P. (2021) book are very informative about the historical development of policy implementation research.

First, Saetren confirms the expansion of this field, especially outside the writings of its original discipline, political science. From 1933 to 2003, the health sector ranked second (15%), after education (38%), in the number of studies on implementation, with nearly 1100 articles, book chapters, or doctoral dissertations. However, many of these studies were conducted in the United States or Canada (69%) and only 4% in Africa (Saetren, 2005). This chapter will show how research conducted outside of the North American continent and the Western context can be

inspiring for health researchers interested in policy implementation. We wish to move away from what Saetren (2005) calls the “*ethnocentric bias in implementation studies*”.

Second, while the concept of implementation seems relatively well established, Saetren’s reviews confirm that “*we are not even close to a well-developed theory of policy implementation*” (Saetren, 2005, p.573). This highlights the importance of theoretical development, or even theoretical tinkering, to speak in the words of Denzin and Lincon (2018). For example, a review of health policy analyses in Africa from 2000 and 2017 (Jones et al., 2021) shows that a third of the articles took a theoretical bricolage approach, i.e., a heuristic mix of different theories and concepts, to better understand policy implementation. This form of hybridization is not without dangers and challenges. Thus, “*the theoretical basis for implementation is relatively new and needs to be tested and operationalized in real-world settings*” (Franks, Bob & Schroeder, Jennifer, 2013 p. 12). According to Winter (2011), despite much work, we are in a situation of “*too little theory accumulation. Implementation is too complex to be accounted for by one theory.*”

Another vital lesson from Saetren's reviews is that he suggests the existence of three generations of implementation analysis. The first generation, in the 1970s, used single-intervention focused approaches, rather qualitative and exploratory methods without any specific theoretical approach. For instance, Hogwood and Gunn (1984) established a list of eight a-theoretical “prerequisites for perfect implementation”. The second generation, in the 1980s, borrowed more conceptual frameworks and theories, and the studies became more empirical with more use of statistical techniques of analysis (Saetren, 2005). According to Saetren (2014), the third generation would be about rigorous research designs, using multiple, clearly defined variables, a willingness to test hypotheses from theoretical propositions using mixed method research, and in a more comparative and longitudinal perspective, from five to 10 years.

Most importantly, Saetren shows a gradual shift amongst scholars from the classic dichotomy between top-down and bottom-up analytical and theoretical frameworks towards “integrative and synthesizing” frameworks as a key feature of third-generation policy implementation research. Here, we briefly review the core components of the debate.

Several policy analysts considered those above “perfect implementation” model as being a top-down, prescriptive and normative model (Palfrey C, 1999). For example, in England, a study in the 2000s based on Gunn's perfect implementation proposals highlighted the challenges associated with implementing top-down guidance in health sector policies (Checkland, K & Harrison S., 2004). In reaction, some suggested ‘bottom-up’ models – Lipsky’s “street-level bureaucrats” being the most well-known of these models looking into the (potential) influence of lower-level actors in the implementation process, e.g., teachers, nurses, and social workers (Lipsky, 1980). For example, in France, a study carried out in the 2000s using the street-level bureaucrat's approach showed how the consideration given by welfare officers to their beneficiaries partly reflects the way in which poverty is understood and considered by the welfare state (Dubois, 2005). The ‘bottom-up’ model thus enables to investigate of the consultation or negotiation process that takes place between those who design policies

(situated at the top) and those who implement them. This proposal is coherent with Pawson (2013), who argued that implementation success will come if social actors, through their reasoning and subsequent actions, decide to support it. In other words, what has been planned before the implementation stage does not necessarily come to fruition on the ground when the new policy encounters key actors and contexts.

Yet, going beyond the classic stakeholder analysis, which is too often the only tool used by certain researchers to analyze the implementation of policies from the perspective of street-level bureaucrats. We are thinking particularly of the cognitive analysis of public policies and the role of ideas or even the ideologies of actors. Their influence is not limited to the emergence but the implementation of policies. This ideological influence has been shown, for example, for the suppression of the policy instrument of direct payment for care and payment by performance in Africa (Béland & Ridde, 2016; Gautier et al., 2018). Since Lipsky's (2010) proposals on the role of street-level bureaucrats and their ideas, it seems that they have rarely been applied to the analysis of the implementation of policy interventions aimed at reducing social inequalities in health. Yet, equity is a central value in our societies, and it deserves attention in the study of health and public policies, especially in low-income countries (Ostlin et al., 2011). Some neoliberal ideas, for example, lead to the sidelining of the need for more equity and social justice when implementing health policies in Africa (Ridde et al., 2018).

As it turned out, neither the top-down model nor the bottom-up model, captured “the full complexity of the implementation process” (Palfrey, 1999, p. 49, citing Elmore, 1978). Studying the factors influencing policy implementation is indeed a worthy, yet complex endeavor (de Leeuw et al., 2014; Durlak & DuPre, 2008, Franks, B., & Schroeder, J. 2013). We can rather speak of two sides of the implementation coin: challenges in the field (*implementation failure*), and challenges in designing the implementation (*intervention failure*). What Saetren and Winter call “integrative and synthesising” frameworks are relevant illustrations of that metaphor: they would simultaneously address the two sides of the implementation coin (Winter, 2012). Matland’s framework (1995) provides a useful analytical lens, but it predominantly features Western-centered characteristics (e.g., public administration culture, democratic institutions, sovereign citizenry, rule of law culture, etc.). Since we adopt a global outlook to policy implementation, it would be challenging to apply Matland’s framework – all the more so in the context of power issues involved in official development assistance funding. Such power dynamics largely influence the formulation and implementation of health policies (Gautier & Ridde, 2017). Similarly, in Pulzi and Treib’s (2006) analysis of theories for the study of policy implementation, what they call “hybrid approaches” also reflect the interface between the top-down and bottom-up approaches. They can thus also be called integrative or comprehensive to follow Hill & Hupe (2021). All cases reviewed in this chapter provide concrete illustrations of applying diverse integrative theoretical and conceptual frameworks globally.

Integrative frameworks may involve a *bricolage*, i.e., “do-it-yourself” strategy in which existing theories and conceptual frameworks are combined. Qualitativist authors describe *bricolage* as combining various elements (interpretations, theories, concepts, tools) to tackle the complexity associated with social phenomena (Denzin & Lincoln, 2011). To Jones et al (2021, p. 1208),

“multiple theories used together provide an overarching frame with more explanatory power for the policy processes in a given context”. The conclusion of a recent book promoted the bricolage approach, calling for a need to move “beyond the tendency towards theoretical monomania”, notably through acknowledging the added value of “flexible” identification and combinations of theoretical models of the policy process (de Leeuw, Cassola & Fafard, 2022, p. 332). In fact, the *bricolage* strategy aligns well with what Winter (2012, p. 265) suggested ten years ago, i.e., that policy implementation research should be “accepting theoretical diversity rather than looking for one common theoretical framework”. Indeed “the theoretical base for implementation is relatively new and needs to be tested and operationalized in real-world settings” (Franks & Schroeder, 2013, p. 12). Some of the cases reviewed in the present chapter indeed feature the bricolage approach (e.g., case 2).

Saetren’s 2014 review provides a last important constitutive argument for our chapter on third-generation policy implementation – his calls for doing more single and multiple case study research. First, Saetren acknowledged the value of *critical* single case studies for demonstrating the relevance of specific theories or conceptual frameworks. Single case studies also allow for in-depth investigations of complex social policies that can be useful to policy-makers. Second, Saetren encouraged the use of multiple case studies, which allow for comparisons across cases. Saetren (2014, p. 92) argues that “the comparative research design is an important defining feature of the third-generation research paradigm” in policy implementation. Building from Saetren’s research method reflections, the cases reviewed in the present chapter reflect single and multiple issues.

The selected cases

In this chapter, we reviewed empirical studies that reflected the defining features of third-generation policy implementation research according to Saetren, and from the global health perspective. Cases were thus selected based on the following criteria: a) to represent the global geographical diversity and contexts where health policy implementation studies remain rare (i.e., Francophone countries and West African countries), b) to feature original research applying a diversity of integrative frameworks, and c) to reflect diverse case study methods.

A global health reflective approach

We wish to position our reflection on a global scale by proposing empirical examples of health policy implementation from several countries on different continents, in a global health perspective transcending national borders. We are thus part of the contemporary call for more reflexivity on the methods used to analyse implementation (Tremblay & Parent, 2014). In this chapter, the authors reflected *a posteriori* on their mobilisation of specific theories and frameworks. Our goal is twofold: i) to provide the readership with empirical examples of how integrative theoretical and conceptual frameworks have been mobilized empirically, and ii) to share lessons about the challenges of using them.

Diverse integrative frameworks

Implementation studies still need to be made available in Africa. This chapter is an opportunity to show how the mobilization of three integrative conceptual frameworks for analysing policy

implementation that are widely used in (and coming from) North America have been applied to the study of health policy implementation in Mali and Senegal. The Quality Implementation Framework (QIF), with its 14 steps grouped into four phases based on a synthesis of 25 analytical frameworks, has yet to be applied in Africa (Eboreime et al., 2019; Meyers et al., 2012) (see Case 1). The first and second phases, i.e., ‘initial considerations regarding the host setting’ and ‘structural features for implementation’ reflect both bottom-up and top-down policy implementation issues. Similarly, the Consolidated Framework for Implementation Research (CFIR), a “meta-theoretical framework” for policy implementation studies and its 39 constructs organised around five domains (Damschroder et al., 2009), is in widespread use now (see Case 5). Four domains, i.e., intervention characteristics, inner setting, outer setting, and characteristics of individuals, provide useful assessment criteria for analyzing not only policy implementation but also policy design. Third, one of our cases (Case 6) featured an application in Mali of Durlak and Dupré's (2008) “ecological framework for successful implementation” of 23 factors that influence policy implementation. While this approach focuses on a list of factors to be considered, it is based on an interdisciplinary synthesis of nearly 600 empirical studies of implementation, both quantitative and qualitative. The ecological framework for understanding the effectiveness of intervention implementation is based on five main areas of influence that cover both bottom-up and top-down processes: innovations, providers, communities, delivery system and the support system (see also case 6). This chapter featured the issue of policy coherence from the perspectives of both policy designers and policy implementers through the analytical lens of OECD's *Policy Coherence for Sustainable Development Framework* (see Case 3).

Finally, without entering the old critical analyses of *stagists*, we thought it was important to show how it is sometimes necessary to go beyond studies of implementation that do not sufficiently consider the “big picture” including the inherent complexity and the effectiveness of policy interventions. A systemic and complex approach to health policy deserves particular attention here. Two reasonably new approaches should be highlighted. First is the realist approach (see Case 7), which stresses the central role of various theories in the implementation analysis, but also that of social actors and the concept of mechanism in explaining the functioning of policy interventions (Pawson, 2013; Ridde, 2016). Second, the theoretical proposals of process tracing (Beach & Pedersen, 2019) aim to understand better the impacts (or lack thereof) of policy intervention. This can be done by uncovering how the policy intervention was organized based on hypotheses of the causal mechanism to be tested. The process tracing approach has not been widely applied in Africa. The example of Burkina Faso (Case 4) showed its heuristic power but also its challenges.

Single- and multiple-case study research designs

Our last criterion was to review cases adopting either a single-case or a multiple-case study research design. Multiple cases reflected either various policies, or implementation in numerous geographical locations.

Thus, each of the seven case studies presented allow us to understand the context and objective of the study, the choice of the integrative approach/framework (and its key components), the research strategy used, the main results, and above all, the lessons learnt process we offer. Because methodological issues are central to the competencies of policy

implementation researchers (Schultes et al., 2021), the focus will be on showing what worked well methodologically, how it could have been done differently and, finally, critical lessons learned that may help improve policy implementation analysis.

1. Single case studies in health policy implementation

Case 1: Using the Quality Implementation Framework (QIF) to analyze the implementation of the national response to SARS-CoV-2 in Senegal

Study setting: Senegal had experience in fighting infectious diseases. As such, the country was early to respond to the COVID-19 pandemic, well before the first case appeared on March 2, 2020. Technical committees planned the national response, and state measures were quickly taken. However, these were soon suspended after widespread protests in the context of an outbreak that remained low in lethality. The government launched an economic and social resilience plan with a projected budget of 1,000 billion CFA francs, financed mainly by international aid.

Study objective: A mixed-methods study was conducted in March and April 2021 with a qualitative component aimed at understanding the national response's design and implementation.

Integrative framework : Quality Implementation Framework (QIF) and factors that support or constrain implementation to determine quality lessons learned (Patton, 2001). The 4 areas of QIF (initial consideration, creating the structure of implementation, implementation support, improving future application) allow an integrative view of public policy processes without focusing solely on implementation and street-level workers agency. QIF also provides for the study of design, decision and capacity-building elements. Moreover, while QIF is originally an integrative framework, the reflection on step 14 concerning lessons learned to improve future implementation should be combined with Patton's conceptual and pragmatic proposals for further clarification (2001).

Research strategy: The implementation study used a case study strategy in eight of the country's 14 regions, including the capital (for design and implementation). The analysis was based on the QIF framework. Data was collected by researchers in Dakar and research assistants in the regions after training and with daily follow-up. A total of 189 interviews were conducted with key stakeholders at the national, regional and local level (decision-makers and implementors).

Summary of results: The implementation of the response was facilitated by good preparation, the ability to adapt, the responsiveness of stakeholders, and the commitment of political and religious authorities. It was confronted with a coercive approach, challenges in the coordination of actors, and the absence of an intersectoral response. The response remained highly politicised, centralized, directive, and limited civil society involvement.

What worked well: It was essential to adapt the design of the original 14 generic steps of the QIF to the context of the study in Senegal. The complementarity and sequencing of the dimensions used were fruitful. Prior reflections on the dimensions of implementation quality, enabling and constraining factors allowed the interviewees to reflect on the lessons learned.

These lessons were also discussed and validated during a national workshop with key officials at the central level.

What we would do differently: Conduct a national survey with a limited budget and during an ongoing pandemic, researchers could not cover every region in-person. The use of research assistants at different levels (national, regional and local) may have reduced the ability to have in-depth data on some dimensions. It may have led to differences in interpretation between the assistants. The QIF and Patton's lessons-learned approach remain very pragmatic and helpful for managers, but the results remain relatively limited in theoretical and conceptual scope. The discussion of our analysis allowed for some ex-post generalization about the role of ideas, actors, and policy instruments to go beyond this overly pragmatic but the useful vision for national leaders.

Lessons learned for analyzing the policy implementation

- The QIF, based on the synthesis of 25 frameworks, is sufficiently broad and generic to address all the elements useful for the analysis of implementation in different types of contexts and by considering the interrelationships (not the steps) between design and implementation.
- QIF is simple and didactic enough to be used in a collaborative research approach with field research assistants who may need to gain interdisciplinary training and experience in using integrative frameworks.
- Challenges associated with testing and adapting questions from the QIF to the specific context of the study and to avoid a dichotomous analysis between a top-down vs bottom-up approach
- Combining the QIF with more theoretical approaches ex-ante or ex-post analysis would provide interesting avenues for future implementation science research.

Case 2: Applying a bricolage framework to explore whether and how the French COVID-19 center considered social inequalities in health when implementing testing and vaccination

Study setting: In France, Seine-Saint-Denis' district bore the burden of social inequalities in health (SIH) during the COVID-19 pandemic, particularly affected by the health crisis and its impacts. Several testing and vaccination centers were set up within the territory's healthcare facilities to reduce SIH in response to the pandemic. The aim was to promote the accessibility, availability, and acceptability of these interventions for the population. Our research was conducted in one of these centers, located within a public hospital.

Study objective: The study aimed to analyze the center's implementation of testing and vaccination, focusing on considering SIH in this process.

Integrative framework : Initially, the Reflex-ISS tool - a health promotion tool designed to encourage the consideration of SIH at each stage of intersectoral and public health interventions (planning, implementation, evaluation, empowerment, sustainability) - was identified as the conceptual framework to guide data collection and analysis. Since the Reflex-ISS tool covered each stage of public health interventions, it allowed us to focus on the implementation and design-related challenges faced by the actors regarding SIH consideration. As per a methodological bricolage, the use of Reflex-ISS was progressively combined with a

more ethnographic method of inquiry. This approach enabled us to investigate in depth both the top-down and bottom-up processes in the center, and to emphasise the center's workers experience with SIH consideration.

Research strategy: The result of this bricolage is a survey combining a deductive approach to the consideration of SIH with an inductive approach to produce a monograph of the center, studying the implementation processes, the work of the agents, their socio-professional trajectory, and their relationship to the function they perform.

Summary of findings: Consideration for SIH is a complex subject to grasp in the implementation of testing and vaccination interventions. This object is constantly (re)negotiated within different spaces. These discussions are led by the center's agents, frontline public service actors, who determine some of how SIH are considered. Most of the young professionals in the center's team have little professional experience in the health field and occupy a marginalized position in the hospital and social hierarchy. They are facing structural and situational inequalities influencing their understanding of SIH. Moreover, they are confronted with multiple administrative and organizational complexities that hinder specific approaches to reducing SIH. The latter sometimes leads to surprising results, such as the confiscation of many vaccination slots by wealthy and non-local populations at the center, at the beginning of the vaccination campaign.

What worked well: The survey allowed us to understand the drivers and determinants of the center's agents' views and consideration of SIH. The implementation of an ethnographic research method detached from the Reflex-ISS framework resulted in the emergence of results anchored in a complex context (societal, hospital, individual), favored by the relationship of trust gradually established between the respondents and the researcher. The observations carried out in different spaces allowed for an in-depth and finely contextualized understanding of these phenomena around the ideas and conceptions of SIH by the actors. This allowed for an increase in the epistemic scope of the investigation by bypassing a form of an invitation to description induced by Reflex-ISS as an investigative tool, which appears ill-suited to a space such as the center. The analyses of this investigation were shared and validated by diverse hospital actors. The links established during this research led to new collaborations.

What we would do differently: Over the course of the research, we experienced some challenges in applying the Reflex-ISS tool on the field, which resulted in a shift in the study from deductive to inductive, accompanied by the gradual abandonment of Reflex-ISS as a data collection tool. These challenges could have been anticipated, as the Reflex-ISS tool appeared difficult to mobilize in a context as singular as the centre's. Specifically, the structuring of the bricolage model along the Reflex-ISS dimensions did not resonate with the study participants' experience on the field. In practice, this issue led to a negative perspective upon analysis of the collected data. It would have been advisable, instead, to favor a predominantly ethnographic approach from the very beginning of the survey, thus avoiding the progressive methodological shift, which was source of questioning for the respondents. The latter, who had been presented with the survey as dealing with the consideration of SIH in response to COVID-19, questioned the purpose of the researcher's prolonged presence at the center, and long-term observation of implementation processes, particularly in spaces where the topic of SIH was not explicitly addressed. If the research requires addressing specific elements, the experience of this survey suggests that a reverse methodological shift - from the ethnographic approach to the deductive

approach, or the less specific to the more specific - would be more comfortable for the respondents and the researchers. It would allow time for each party to understand the other outside of any conceptual framework. At the same time, a relationship of mutual trust is established, before explicitly tackling the more specific elements of interest for the researcher (which are not necessarily those on which the respondents wish to dwell).

Lessons learned for analyzing policy implementation.

- The use of the Reflex-ISS integrative framework allowed investigators to explore the different dimensions of the intervention implementation. This approach appeared highly relevant in the health crisis context in which all stages of the intervention were blurred, actors multiplied, and traditional implementation processes disrupted.
- A better anticipation of the challenges of interdisciplinary research practice and integrative framework (i.e.: theoretical bricolage, in our specific case) could have smoothed the empirical research work. This could be achieved by intensifying a dialogue between researchers from different disciplines to stabilize consensual methodological choices before launching the survey.

Case 3: Using the Policy Coherence for Sustainable Development Framework to analyze the implementation of the Health in All Policies approach in Kenya

Study setting. Kenya is one of the few Sub-Saharan African countries adopting Health in All Policies (HiAP). Kenya's sixth policy objective in the national Health Policy for 2014-2030 aims to "strengthen collaboration with private and other sectors that have an impact on health" and explicitly addresses various social determinants of health through HiAP.

Study objective. This single, qualitative case study aimed to assess how the HiAP approach was implemented alongside the Sustainable Development Goals (SDGs) agenda.

Integrative framework : To reflect the complexity associated with HiAP policy implementation in a low and middle income country such as Kenya, we chose the Organisation for Economic Co-operation and Development (OECD)'s Policy Coherence for Sustainable Development (PCSD) Framework (OECD, 2016, 2018). The PCSD framework was initiated as the agenda of the SDGs was gaining momentum. It provided a roadmap for ensuring the congruence of national policies with the SDG agenda. The framework features five components: (a) political commitment, (b) inclusion (stakeholders' engagement, involvement of all juridical levels including subnational and local levels), (c) policy coherence (coordination, integration, and effects), (d) long-term planning, and (e) monitoring and reporting. These key components emphasize intersectoral collaboration, multistakeholder engagement (i.e., from designers, funders, to implementers), and accountability, i.e., core 'success factors' of successful health policy implementation.

Research strategy. We conducted an exploratory single case study. Individual interviews were conducted using a purposeful sampling approach with 24 key informants, including government, development partners, NGO employees, and independent consultants. The PCSD framework guided the policy implementation analysis.

Summary of findings. HiAP and SDGs implementation coherence primarily relied on policy coordination and mapping of stakeholders' engagement, as they allowed to strengthen both horizontal and vertical coordination. The study also highlighted the need for more appropriate coordination mechanisms to allow ministries and other key stakeholders at lower levels (e.g.,

street-level bureaucrats in public sector agencies) to share information, define and distribute responsibilities, allocate resources, and monitor progress more efficiently. Relying on existing local structures could prove a critical leverage for overseeing the implementation of both SDG and HiAP policies (e.g., through county-level oversight bodies).

What worked well: This work was one of the first of its kind to apply the OECD framework for scientific research (Mauti et al., 2020). The integrative framework approach enabled to reflect of complex policy implementation processes involving actors at the various levels, particularly through the dimensions of inclusion (stakeholders' engagement at all juridical levels) and policy coherence (coordination, integration, and effects).

What would we do differently: Two of the framework's components (i.e., subnational, and local involvement; policy coordination) highlighted the importance of assigning responsibilities at all juridical levels. Our analyses could not feature the county level as time and resource constraints prevented us from interviewing informants at the county level.

Lessons learned for analyzing policy implementation

- The PCSD framework offers a flexible, user-friendly guide for documenting policy implementation in diverse governance contexts, reflecting both the perspective of policy designers and policy implementers at subnational and local levels.
- The PCSD Framework principles proved useful to assess the implementation of HiAP from the perspectives of both policy-makers (i.e., those who designed the HiAP policy) and implementers (i.e., those who participated in policy implementation) through the lens of policy coherence analysis. Specifically, the framework enabled us to focus on coordination mechanisms in implementing the HiAP approach, which led us to examine the linkages between decisions and actions across different governance levels, from international to national and local levels (i.e., 'vertical coherence').
- In addition, the framework featured sustainability as a guiding principle in two ways. First, long-term sustainability lies at the framework's core in the 'long term planning horizons component. HiAP implementation was portrayed as benefiting from the long-term planning horizons of the SDGs, which were able to move past the quick turnover of political cycles effectively. Second, the PCSD framework's specificity lies in its integrated evaluative component 'monitoring and reporting' (i.e., to systematically track progress as the implementation progresses). Informing this component is often a blind spot of implementation frameworks.

Case 4: Using process tracing to explain why performance-based financing in Burkina Faso failed to achieve the intended equity effects

Study setting. Performance-based Financing (PBF) has been extensively tested as a way of reforming provider payment to improve access to and quality of care in low- and middle-income countries over the past 20 years. Addressing criticism that PBF might benefit the best-offs and damage the worst-offs, PBF has also been tested in conjunction with demand-side interventions to enhance access to healthcare among the ultra-poor. One of these pilot interventions took place in Burkina Faso between 2014 and 2018. An impact evaluation showed that the specific equity measures did not produce the intended effects.

Study objective. We used a process tracing approach to understand the reasons for the lack of impact produced by the equity measures.

Integrative approach: At the time we conducted the study, a wealth of knowledge on the intervention and its impacts had already been generated. What was lacking, however, was an understanding of how the logic of the intervention design was aligned with local needs, expectations, and capabilities and, therefore capable of producing the intended change through the implementation of specific actions. *Process tracing* was instrumental in this regard because it allows mapping implementation realities against the underlying design construct. The wealth of data and evidence already available on the intervention enabled us to adopt process tracing. Had we not had access to such a wealth of data ex-ante, the method might have been out of reach, albeit perfect to confront design intentions with implementation realities, given that mapping the details of the mechanism chain is inevitably very data-demanding.

Research strategy. Process tracing is a qualitative method originating in political science. Process tracing aims to establish confidence in how and why something occurred through formulating and testing detailed hypotheses to specify the assumed causal mechanisms of an intervention in a single-case, uncontrolled design. The development of a clear understanding of implementation context, successes, and failures is an inherent component of the method. We reconstructed the theory of change of the equity measures through implementation documents, stakeholder feedback, and our own knowledge of the intervention and its context. We then supported or invalidated the reconstructed theory of change elements with published evidence, secondary data, and a qualitative study. While process tracing is usually employed to understand how and why an intervention produced an effect, we instead employed the method to understand the known lack of impact by investigating where and how the theory of change failed to play out as planned.

Summary of findings. Our study revealed that the logic of the intervention was not always aligned with its implementation's needs, expectations, and capabilities. This allowed only limited change to take place insofar as the equity measures embedded within the PBF program were concerned. We could look at how incentive payments intended to motivate providers to privilege care for the ultra-poor failed to do so, not because the logic underpinning the mechanism of action was, *per se* faulty, but because payment levels did not meet needs and expectations of healthcare providers to cover basic healthcare costs. Similarly, the rationale of targeting the ultra-poor and enabling prompt identification in the healthcare system was not *per se* faulty at the design stage. Still, the actual process of targeting and distributing cards faced several challenges impeding the expected mechanism to work out as planned in promoting change. These examples illustrate how the intervention design interacted with implementation challenges to partially impede the theory of change from translating into practice. This explains why the equity measures failed to produce the anticipated effect of enhancing healthcare utilization among the ultra-poor.

What worked well: Our study is one of the first attempts to translate the process tracing method to evaluate complex health interventions. We were therefore faced with few "precedent cases" to learn from. This proved challenging but also gave us flexibility in adapting the approach to the realities of complex intervention research in global health. We found the approach extremely helpful in decomposing the theory of change and systematically understanding shortfalls. With a view towards the practical value of the research, our findings

are easily accessible to implementation stakeholders, clearly showing critical elements and their influence on the success of the intervention.

What would we do differently: First, we identified process tracing as a potentially helpful methodological approach relatively late along the path of our overall evaluation of PBF in Burkina Faso. We applied the method rigorously, but we inevitably missed the opportunity to plan ex-ante for data collection activities geared specifically at generating evidence for our process tracing. Hence, we sometimes struggled to identify sufficient evidence to elucidate a given mechanism and had to use existing data sources falling somewhat short of meeting our expectations. Second, we recognize that process tracing entails reducing a complex reality to a simplified series of sequential steps. On one side, we found this helpful process since it forced us to think through what elements were essential for the success of the intervention. On the other side, given the complexity of the intervention, tapping into multiple health system dimensions on both the demand- and the supply-side, we often questioned our decisions. Third, even though we reduced the intervention to a minimum of sequential steps, we struggled to identify a strategy to communicate findings concisely, comprehensibly, and meaningfully for both policy and academic audiences. We felt we had more data than we could handle in a single study. Fourth and last, we struggled to decide the extent to which a mechanism having played out only partially or only weakly represented a problem for the overall realization of the intervention. While the method is set to validate or invalidate working hypotheses on how a mechanism plays out to produce a given effect, the reality is rarely set around such a strict dichotomy. In practice, we had to rely on our extensive knowledge of the intervention to gauge the role that a given part of the theory of change played in relation to its achievements or shortcomings.

Lessons learned for analyzing the policy implementation

- Process tracing can successfully be used in global health studies to map the design of a policy against its implementation, capturing different dimensions of action in detail.
- Given the wealth of data needed, it is best to plan for it ahead of starting an evaluation to ensure adequate primary data collection and access to reliable secondary data sources/evidence
- "It takes a village" to lead a process tracing evaluation towards a successful end, so it is best to engage several experienced researchers on the project, along with all phases from theory development to evidence appraisal.

2. Multiple case studies in health policy implementation

Case 5: Using the Consolidated Framework for Implementation Research to Analyze the Implementation of Performance-Based Financing in Mali

Study setting: This research focuses on the implementation of the pilot of a health system strengthening intervention – performance-based financing (PBF) – in district hospitals (DH) in the Koulikoro region of Mali. PBF aims to increase the productivity and quality of health care delivery to populations by paying health centres based on their performance, measured by the quantity and quality of services provided.

Study objective: This research was conducted from December 2016 to January 2017, focusing on stakeholder perceptions and the context of PBF implementation in DHs. The aim is to understand the issues related to the design of the PBF intervention model, the influence of the local context and to show the specificities of local norms and values when implementing PBF in DHs.

Integrative framework: The theoretical framework used is the Consolidated Framework for Implementation Research (CFIR) with its different taxonomies, dimensions, and constructs (Damschroder et al., 2009). There are five main dimensions to understanding policy implementation: the characteristics of the intervention, the external context, the internal context, the characteristics of the individuals, and the implementation process. In the case of PBF in Mali, two dimensions of the CFIR, i.e., characteristics of the intervention and the external context, helped to address the design challenges of the PBF intervention. In contrast, the other helped to inform the implementation of the intervention for stakeholders.

Research strategy: We adopted a qualitative approach based on a multiple case study design. The cases are three among the 10 DHs in the Koulikoro region. We conducted 36 interviews, 24 non-participant observation sessions, 16 informal interviews and used a literature review.

Summary of findings: The findings showed that most health workers were committed to the PBF policy intervention. However, except for the key implementation actors, and those from one district already experienced a pilot PBF project, respondents needed more knowledge of the intervention. Stakeholders perceive the PBF pilot as a vertical intervention, externally driven, and focused on reproductive health. In addition, local stakeholders were not involved in the design of the PBF model. Several challenges to the quality of its design and implementation were highlighted: the intervention was too short (eight months), the choice and number of indicators were insufficient for the donor (World Bank) priority, and the model could not be modified during implementation. Only respondents from one district with prior PBF experience provided some insights on implementation success.

What worked well: The choice of the different taxonomies, dimensions, and constructs of the CFIR was made by several researchers from different disciplines (anthropology, public health, and psychology). A prior discussion of the CFIR conceptual framework within the research team allowed us to retain certain constructs and remove those that did not apply to the context of PBF implementation in Mali. We used the French version of the CFIR, which allowed us to create a table that includes the different constructs retained and their descriptions, the constructs not retained, and the justification for why they were not kept. In addition, the multiple case study approach allowed for reporting on contrasted findings across the three implementation locations.

What we would do differently: We believe that the results of using the CFIR during the implementation of an intervention should be used to inform implementers and decision-makers about adaptations to the intervention during its implementation, scale-up, or termination.

Lessons learned for analyzing the policy implementation.

- The CFIR provided evidence on the design and implementation challenges of PBF in Mali.
- The evidence produced was summarized and transferred to the implementing agency, and the donor helped to improve the design of the new PBF project, taking into account the design and implementation challenges of the previous project.

- The CFIR did not allow the identification of causal links (between the different components/implementation process/internal and external context on the one hand, and the effects on the other).
- A longitudinal study was initially planned to enable us to see the evolution of PBF implementation over time. However, due to significant delays in implementation, we had to conduct a cross-sectional study covering only the 8-month implementation time of the PBF pilot project.

Case 6: Applying Durlak and Dupré's 23 influencing factors for analyzing the implementation of a method for targeting vulnerable households in two Northern Mali communities

Study setting: Identifying and selecting individuals or households to benefit from social interventions remains a challenge in Africa. Several methods for targeting these people exist. Inspired by the experiences of Niger and Burkina Faso, in 2014, six international NGOs funded by the European Commission Humanitarian Office launched a pilot project in the Gao and Timbuktu regions. Through a cash transfer intervention, its objective was to mitigate the consequences of food and nutrition insecurity during the pastoral and agricultural lean seasons for the most vulnerable households. The Household Economy Approach (HEA) targeting method was the preferred method used by two NGOs to select households eligible for receiving the cash transfer. The pilot project was implemented in Northern Mali between June 2016 and October 2017.

Study objective: To understand how the HEA method is implemented by two NGOs, in two different villages (a pastoral and an agricultural village) and how the context shapes the intervention, and to identify factors that constrained or facilitated the HEA method's implementation.

Integrative framework: The Durlak and Dupré (2008) framework used to identify and classify factors was developed following an analysis of 542 health promotion and prevention programs. From this analysis, the authors extracted 23 factors identified in at least five studies. The 23 factors were grouped into 5 categories reflecting bottom-up and top-down processes, i.e., I. Community-level factors, II. Provider Characteristics, III. Characteristics of the Innovation, IV. Prevention Delivery System: Organizational Capacity and V. Prevention Support System: Training and technical assistance.

Research strategy: This was an exploratory qualitative multiple case study reflecting various implementation sites. Two villages in an agricultural community and two fraction locations in a pastoral community were selected as implementation sites. Data collection (48 interviews and 15 document) was conducted between April and November 2016. Data analysis was carried out based on the 23 factors that influence implementation.

Summary of findings: The results showed that household identification is based primarily on geographic and community targeting. The factors that influenced the targeting process were the low knowledge of the HEA method, the fatigue and low motivation of the people involved, the top-down management, and the need for more transparency in the decision-making processes. We also identified the logics of domination and power relations within the communities and issues related to funding, hegemonic relationships of humanitarian aid and official development assistance. The context of insecurity in the pastoral community (vs. the other agricultural

community) contributed to impede communication between implementation actors, which had some negative impacts on the implementation.

What worked well: The researcher's introduction to the field by people with prior knowledge of the context and the participants' collaboration (openness and transparency) was beneficial to the study. The prior development of the interview guide based on Durlak and Dupré's (2008) conceptual framework facilitated the identification of factors that influence implementation.

What we would do differently: Insecurity in northern Mali limited access to the field as some sites had to be removed from the geographic sample. Insecurity hurt matching time and resources (human and financial) for data collection. The difficulty in recruiting professional and accredited interpreters was an issue. Better reporting of results to stakeholders would have enriched this research. The late analysis and publication of the research results (in 2019 when the intervention occurred in late 2016) prevented process improvement.

Lessons learned for analyzing the policy implementation

Given the complexity associated with the different levels of analysis (institutional, organizational/community, and individual) and the diversity of actors involved in the process of implementing an intervention, researchers are increasingly encouraged to explore and use combinations of concepts, theoretical approaches, or methodological approaches in order to capture best the real-world conditions in which an intervention takes place. In this case study, process analysis combined with Durlak and Dupré's (2008) Framework allowed for the identification of factors that influenced the implementation of the HEA targeting method in two distinct communities: one agricultural, one pastoral – with some variations mainly due to a different political context. While context shaped the intervention, we also noted that adaptation takes time and depends on the original intervention's design flexibility. We strongly recommend that time be secured for adapting to the context of the mechanisms inherent in an intervention's design. This time should be planned in advance, factored into the timeline, and protected.

Case 7: Realist Evaluation and integrative framework for collaborative governance to understand the Contribution of WHO in supporting health policy dialogue

Study setting: WHO supports several countries worldwide in their efforts to achieve universal health coverage (UHC), including through the Universal Health Coverage Partnership. This Partnership aims to support policy dialogue, a collaborative governance instrument placed under the leadership of ministries of health. Policy dialogue initiatives can address different topics related to UHC: health financing, health planning, coordination of health stakeholders, etc.

Study objective: The objective was to understand how the Partnership was working, in what context(s), particularly in African countries, and identify its outcomes on collaboration dynamics.

Integrative framework: The research drew on Emerson and colleagues (2012) integrative framework of collaborative governance, to understand the role of the Partnership and the policy dialogue dynamics. This framework is integrative because it draws on concepts and knowledge from a variety of disciplines; it exposes the multiple relationships between system contexts, actors' roles and behaviors, process outcomes and long-term impact; and it allows for

the study of various interventions or phenomena affecting or contributing to collaborative governance, as part of the collaborative governance process.

Research strategy: To consider the diversity of contexts in which the Partnership was implemented and the variety of topics policy dialogue initiatives may address, we conducted a realist evaluation using a multiple case study design in six African countries. We used qualitative research methods, including interviews, observations, and document analysis.

Summary of findings: Two implementation modalities strongly influenced outcomes: the modalities for deploying the Partnership in-country (one expert in-country; multiple experts in-country; one expert available for several countries); and the leadership, expertise, and collaborative know-how of Partnership experts. Context also strongly influenced the ability of Partnership experts to initiate and support policy dialogue, such as the level of involvement of ministries of health, the transparency of policy dialogue processes, and stakeholders' sense of meaningful contribution to policy dialogue.

What worked well: Developing the intervention theory of the Partnership and its intended outcomes helped identify the accountability threshold of the Partnership. It also helped to distinguish the Partnership outcomes from the effects of policy dialogue. The use of qualitative methods (interviews, observations, document analysis) combined with the investigation of several cases provided a wealth of data that facilitated a realistic transversal analysis (Pawson, 2013). Finally, the emphasis on actors' roles, behaviors, and attitudes - through the mechanism concept - contributed to the identification of complex causal relationships that are particularly enlightening for understanding the sequence of events that led to more or less fruitful policy dialogue initiatives. A research strategy rooted in realistic evaluation allows researchers to go beyond the simple statement of factors that facilitate or hinder the implementation of an intervention or influence its outcomes.

Methodological challenges: The main methodological challenge was the diversity of the cases and the strong influence of context, both on implementing the Partnership and policy dialogue. It was indeed challenging to identify standard levers for action that may also be relevant at the local level. That is why it required a sufficiently high level of abstraction to draw cross-cutting lessons. Such a challenge is inherent to the realist evaluation of highly context-dependent interventions. Emerson's integrative framework was instrumental in supporting this abstraction process.

Lessons learned for analyzing implementation: Integrative theoretical frameworks can prove valuable for implementation science. However, they can also be empty shells when no epistemological grounding allows researchers to use them 'integratively'. Thus, researchers whose reasoning relies on linear causation can hardly use such frameworks to their full potential. Our research showed the relevance of combining realist evaluation and Emerson's integrative framework. Connecting the framework's components through reasoning based on generative causation has made it possible to generate robust knowledge. In addition, it became possible to produce knowledge beyond the organizational, logistical, and financial arrangements on which many implementation evaluations usually focus, by highlighting contextual influences, the importance of collaborative relationships, and their interactions. The challenge is not to get lost in the variety of interactions and refocus on the most critical implementation issues, particularly those that will interest decision-makers or sponsors of the evaluation.

Conclusion

This chapter provided a helicopter view of third-generation policy implementation studies mobilising conceptual and theoretical approaches in diverse contexts. We reviewed seven case studies illustrating the application of diverse integrative frameworks to analyze policy implementation methods, frameworks, and approaches. Among the critical dimensions of third-generation implementation studies as stated in Saetren's 2014 review, we emphasised authors' ability to apply an integrative approach. Our chapter and reviewed policy implementation cases also reflected another key dimension of third-generation implementation studies, i.e., a diversity of case study approaches – using both single and multiple case studies, thus allowing for comparative work, which proved relevant for highlighting contrasted implementation experiences (see Case 5 in particular). In addition, one case (Case 1) also featured mixed-method research – which, according to Saetren, should become more mainstream in policy implementation studies. However, we could not integrate each third-generation dimension. Missing dimensions included the ability to carry-out analyses over time. Indeed, in a context of scarce resources for implementation science, both in the North and the South, it is never easy to maintain a longitudinal research plan, even if the research proposal includes such a longitudinal approach (Ridde et al., 2014). Moreover, the high turnover of decision-makers and implementers, as well as the socio-economic vulnerability of academic actors (especially in the South) does not always make this approach easy. For example, we had planned a multiple and longitudinal case study to study the implementation of a health financing policy in Burkina Faso. Despite the proposal's publication (Ridde et al., 2014) we could not carry out all the planned phases due to the lack of availability of certain researchers, who were challenging to mobilize over the long term. This will certainly be one of the following major challenges for students of health policy implementation.

Our chapter also featured policy implementation scholars' capacity to apply *bricolage* approaches, combining existing theories and conceptual frameworks (see cases 1, 2, and 7). This aspect reflects a broader trend in health policy and systems research, which typically involves scholars with diverse backgrounds and disciplinary traditions (Jones et al., 2021); a movement that can also be found in public policy scholarship (e.g., de Leeuw, Cassola & Fafard, 2022; Jones et al., 2016; Pierce et al., 2017). Despite sometimes conflicting epistemological and conceptual approaches (see case 2 for instance), the *bricolage* strategy thus may indicate a promising avenue for policy implementation research.

Our chapter provided the opportunity to cover a primarily overlooked region for health policy implementation scholars – Francophone sub-Saharan Africa. Indeed, most reviewed case studies were carried out in that region, where this type of research is still under-represented in the field of health care policy research. This characteristic highlights how much public policy scholars investigating and/or based in that geographical region can innovate in policy implementation, applying unexplored or overlooked theories and frameworks and building new, adapted ones, thereby making the public policy research field thrive.

On a related note, the chapter is a clear reminder that policy implementation primarily investigates a policy's capacity for adaptation – adaptation to complex local, organizational, and

sociocultural contexts. It is a central element in contexts where official development assistance is important and often influences decision-making, the choice of policy instruments and the implementation of health policies and interventions. One cannot look at policy implementation without considering the “big picture,” i.e. the broader ecosystem in which said the policy is being introduced. The current, interrelated health and climate crises should also urge public policy researchers to embrace ambitious implementation science approaches because they allow for a flexible study design that can be continuously adapted to account for structural and temporary shocks affecting the interventions studied and the research process.

Many of these policy implementation approaches can guide us through a much-needed space for reflexivity. The reflective process may be undertaken both by public policy scholars and policy implementers separately or, more remarkably, in a joint effort (Jones et al., 2021; Tremblay & Parent, 2014). The reflective process can thus be continuous to reflect the feedback loop between implementers and researchers, what this interaction meant for both categories and what tangible impacts it may have had on a given policy's routine adaptations.

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