https://ijhpm.com
Int J Health Policy Manag 2026;15:9941

OPEN ACCESS

doi 10.34172/ijhpm.9941

IJHPM
International Journal of Health Policy and Management

Viewpoint

Evidence, Power and Implementation in Global Health Policy

Charles Birungi[1,2*]

***Correspondence to:** Charles Birungi, Email: birungic@unaids.org

Copyright: © 2026 The Author(s); Published by Kerman University of Medical Sciences. This is an open-access article distributed under the terms of the Creative Commons Attribution License (https://creativecommons.org/licenses/by/4.0), which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Citation: Birungi C. Evidence, power and implementation in global health policy. *Int J Health Policy Manag.* 2026;15:9941. doi:10.34172/ijhpm.9941
Received: 18 April 2026; Accepted: 11 October 2026; ePublished: 11 October 2026

Background

The familiar evidence-to-policy story is attractive because it offers a clear division of labour. Researchers generate knowledge, decision-makers select the best option, and administrators implement it. Health policy scholarship has challenged this linear account for decades. Policy content is inseparable from actors, institutions, process, and context. Evidence enters arenas already structured by power, ideas, interests, and administrative routines.[1-3] The problem, therefore, is not that global health has ignored politics altogether, but that professional practice and training still too often treat political and implementation questions as secondary to technical design.

Here, global health refers to policy problems and governing arrangements whose causes, financing, authority, or consequences cross borders and involve actors operating at more than one level.[4] This includes national and local policy processes shaped by multilateral agencies, donors, transnational firms, professional networks, and cross-border risks. These processes do not operate identically across settings. Donor dependence, fiscal constraint, fragmented authority, conflict, informality, and weak administrative reach may be especially consequential in some low- and middle-income settings, while legal fragmentation, organised interests, and polarisation may dominate elsewhere. The relevant question is not whether politics matters in one context and not another, but how its configuration varies.

This viewpoint synthesises established insights from health policy analysis, political science, and implementation research into a six-force heuristic covering evidence, interests, institutions, ideas and framing, incentives, and implementation capacity. It operationalises the synthesis through guiding questions and complementary methods and illustrates its use across HIV financing transitions, pandemic preparedness, and health taxes. Its practical contribution lies in integrating and applying established insights across contrasting policy domains. The heuristic is an accessible diagnostic bridge between scholarship and policy practice, not a predictive or universally applicable theory.

Established frameworks illuminate actors, context, agenda setting, evidence use, institutions, and implementation. The six-force heuristic does not replace them; it brings their practical implications into one operational lens for assessing whether a proposal is evidentially credible, politically supportable, institutionally authorised, normatively legitimate, behaviourally incentivised, and operationally deliverable.

Its practical contribution is therefore not theoretical invention, but making these established insights easier to use prospectively in policy strategy and retrospectively in explaining adoption, adaptation, or failure.

Approach, Scope and Authorial Reflexivity

This is a conceptual viewpoint, not an empirical study. The six-force heuristic was developed through an interpretive synthesis of canonical and contemporary work on evidence use, agenda setting, power, institutions, framing, and implementation, read alongside three deliberately contrasting policy domains: HIV financing transitions, pandemic preparedness, and health taxes. The cases are illustrative rather than sampled to test causal propositions. They clarify mechanisms and levels of application, but do not establish generalisable effects. The heuristic should therefore be judged by its transparency and usefulness as a diagnostic aid, not as a validated or exhaustive theory. No primary data were collected, and no statistical analysis was undertaken. Accordingly, the article does not report empirical results in the manner of an original research article.

This viewpoint is written from the standpoint of a pracademic working across global health financing, multilateral policy and country-level reform. That position offers close exposure to how evidence is negotiated and translated into advice, budgets and implementation, but may privilege policy advisers and senior decision-makers over frontline workers, communities and groups with limited formal authority. The argument is therefore a situated, practice-informed synthesis. The heuristic partly addresses this limitation by asking whose knowledge and interests are recognised, who carries implementation burdens, and how power operates across levels.

Future comparative case studies, structured process tracing and prospective policy analyses could assess which configurations matter under different conditions and whether the heuristic improves diagnosis or strategy.

[1]Sustainability Team, The Joint United Nations Programme on HIV/AIDS (UNAIDS), Nairobi, Kenya. [2]The UCL Centre for Global Health Economics, University College London, London, UK.

Agenda Setting: Attention, Framing and Windows

Evidence can document severity without securing priority. Kingdon's multiple-streams framework links problems, policy proposals and politics when a window opens, while Zahariadis highlights power, perception, potency and proximity in allocating attention.[5,6] In global health, windows may arise from outbreaks, elections, fiscal crises, litigation, donor reviews, or scandal. Shiffman and Smith similarly show that priority depends on actor power, ideas, political context, and issue characteristics.[7] Analysis should therefore ask who defines the problem, whose testimony counts and who can keep an issue off the agenda.

From Policy Choice to a Six-Force Diagnosis

The heuristic should be understood as complementary to, rather than a replacement for, established health policy analysis frameworks. Whereas broad models such as the policy triangle help analysts locate actors, context, content and process, the six-force heuristic disaggregates some of the mechanisms through which policy decisions are authorised, contested, framed, incentivised, and implemented.

The six forces are analytically distinct but empirically entangled. Evidence shapes what can be claimed, but its authority depends on institutions and trusted messengers. Interests influence which costs and benefits are emphasised. Institutions distribute access, authority, and veto power. Ideas and framing make some options appear necessary, fair or feasible while rendering others unthinkable. Incentives affect whether political leaders, ministries, providers, and partners gain from cooperation or delay. Implementation capacity determines whether commitments can be converted into budgets, procurement, supervision, frontline routines, and learning.

The heuristic is a dynamic diagnostic system, not a checklist of separate variables. Policy formulation, implementation, and learning occur within a decision arena in which the six forces interact continuously. Power is not a seventh force; it operates through all six by shaping recognised evidence, access, institutional authority, legitimate frames, incentives, resources, and discretion. Context, scale, and time condition these interactions across global, national, and local arenas. Table 1 translates this architecture into guiding questions and methods.

This synthesis avoids a technical-versus-political dichotomy: technical analysis is produced and used within political institutions, while political feasibility without credible evidence or delivery capability may generate symbolic or harmful policy. The six forces are interacting lenses, not variables to be scored. No single method is sufficient: stakeholder and power mapping can identify influence; process tracing can reconstruct decisions and veto points; discourse analysis can reveal framing; institutional analysis can locate rules; and implementation research can examine how policy is remade in practice.[8-14]

Prospective use begins with a concrete decision: specify the venue and time horizon; identify actors who can authorise, block, finance, or deliver it; test how competing frames distribute benefits, blame and risk; and map the administrative chain and vulnerable assumptions. Retrospectively, the same questions can explain why a policy advanced, stalled or changed form. The output is a plausible account of interaction and strategic choices that can be revisited as conditions change.

Formulation and Implementation Are Recursive

Formulation is bargaining under constraint, not a neutral search for the technically optimal option. Proposals are filtered through budgets, legal mandates, bureaucratic jurisdictions, coalition needs, and anticipated resistance. Sequencing, compensation, and strategic ambiguity may preserve enough agreement for action, but they can also displace costs or weaken equity. Analysts should therefore distinguish

Table 1. Six-Force Diagnostic Heuristic for Global Health Policy Analysis

Force	Working Definition	Guiding Questions	Indicative Methods and Evidence Sources
Evidence	What is known, measured or modelled, including uncertainty and competing knowledge claims.	What evidence is treated as credible? What is uncertain? Whose knowledge is excluded?	Evidence appraisal; document and data review; uncertainty analysis; participatory knowledge elicitation.
Interests	Actor stakes, preferences, and distributional consequences, including who gains, loses, pays, or carries risk.	Who gains, loses, pays, or carries risk? Who can mobilise support or opposition?	Stakeholder and power mapping; interviews; network analysis; political economy analysis.
Institutions	Formal and informal rules, mandates, and routines that distribute authority, access and veto power.	Where is the decision made? Which rules, budgets or routines enable or block change?	Institutional mapping; legal and budget analysis; process tracing; organisational analysis.
Ideas and framing	Problem definitions, causal stories, values, and narratives that shape what appears legitimate or feasible.	How is the problem named? Which values and identities are activated? What alternatives are rendered invisible?	Discourse and frame analysis; document and media analysis; interpretive interviews.
Incentives	Formal and informal signals, rewards, sanctions, and expectations that shape action, delay, compliance, or adaptation over time.	What encourages action, delay, compliance, or adaptation? Are incentives aligned across levels?	Incentive mapping; payment and budget analysis; interviews; behavioural and organisational analysis.
Implementation capacity	The people, finance, infrastructure, discretion, routines, and learning systems needed to deliver, adapt, and sustain policy in practice.	Who will deliver, with what resources and discretion? Where can the delivery chain fail or adapt?	Implementation research; process evaluation; observation; ethnography; routine-data and workflow analysis.

acceptable adaptation from the quiet abandonment of a policy's core purpose.

Implementation is not a downstream managerial stage. Street-level actors interpret rules, ration scarce resources, and translate national commitments into locally variable practice.[11,12] Implementation science can help specify determinants and outcomes, but a narrowly positivist application may recast power, conflict, and discretion as decontextualised "barriers." Political and interpretive inquiry must remain inside implementation analysis: who controls resources, whose workload rises, whose knowledge is discounted, and which adaptations redistribute voice or risk? Policy success is also multidimensional. As McConnell argues, a policy may succeed programmatically while failing politically or procedurally, and many outcomes occupy contested grey areas rather than a binary of success and failure.[15]

Illustrative Applications

Table 2 applies the six forces to domains that vary in time horizon, actor configuration, financing, and political contestation. HIV sustainability foregrounds transition and service continuity; pandemic preparedness highlights sustaining attention between crises; and health taxes illustrate commercial opposition, fiscal bargaining and distributive framing. The heuristic reveals different bottlenecks and levers rather than a universal recipe.

In HIV sustainability, evidence on need and fiscal space cannot decide which services governments, donors or communities should finance, how transition risks should be shared, or whether marginalised groups remain protected. Local ownership requires authority, resources and accountability.[16] Botswana's extension of free antiretroviral treatment to non-citizens shows how epidemiological evidence gained traction when exclusion was reframed as an epidemic-control and public-value problem.[17]

Pandemic preparedness poses a temporal problem: documented future benefits compete poorly with immediate budget claims, while crisis temporarily raises incentives and salience.[18] The challenge is to institutionalise financing and routines after attention recedes. Health taxes instead combine concentrated commercial losses with visible consumer costs; adoption depends on evidence, industry power, inter-ministerial bargaining, revenue credibility and frames of fairness, jobs and household burden.[19,20]

Table 2 summarises these contrasting configurations.

Context, Scale and Time

The six forces vary by context and scale. Funding conditions, board governance and transnational advocacy may dominate a donor-funded initiative; cabinet rules, treasury ceilings, and mandates may dominate a ministry; and staffing, professional norms, workarounds, and managerial discretion may determine practice at district or facility level. Analysts should trace connections across levels rather than assume that a global decision travels intact.

Time also matters: agenda windows may be brief, while coalition-building and institutional reform are slower. Diagnosis can distinguish near-term adoption requirements, medium-term administrative investments and long-term shifts in norms or power. The heuristic should be revisited as conditions change. Its categories overlap, may conceal structures such as colonial legacies or class and gender relations, and cannot establish causality alone. Used as a checklist, it would reproduce the simplification it seeks to correct.

Implications for Research, Practice, and Training

First, researchers should specify the policy process and level, state assumptions about power and institutions, and use methods that reveal hidden as well as formal influence. Documentary and budget analysis can establish commitments; interviews and observation can surface informal rules; process tracing can test explanations; and discourse analysis can show how affordability, efficiency, or fairness are constructed.

Second, practitioners should replace appeals to "political

Table 2. Illustrative Application Across Three Global Health Policy Domains

Policy Domain	How the six Forces Interact	Primary Analytical Lesson
HIV sustainability and transition	Evidence: epidemiological need, expenditure, and fiscal-space analysis. Interests: governments, donors, communities, providers, and marginalised groups face different transition risks. Institutions: budget rules and service mandates determine who can assume functions. Ideas/framing: sustainability may be framed as ownership, austerity, integration or equity. Incentives: donors seek exit while ministries face competing demands. Capacity: domestic financing, procurement, and community-linked delivery must be sustained.	Transition is a redistribution of authority, risk, and accountability, and not only a financing calculation.
Pandemic preparedness	Evidence: risk assessments and readiness gaps are well documented. Interests: benefits are diffuse while current spending has visible opportunity costs. Institutions: cross-sectoral authority and contingency financing are often weak. Ideas/framing: preparedness competes with narratives of immediate need. Incentives: political rewards rise during crisis and fall between events. Capacity: surveillance, supply chains, workforce and coordination must be maintained.	The central challenge is institutionalising attention and resources after the crisis window closes.
Health taxes	Evidence: consumption, health, and revenue effects. Interests: public-health actors and treasuries confront concentrated commercial opposition. Institutions: tax authority, cabinet processes, and earmarking rules matter. Ideas/framing: health, fairness, jobs, regressivity, and revenue compete. Incentives: ministries and politicians face different fiscal and electoral rewards. Capacity: tax design, administration, enforcement, and communication shape delivery.	A technically strong tax succeeds only when fiscal, political, and administrative coalitions are built and distributional concerns are addressed.

will" with a diagnosis of actors, rules, narratives, incentives, and delivery chains, identifying what can change, by whom, at what cost and over what period. Strategy should be judged against substantive goals, procedural fairness and the distribution of benefits and burdens. Coalition-building, framing, sequencing or compensation are defensible only when they support, rather than reverse, the policy's public purpose.

Third, training should combine epidemiology, economics and evaluation with political analysis, institutional reading, negotiation, communication, and implementation judgement. Practitioners must move between a regression table, budget, stakeholder map and frontline workflow without treating any as the whole reality. They should also recognise when a policy window invites premature adoption because evidence is weak, safeguards are absent or burdens fall on those with least voice.

Conclusion

Global health policy is neither the automatic application of evidence nor politics unconstrained by knowledge. It emerges from evidence, power, institutions, meaning, incentives, and capacity. The six-force heuristic offers no shortcut; it helps explain why sound proposals stall, why adopted policies change during delivery, and where evidence can be joined to political and administrative strategy. Its practical contribution is to translate dispersed scholarship into a usable diagnostic without reducing complexity to a checklist. It is a structured way of asking better questions, not a predictive theory or scoring formula. The strongest policy advice is not merely technically correct or politically expedient; it is empirically credible, institutionally situated, ethically defensible and implementable over time.

Acknowledgements

This manuscript was developed from a global public health policy talk delivered at Nottingham Trent University on April 16, 2026. No part of the manuscript has been published in journal article form. The author gratefully acknowledge the insightful comments, questions, and suggestions provided by participants, which helped improve this paper.

Disclosure of artificial intelligence (AI) use

During revision, the author used OpenAI's ChatGPT for editorial and drafting assistance, including restructuring suggestions, language refinement, and document preparation. The author retained control of the argument, critically reviewed and verified all substantive content, interpretations and references, and takes full responsibility for the final manuscript. The tool was not used to generate or analyse data, replace the author's original conceptual thinking, interpret empirical findings or create figures.

Ethical issues

Not applicable.

Conflicts of interest

The author is employed by UNAIDS. This manuscript was prepared in a personal capacity. No other competing interests are declared.

Disclaimer

The views expressed in this manuscript are those of the author and do not necessarily represent the views, decisions, or policies of UNAIDS or the United Nations.

References

1. Walt G, Gilson L. Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy Plan*. 1994;9(4):353-370. doi:10.1093/heapol/9.4.353
2. Walt G, Shiffman J, Schneider H, Murray SF, Brugha R, Gilson L. 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy Plan*. 2008;23(5):308-317. doi:10.1093/heapol/czn024
3. Gilson L, Walt G. Doing health policy analysis: the enduring relevance of simple models: Comment on 'Modelling the health policy process: one size fits all or horses for courses.' *Int J Health Policy Manag*. 2023;12:8223. doi:10.34172/ijhpm.2023.8223
4. Koplan JP, Bond TC, Merson MH, et al. Towards a common definition of global health. *Lancet*. 2009;373(9679):1993-1995. doi:10.1016/S0140-6736(09)60332-9
5. Kingdon JW. *Agendas, Alternatives, and Public Policies*. Updated 2nd ed. Longman; 2011.
6. Zahariadis N. Delphic oracles: ambiguity, institutions, and multiple streams. *Policy Sci*. 2016;49(1):3-12. doi:10.1007/s11077-016-9243-3
7. Shiffman J, Smith S. Generation of political priority for global health initiatives: a framework and case study of maternal mortality. *Lancet*. 2007;370(9595):1370-1379. doi:10.1016/S0140-6736(07)61579-7
8. Cairney P. The Politics of Evidence-Based Policy Making. Palgrave Macmillan; 2016. doi:10.1057/978-1-137-51781-4
9. Topp SM, Schaaf M, Sriram V, et al. Power analysis in health policy and systems research: a guide to research conceptualisation. *BMJ Glob Health*. 2021;6(11):e007268. doi:10.1136/bmjgh-2021-007268
10. Stone DA. Causal stories and the formation of policy agendas. *Polit Sci Q*. 1989;104(2):281-300.doi:10.2307/2151585
11. Pressman JL, Wildavsky AB. *Implementation: How Great Expectations in Washington Are Dashed in Oakland*. University of California Press; 1973.
12. Lipsky M. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. Russell Sage Foundation; 1980.
13. Gore R, Parker R. Analysing power and politics in health policies and systems. *Glob Public Health*. 2019;14(4):481-488. doi:10.1080/17441692.2019.1575446
14. Peters DH, Tran NT, Adam T. *Implementation Research in Health: A Practical Guide*. Alliance for Health Policy and Systems Research, World Health Organization; 2013.
15. McConnell A. Policy success, policy failure and grey areas in-between. *J Public Policy*. 2010;30(3):345-362. doi:10.1017/S0143814X10000152
16. Murphy LM, Stenoien DV, Love E, et al. Supporting local ownership of transition processes: a key pathway to sustaining the HIV response. *BMJ Glob Health*. 2025;10(6):e018190. doi:10.1136/bmjgh-2024-018190
17. UNAIDS. Botswana extends free HIV treatment to non-citizens. https://www.unaids.org/en/resources/presscentre/featurestories/2019/september/20190924_Botswana_treatment_non-nationals. Published September 24, 2019. Accessed July 10, 2026.
18. Global Preparedness Monitoring Board. *A World at Risk: Annual Report on Global Preparedness for Health Emergencies*. World Health Organization and World Bank; 2019.
19. Elliott LM, Dalglish SL, Topp SM. Health taxes on tobacco, alcohol, food and drinks in low- and middle-income countries: a scoping review of policy content, actors, process and context. *Int J Health Policy Manag.* 2022;11(4):414-428. doi:10.34172/ijhpm.2020.170
20. Lwin KS, Koon AD, Rasanathan K, Ahsan A, Erku D, Mialon M, et al. Framing health taxes: learning from low- and middle-income countries. *BMJ Glob Health*. 2023;8:e012955. doi:10.1136/bmjgh-2023-012955