

Exploring the concept of power in the implementation of South Africa's new community health worker policies: A case study from a rural sub-district

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**In the Regional Network for Equity in Health in east and southern Africa (EQUINET)
with the Centre for Health Policy, University of Witwatersrand**

DISCUSSION PAPER 64

April 2008

With support from IDRC Canada

Table of contents

Executive summary.....	2
1. Introduction	4
2. Methodology and objectives of this study	7
3. Results	9
3.1 The policy context	9
3.2 Profiling the community health workers in this study	12
3.3 The policy implementation process	13
3.4 Community participation in selecting, managing and co-ordinating CHWs.....	24
3.5 Impact of the CHW policies on service delivery	25
4. Discussion of results	26
4.1 Relationships between key role players	27
4.2 Communication and information flows during the implementation process	29
4.3 The use and abuse of power by role players.....	30
5. Conclusion and recommendations.....	34
References.....	36

Cite as: Lehmann U and Matwa P (2008) 'Exploring the concept of power in the implementation of South Africa's new community health worker policies: A case study from a rural sub-district,' *EQUINET Discussion Paper Series 63*. EQUINET, CHP: Harare.

Executive summary

There is widespread concern among public health practitioners and scientists about poor policy outcomes. Decades of health sector reform initiatives, particularly in low- and middle-income countries have, as a rule, not generated substantive and sustained improvements in access, coverage, quality and equity of health care for large populations. While the reasons for this are complex, discrepancies between policy intent and policy outcome, which emerge in the process of policy implementation, as well as unintended outcomes of policy processes, have been identified by many authors as a cause.

The work was implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET) policy analysis theme work, in conjunction with the Centre for Health Policy, University of Witwatersrand. In the study, we explore how policies are shaped and transformed in the process of implementation, using as a case study the implementation of two community health workers policies in a rural sub-district in South Africa (which remains anonymous to protect the privacy of all interviewees). More specifically, we investigated how role players at different levels of the implementation process interacted with each other and the policy and how they used power at their disposal in this process.

Rather than focusing on the gap between policy formation and policy outcome, with implementation being a mere administrative follow-on, we take a 'bottom-up' perspective, which allows one to view implementation as an integral and continuing part of the policy process. Within the policy-action dialectic of the implementation process, we were particularly interested in the use of discretionary power or 'scope of action' exercised by the apparently powerless: how such discretionary power was used by front-line implementers either to develop 'coping mechanisms' in the absence of clear policy rules or to negotiate policy modification in action.

Results show that tensions between role players, as well as selective communication and lack of information, led to a 'thinning down' of a complex and comprehensive policy to focus solely on the payment of stipends to community health workers. As frontline implementers at the district and community levels did not have information to understand the content and scope of the policy, their actions were shaped by what they were informed about: the need to pay stipends to selected community health workers (CHWs) and to have them work in specialised fields. While they did not have the power to change the rules that were set and implemented by the provincial actors, they used their knowledge of local conditions, control over local knowledge and distance from the provincial capital to shape implementation at the service level.

Information, communication and knowledge turned out to be the most crucial elements impacting on how the policies were translated into practice. Access to information allowed the provincial actors and facility managers to select which aspects of the policies they wanted to see implemented, choosing the narrowest possible interpretation of the policies. Both were concerned primarily with 'conformance' rather than 'performance'. Only one actor in the implementation process, a sub-district programme manager recognised the policies' potential for the improvement of access, equity and quality of care and pursued it vigorously. She had appropriate training, experience in another sub-district and the confidence and skills to follow her goals against significant resistance. The unquestioned exercise of authoritative power by the province and the non government organisation (NGO) offered no scope for negotiation and rendered CHWs powerless in this context, except for their ability to withdraw their input – which many of them did at the expense of coverage and access. Community-level actors, both community health workers and community health committees, had no authoritative power at all to influence the policy implementation process. Even discretionary power was used to only a very limited extent. Some community health workers used the only

discretionary power at their disposal, namely the withdrawal of their services, to express their unhappiness with the implementation process.

Both authoritative and discretionary power was used in the policy implementation process. All but one role player used power, whether authoritative or discretionary, to narrow and thin the scope of the policy from its initial intent. Only one role player, the sub-district health promotion manager used her discretionary power, against those in authority, and against resistance from authority, to strengthen and be true to the underlying values and the mission of the policy. While the health promotion (HP) manager did not 'conform' to policy processes, as set out by authority, she undoubtedly enhanced the 'performance' of the policy through her actions.

Some general concerns with policy implementation processes remain. As long as it is not acknowledged by those in charge of policy formation that "implementation should be regarded as an integral and continuing part of the political policy process rather than an administrative follow-on", as one respondent in this study noted, we are likely to find vast divergence between policy formulation and policy outcome. There is a need for those in charge to ensure that policy formulation accompanies the implementation process. Their activity ought to begin with a careful assessment of the status quo and possibly result in less complete (and complex) and more flexible policy documents, which are suited to negotiation and reshaping in the implementation process.

1. Introduction

There is widespread concern among health practitioners and scientists around the world about poor policy outcomes in the public health sector. Despite decades of health sector reform initiatives by governments in low- and middle income countries, these governments have not yet generated substantive and sustained improvements in access, coverage, quality and equity of health care for large sections of their populations (Kolehmainen-Aitken, 2004). While the reasons for this are complex, many authors point to discrepancies between policy intent and policy outcome, which emerge in the process of policy implementation, as well as unintended outcomes of policy processes, as underlying causes (Watt, 2005; Penn-Kekana, 2004; Walker, 2004).

While the discrepancy between policy intent and policy outcome is well acknowledged in public health studies, attention is usually focused on the problem of unmet policy objectives, so recommendations are primarily aimed at ensuring a better match between objectives and outcomes. However, this focus leads to a strong emphasis on the 'implementation deficit'. Several authors have pointed out that invariably "policies will not live up to the rhetoric of those who formulated them", so discrepancies should be considered the norm rather than the exception (Hill, 2002: 140). De Leon points out that "'things' do get implemented and carried out on a regular basis. [...] The main problem with implementation is that the discrepancy between 'something' and 'the idealised thing' is often a matter of rose-colored expectations. [...] It might be arduous and uncertain but implementation is a bureaucratic fact of everyday life" (ibid).

Several authors have therefore argued that, instead of focusing attention on discrepancies between the "idealised thing" and the "something", it may make more sense to ask how and why policy is implemented in particular ways and who shapes implementation. In their approach, they investigate and analyse policy implementation from the 'bottom up', emphasising the importance of target groups and service deliverers and arguing that "policy is really made at the local level" (Matland, 1995: 146). This conceptualisation moves away from the old idea that policy outcomes should ideally mirror policy intent, with implementation being merely the means to match outcome to intent. Instead, implementation is "regarded as an integral and continuing part of the political policy process rather than an administrative follow-on, and seen as a policy-action dialectic involving negotiation and bargaining" (Barrett, 2004: 253). Policy is 'alive' and is constantly shaped and reshaped during the implementation process.

Different models have been developed to analyse and understand policy processes. Elmore developed the concept of 'backward reasoning', in which processes are explained by starting with the individual and organisational choices that are the hub of the problem to which policy is addressed, then looking at to the rules, procedures and structures that have the closest proximity to those choices, and finally analysing the policy instruments available to address the abovementioned factors and make policy objectives feasible (1980: 1; cited in Ham, 1984: 106–107). Michael Lipsky focused on the role of what he terms 'street-level bureaucrats', namely the frontline providers who effectively shape the policies they carry out through their action, lack of action and any strategies they use to cope with uncertainties and pressures in the workplace (Hill, 2002; Lipsky, 1980).

In the two approaches we've discussed, a major implication is the role of relationships and the exercise of power between different role players along the policy formation-outcomes continuum in the policy process. How different role players interact with each other and how they exercise power on each other and in their scope of actions to implement a policy has fundamental importance for the implementation process.

Understanding policy implementation processes is not only important for an academic understanding of policy, but has immediate importance for policy practitioners who "need to answer questions of how to act" in their daily practice (Hill, 2002: 160). An understanding of how policy is shaped and recreated in the implementation process might enable practitioners not only to improve policy content, but also to design processes that respond to the iterative nature of implementation, allowing for flexibility to address organisational, professional and social contexts.

A deeper understanding of policy implementation processes is of particular relevance in the South African context. After 1994, many policy initiatives were started, which were intended to replace apartheid policies, and this meant that "implementation agencies [were] likely at any point in time to be responding to a wide variety of policy initiatives or environmental pressures from a range of sources" (Barrett, 2004: 254). There is mounting evidence that frontline workers are growing increasingly restless and fatigued by the frequency of policy interventions, which are experienced as destabilising, often contradictory and ultimately demotivating (Penn-Kekana, 2004; Walker, 2004; Lehmann, 2005; Lehmann, 2005). While some may actively or passively resist the implementation of certain policies, such as the Termination of Pregnancy policy, others may ignore policy directives in their daily practice. In many cases, however, frontline implementers make every effort to comply with policies, yet have to adapt them to local circumstances, workload realities or resource constraints (Penn-Kekana, 2004; Lehmann, 2005). In the process, they make use of whatever means are available to them to make the policy 'work' for themselves and their immediate circumstances. The exercise of power by different role players to achieve their goals and the inter-relationships between role players are significant equity issues here.

The work was implemented within the Regional Network for Equity in Health in East and Southern Africa (EQUINET) policy analysis theme work, in conjunction with the Centre for Health Policy, University of Witwatersrand. In this study, we set out to explore two inter-related community health worker policies that are considered relevant to growing health worker shortages in South Africa, namely the Extended Public Works Programme and the National Community Health Worker Policy Framework (which are described in section 3.1 of this paper). We aimed to develop an understanding of how and why these community health worker policies were shaped and transformed in the process of being implemented in one sub-district of South Africa. The district remains anonymous to protect the privacy of those community members who were involved in the focus group discussions. How do role players at different levels of the implementation process interact with each other and the policy? How have they used the powers at their disposal to make sense of and shape the policy? While we examined the authoritative power exercised by different government agencies, we were particularly interested in the use of discretionary power or 'scope of action' exercised by the apparently powerless: how such discretionary power "was being used by front-line operatives either to develop 'coping mechanisms' in the absence of clear policy rules or to negotiate policy modification in action" (Barrett, 2004).

This study took place in one of South Africa's poorest and most rural provinces (which will remain anonymous, for reasons of privacy). Four of the six district municipalities in the province have been designated rural nodes, which means that they have been identified as priority areas for rural development and investment (ISRDS, 2000). Some common characteristics of rural nodes are high levels of unemployment, illiteracy and poverty, which all impact negatively on the population's health status. Much of the province used to be a 'homeland' (or 'Bantustan') under the apartheid regime; 'homelands' were rural black areas that served as a pool of cheap migrant labour for the white economy and a dumping ground for women, children, the old and others not wanted in the white economy. Ex-homelands are characterised by a largely collapsed agriculture, high unemployment levels and a high disease burden. The current official unemployment figure for the province is 32% (Stats SA, 2007), although this figure hides substantial differences between different areas within the

province itself. The district we studied has unemployment rates of 55% and higher, while 73% of the population live in informal housing and only 28% of them have access to potable water. HIV prevalence is estimated to be around 22% (ibid).

Responsibility for health care lies primarily with the provincial department of health, which is organised in different chief Directorates and Directorates. Two programme Directorates that were relevant to this study are the HIV/AIDS Directorate and the Health Promotion Directorate. A provincial NGO (which has been active in the area for about twenty years and which will remain anonymous for privacy reasons) has been commissioned by the provincial government to administer the provincial community health worker programme. Three types of primary health care (PHC) facilities, namely fixed clinics, mobile clinics and district hospitals, cater for the health needs of the population in each sub-district. Primary care services are rendered primarily by the provincial government in clinics (including mobile clinics), which are usually staffed by nurses, assistant nurses and some general workers. The district has seen substantial and ongoing restructuring of health services, focusing on the integration of a very fragmented health system as a consequence of the old 'homeland' system and the introduction of a district health system. In 2003, clinics were organisationally separated from district hospitals and independent management structures were established. All clinics are now part of a sub-district and report to the sub-district manager via programme managers and clinic supervisors.

The sub-district office is located in one of the small rural towns of the district. It has a sub-district manager, as well as several programme managers and clinic supervisors. Of importance for our study were the sub-district manager, two HIV managers, and the health promotion manager. The three clinics we studied were scattered throughout the sub-district and chosen purposefully for their different locations: clinic A was within walking distance from the sub-district office, clinic B was located 20 km by tar road from the office and clinic C was about 30 km from the office, accessible on a very rough dirt road up into the mountains, which is often impassable during the rainy season. All three clinics were located in new buildings, with good internal infrastructure, but differing in size and staffing levels. Clinics A and B were staffed by several professional and assistant nurses, while clinic C only had one professional nurse at the time of the study (both a second professional nurses and an assistant nurse were absent on study leave).

For the community health workers (CHWs) in all three clinics, a distinction was made between those receiving government stipends and those *not* receiving stipends. Overall, those on stipends tended to be somewhat younger than those without stipends, and had higher levels of schooling. All clinics had between 10 and 15 active, and a large number of inactive, CHWs. Importantly, the sub-district has a tradition of community health workers. Village health workers were first introduced in the area under the apartheid regime in the 1980s and then again in the mid-1990s. Many of the CHWs we encountered had been recruited during these times. All three clinics had had large numbers (between 12 and 32) of volunteer CHWs prior to the implementation of the new policies, most of them mature women with little formal education.

All three clinics had community health committees (CHCs), which were considered crucial to the implementation of community health worker programmes. Although clinic C already had an active and established committee, clinics A and B had only recently finalised their committees at the time of the study.

The specific research objectives of this study were:

- to assess and document what CHW arrangements existed in the chosen facilities prior to the new policies;
- to describe and document the changes brought about by the new CHW policies;

- to assess how power dynamics have impacted on the process of implementing the new policies and its outcomes;
- to assess contextual factors impacting on the implementation process;
- to explore whether and where different actions in the policy development and implementation process might have led to strategically different results; and
- to find out which aspects of the design, particularly regarding the implementation of the policy, support or counteract equity aims or equity gains in terms of an increase or reduction in numbers of CHWs, changes in coverage or changes in the scope or quality of service delivery.

2. Methodology and objectives of this study

A qualitative, inductive approach was used in this study, using a grounded theory approach (Strauss, 1998) and including 'thick description' and some ethnographic methods, such as ethnographic field notes (Emerson, 1995). The study district was chosen because we had been working in the area for a number of years and had an established research infrastructure and good working relationships with key participants, particularly in the sub-district. Given the time constraints and small scale of the study, these criteria were very important as they meant that we could access the site without delay. Furthermore, we also had insight into the local situation, and could therefore assess with some certainty that the study would in fact generate results according to the intended objectives.

The study was discussed telephonically with key participants before it commenced, so data collection then proceeded fairly smoothly. Data was collected during two visits to the study site. One of the researchers was a home-language speaker of the local language who was very familiar with local contexts, as she had worked in the health services in a neighbouring district for many years and had conducted research in the study site previously. During the first visit we interviewed staff at the provincial health promotion Directorate and the NGO. Staff at the HIV Directorate unfortunately did not make themselves available for an interview, despite daily phone calls to them. We interpreted their reluctance as a reaction to the crisis around patients' deaths and conditions at East London's Frere Hospital, a story that had been in the media for several weeks and clearly had particularly provincial and district level staff extremely nervous. We also interviewed staff at the sub-district office and facility managers in the three selected clinics. During these interviews we arranged dates and times for a second visit to engage with community health workers and CHCs.

During the second visit focus group discussions (FGDs) were held with CHWs and CHCs in all three clinics. Three unexpected complications arose:

- Although we had asked to conduct separate FGDs with CHWs with and without stipends, all CHWs arrived at the same time. As it became clear very quickly that separate interviews would have created tension and suspicion among the CHWs, we decided to conduct one joint FGD. In all facilities CHWs were fairly open to talk about most issues, except details of stipends and contracts. We circumvented this problem by having informal talks with individual CHWs after the large meeting.
- In two facilities (clinics B and C) a much larger-than-expected number of CHWs arrived – 34 in clinic B and around 20 in clinic C. In clinic B we were told that many of the by now inactive CHWs had heard of our research and had decided to join the FGD to present their case and voice their grievances. It was clear that sending these women back, many of whom had travelled long distances, would have created serious tension in the community and would have been highly disrespectful. We therefore changed the venue and format of the FDG and proceeded with a large meeting. This had the disadvantage that there was less opportunity for in-depth discussion and younger FGD participants were reluctant to talk openly in front of their elders (for cultural reasons).

Nonetheless, we gained insights into the history of CHW practices in the area, which we otherwise would not have gained. Again we attempted to ameliorate the silence of the younger CHWs by having informal discussions with them after the meeting. In clinic C we encountered a similar situation, although here there were only 20 CHWs, active and inactive, with and without stipends. We took the same approach as in clinic B.

- In clinic B, two members of the CHC arrived during proceedings and joined the discussion, which meant we did not have a separate FGD with the community health committee (CHC). In clinics A and C, separate FGD discussions were held with CHCs.

We conducted interviews during the first visit, using a narrative approach aimed at eliciting "a less imposed and therefore more valid account of the informant's perspective" (Bauer, 1996: 2–3) While we developed interview guides in preparation for visits, the emphasis was on encouraging interviewees to tell their "story". Interviews were therefore fairly unstructured. Furthermore, interview guides were revised and adapted after each interview, as new questions and relevant information arose. While all interviews were taped and later transcribed, we also took notes, which were later turned into analytic memos to document respondents' own observations of events, behaviours and contexts (Emerson, 1995). Very importantly, we took great pains and considerable time before commencing each interview and later FGDs to explain the purpose of our research, present an overview of the questions we would ask, invite comments and questions for clarification, and invite participants to speak in the language they were most comfortable with. While most interviews were conducted in a mix of English and the local language, isiXhosa, all FGDs were conducted in isiXhosa. These preliminaries played a crucial role in setting a relaxed tone of interaction and putting participants at ease.

The focus group discussions during the second visit took a similar approach. Again, discussion guides were developed prior to the FGDs, but were adapted after each discussion. In the larger meetings participants tended to speak once, but for longer periods of time, presenting their input and insight. Proceedings were again taped and later transcribed, and we took notes. We did not have occasion to observe CHWs in their daily activities. However, we were given the opportunity to take part in one of the sub-district's regular monthly meetings with CHWs. While we did not actively participate in the proceedings of the meeting, we were welcomed and given an opportunity to explain our presence and our study to all present, which greatly facilitated our acceptance in the sub-district. We took detailed field notes during the meeting.

As is often the case in qualitative research studies, data analysis ran parallel to the data collection process. After each interview or FGD, we would compare notes, discuss insights and findings, generate additional questions and develop themes for analysis. Following each visit, interviews and FGDs were transcribed and, where necessary, translated into English. Following the completed data collection process, data were again systematically coded and themes extracted, first by each researcher individually and then jointly. In several cases data was validated telephonically with study participants. Researcher and thematic triangulation was ongoing and was conducted systematically in the data analysis process. We used the five-stage framework approach recommended by Pope et al (2000) for analysing applied or policy relevant qualitative data:

- i. familiarisation
- ii. identifying a thematic framework
- iii. indexing
- iv. charting
- v. mapping and interpretation.

This study was approved by the University of the Western Cape (UWC) Higher Degrees Research Ethics Committee. Meetings were held with the provincial, district and LSA Programme coordinators, as well as facility managers, who in turn recruited community

representatives and CHWs at their clinics to secure permission to conduct the assessment. An informed written consent for participation was sought from all the focus group participants, while verbal consent was obtained from all the other interviewed informants. Consent forms for focus groups were written in both isiXhosa and English, and the explanation of the purpose of the study was given in Xhosa. Participants were assured that confidentiality would be maintained and no data would be associated with any particular person. Only researchers had access to audiotapes in which interviews were recorded. Names of people and places mentioned during the interviews were erased and replaced with codes, for example the sampled clinics were referred to as clinics A, B and C. Participants were informed of their right to withdraw from taking part at any stage and to answer only those questions they were comfortable answering. Focus group participants in clinic B exercised this right. All participants were informed about possible research reports and publications that could emanate from this project.

3. Results

3.1 The policy context

The 2006 *World Health Report* (WHO, 2006: XIII) focused the world's attention on human resources as the key ingredient to the successful functioning of health systems and highlighted the growing human resource crisis, particularly in low-income countries. In its foreword the late Director-General of WHO argued that: 'There is a chronic shortage of well-trained health workers. The shortage is global, but most acutely felt in the countries that need them most. For a variety of reasons, such as the migration, illness or death of health workers, countries are unable to educate and sustain the health workforce that could improve people's chances of survival and their well-being.'

The *World Health Report* is a culmination of initiatives acknowledging the significance of human resources, which began with the Joint Learning Initiative on health human resources in 2003 (JLI, 2004). It led to a flurry of policy initiatives and guideline development at international, national and local levels, all aimed at putting in place strategies to improve the human resource situation in countries hit hardest by the crisis. One strategy advocated worldwide as a response to the growing crisis, and in particular in response to the HIV pandemic, is so-called 'task-shifting' – a review of and subsequent delegation of tasks to the 'lowest' cadre who can perform them successfully. In the context of task-shifting, the concept of using community members as health workers to render certain basic health services to the communities they come from has gained currency again (WHO, 2006; Lehmann, 2007). In South Africa, the role of CHWs and their relationship with the formal health system is a much-debated issue. CHW programmes run by non-governmental organisations have existed since the mid-1970s. In the 1980s, a few notable programmes impacting on child survival flourished with support from international donors (Friedman, 2006). The policy documents in the early 1990s, most notably the *ANC Health Plan* (Friedman, 2003: 163) identified CHWs as an important resource for PHC implementation: 'They were viewed as catalysts for community development, who could mobilise people around issues such as the need for clean water, sanitation, waste disposal, safe playgrounds and parks. [...] It was envisaged that they would form an integral part of the decentralised health services, and be compensated, either by the Government, or the local community.'

Initial enthusiasm waned in the late 1990s and support for CHW programmes was uneven, although CHW programmes continued in most provinces. The early 2000s, however, saw a change in the policy environment with regard to CHWs, partly in response to increased care needs due to the HIV/AIDS pandemic. Growing concerns regarding the impact of HIV/AIDS on the public health system and needs of affected patients highlighted the need for home- and community-based care (HCBC). Simultaneously, concern about the growing number of

unemployed youth led to the development of a broad job and skills creation strategy, which included training various forms of community-based workers. Two key policies today inform and define the sector - the Extended Public Works Programme (EPWP) and the National Community Health Worker Policy Framework (NCHWPF). Both were developed between 2003 and 2004, but are very different in focus, content and structure. The former, developed by the Ministry of Public Works, spans a wide range of public works initiatives, including infrastructure development, education and social sector activities. The latter was developed by the Ministry of Health in the tradition of CHW initiatives in the health sector. While they have some overlaps, they do not 'talk to' or build on each other and provide policy implementers with two very different sets of guidelines and rules.

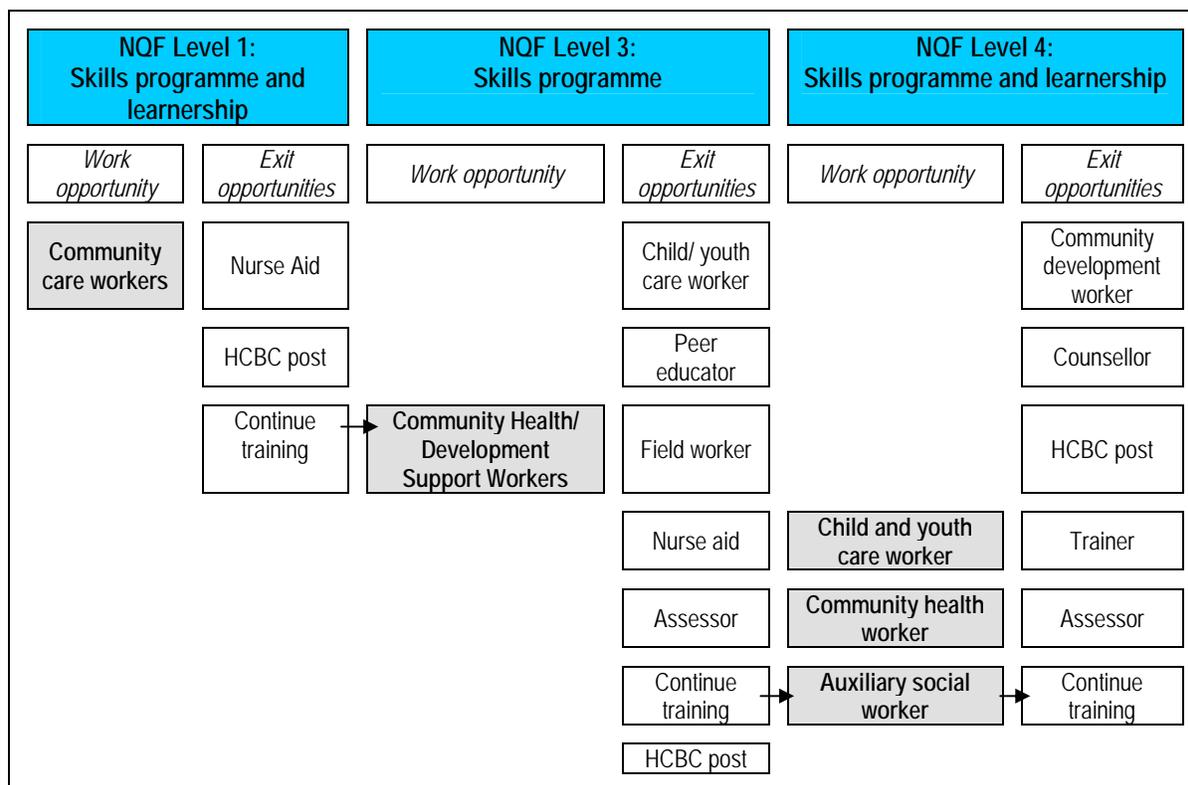
3.1.2 The Extended Public Works Programme

The Extended Public Works Programme (EPWP) has its origin in agreements of the Growth and Development Summit between organised labour, business and government in June 2003. Its broad aim is to create "temporary work opportunities for the unemployed, using public sector expenditure". The policy further aims to ensure all work opportunities "generated by the EPWP are therefore combined with training, education or skills development, with the aim of increasing the ability of people to earn an income once they leave the programme". In the social sector, which includes the health sector, the EPWP "employs people, through NGOs and CBOs [community-based organisations], to work on home-based care and early childhood development programmes" (website of the Department of Public Works). Certain Department of Health programmes and services are the responsibility of the EPWP, e.g. directly observed therapy (DOT), voluntary counselling and testing (VCT), nutrition advisors, lay counsellors and community health workers.

Three principles of the EPWP are relevant for this study: those people who are employed through the EPWP should be volunteers (must have done voluntary work in communities); they should undergo skills training in line with NQF requirements (ultimately leading to a formal qualification); and matriculants (those who have finished schooling or secondary education, at NQF level 3) should be targeted for higher-level training at NQF level 4. *Figure 1* illustrates the range of training, work and career opportunities that the EPWP intends to make available within the sector of home community-based care.

The EPWP Social Sector Plan recommends a minimum of 10 home-based carers per site offering home-based care and estimates that 35,000 community-health workers at NQF level 4 are needed nationally. While specific home-based care programme at all levels should be organised through skills programmes (according to the Skills Development Act) and funded through the National Skills Fund, generic health worker training should be organised and funded through the Department of Health.

Figure 1: Training, work and career opportunities in home community-based care



Source: EPWP Social Sector Plan, 2004

3.1.3 The National Community Health Worker Policy Framework

Since 2003, the Department of Health has been developing and implementing a new community health worker policy, the National Community Health Worker Policy Framework, which is aimed at institutionalising CHWs and bringing uniformity to diverse and fragmented existing CHW schemes (Friedman, 2006). The implementation framework for the policy (which was launched in 2003) makes provision for the appointment of generalist community health workers, who are to be paid a stipend by respective provinces through appointed NGOs and who, attached to primary care facilities, should perform a wide range of community-based care and support functions. These functions include community mobilisation, advocacy, health education, basic counselling services, referrals and specified primary care activities. Each CHW should cover between 80 and 100 households in rural areas and between 100 and 150 households in urban areas. CHWs should be trained according to registered unit standards (national curricula), training providers should be accredited and learnerships should be established. Importantly, CHCs were charged with providing a governance mechanism for CHWs. Lastly, the policy stipulates that fully trained generalist CHWs should receive a minimum stipend of R1,000 per month (Friedman, 2006). The policy has been in implementation for some three years, but so far little is known about the successes or challenges experienced during its implementation.

Like with many other health policies, it can be assumed that the vision, aims and objectives of both policies (job creation, skills development and community participation) find large-scale support among most, if not all, stakeholders, carrying neither a great deal of ambiguity nor conflict in the policy's intent (Matland, 1995). However, "a great deal of policy is in fact made, or modified, in the implementation process" (Ham, 1984: 131). And it is in the implementation process that the much-supported CHW policies begin to change shape.

At the initial levels of the process, implementation (including funding) was delegated from national to provincial departments. In this study, we look at the implementation process at provincial level, focusing on sub-district and community levels.

3.2 Profiling the community health workers in this study

The CHWs we encountered fell into two fairly distinct groups. The larger group was made up of mature women with different levels of schooling, most of them very experienced, articulate (in their home language) and vocal. Some of them were receiving stipends, but the majority were volunteers, both active and inactive. The much smaller group was made up of young people in their late teens and early twenties (mostly women), who remained quiet in meetings and FGDs. Most of them had a grade 12 qualification, and many had become community health workers because they could not qualify for or afford nursing or other formal tertiary education. These young people were all on stipends.

We had three occasions to observe CHWs and their interaction in large groups. First, in clinics B and C, we had requested FGDs with small samples of active and inactive CHWs, which turned into large meetings as word of our research got round to all CHWs and many viewed this as an opportunity to air their concerns and frustrations. Second, at clinic B, 34 volunteers and (active and inactive) CHWs on stipends arrived for the meeting, necessitating a change of venue and approach to the discussion. At clinic C, a large number of about 20 active and inactive CHWs participated in the focus group discussion. The third opportunity was our participation in the regular monthly meeting of all CHWs in the sub-district, initiated and hosted by the health promotion manager. Here, like in the facility meetings, it was striking that the younger CHWs remained almost entirely passive and quiet, while the older women engaged in lively and confident debate. It was also noteworthy that most of the older women arrived with notebooks and took copious notes during the meeting.

There can be little doubt that there existed a large generation gap between the CHWs, but also between parts of management and the younger CHWs, which led to underlying, quiet tension. Given the cultural norms in this rural area, the younger CHWs did not feel free to speak in front of their older 'colleagues' and huddled together in their own age group on all occasions. They were effectively silenced. Because we had limited opportunity to speak with them separately, we did not gain much insight into their perspective and experiences with the programme, which undoubtedly is a great limitation. Some of the sub-district and facility managers furthermore reported problems with the acceptability of the young CHWs in the communities where they worked, as they were perceived to be unreliable, inexperienced, untrustworthy around issues of confidentiality and unstable in their commitment to the community. However, these concerns were not raised by the CHWs themselves or the CHCs. It is likely that the managers' comments reflect some generational bias. Furthermore, it also reflects a lack of adequate preparation and support for the younger CHWs. While the older CHWs had the benefit of years of experience, which included periods of training and support, the younger ones had had very limited training and hardly any supervision or support. Poor performance may thus reflect poor management rather than the unsuitability of young CHWs.

We heard many different stories of how the community members became volunteer CHWs, ranging from simply presenting themselves at the clinic to being asked by their communities or facility managers:

We were chosen by a certain lady who was our leader previously. She told us that the government's decisions 'just happen'. A message had arrived saying only five people were to be chosen for the programme. We do not know at this moment what the government will decide in the future, they could ask for more people. You will join in small groups at a time. It was stipulated that only one person from each

village would be chosen and those villages will belong to the clinic. That is briefly how we came to work here at the clinic (CHW, clinic B).

How I came to be here at the clinic is because of one lady who works here, [name deleted for anonymity], who is a cleaner here at the clinic. She took me by hand and said: "You have now finished school, [...] come with me even if you are not getting paid yet, your work will have progress. You will not be using transport because you will be from the village which is close to the clinic, you can walk." It is she. She was involved in the Red Cross programme at the clinic. She is the one who encouraged me to join saying that loitering around the village is not good because it can lead me astray. She begged me to try this thing (CHW, clinic A).

I was elected by the residents to become the community worker. We started in 1995 with others who were elected just like me (CHW, clinic C).

Most younger CHWs told us about their incomplete highschool education (matric/ NQF 3) qualifications, the inability to enter formal nursing education and how they chose community health worker work as a second-best and temporary alternative. Many of them made no secret of the fact that they were planning to move on, should the opportunity arise. None of them had heard of a possible career path from community health worker work into nursing or other health sciences.

Altogether, the CHWs we encountered were a diverse group. They included young and old, mostly women and some men, with very different levels of experience and qualifications, and many different histories of their entry into the community health worker field. Common to their stories was a lack of systematic recruitment, training and support.

3.3 The policy implementation process

3.3.1 Responsibilities of key role players in policy implementation

A number of key role players had responsibilities for policy implementation at different levels of the health services (see *Table 1*).

In line with the stipulations of both policies, the provincial Department of Health (DoH) is charged with the implementation of the CHW policies in the health sector. While both policies are clear about the provincial responsibility for the programme, they do not provide more detail on where within the provincial government this responsibility should lie. In the studied province, responsibility for the programme had been lodged with the HIV Directorate, which is the budget holders and ultimate 'owner' of the policies. As we did not succeed in securing interviews with the HIV Directorate, we had to rely on the Health Promotion Directorate's views only when they claimed that discussions had been held, but not finalised, to determine that they should co-ordinate the CHW programme:

But the SGH (Superintendent General for Health) has not actually written down a mandate that we must take over community health workers, but what is happening is that if there is any information then we say go and look at such and such a place at promotion and give us information of such and such a thing. But the actual management and ownership has not yet been handed over to us (interview with provincial HP managers).

While the HIV Directorate is the ultimate 'owner' of the CHW programme, it plays and oversight rather than a hands-on role in the implementation of the programme. In line with policy stipulations, the DoH commissioned a local NGO with the task of implementation. The main reason for this arrangement, which is common throughout the country, is to outsource the formal relationship with CHWs and thus avoid making them state employees and

therefore public servants, subject to and eligible for provisions under general public service regulations. The NGO has a contract with the Department of Health and HIV (DoH/HIV) Directorate to administer the stipends; not, according to the NGO representative, to run the entire programme. The NGO therefore considers itself no more than "the paymaster of government", charged with managing the payments of stipends, as one interviewee noted.

Table 1: Responsibilities of key role players in policy implementation

Key role players	Responsibilities
Department of Health and HIV Directorate	<ul style="list-style-type: none"> • Overseeing implementation • Holder of CHW budget • Influence policy development
Department of Health and HP Directorate	<ul style="list-style-type: none"> • No designated role • Influence policy formation • Attempt to access resources
NGO	<ul style="list-style-type: none"> • Control over funds and contracts • Accountable to Department of Health for HIV
Sub-district: HIV programme	<ul style="list-style-type: none"> • Claims authority over CHWs because of budget location • In charge of training
Sub-district: HP programme	<ul style="list-style-type: none"> • No designated role • Institute monthly meetings • Organises continuous education
Sub-district manager	<ul style="list-style-type: none"> • Little involvement but appears to be supporting HIV manager over HP manager
Facility manager	<ul style="list-style-type: none"> • Information node between sub-district, CHC and CHWs • Ultimately controlled appointment of CHWs • Day-to-day supervision
CHW with stipend	<ul style="list-style-type: none"> • Service implementation • Chosen by virtue of their education qualifications • Receive stipends, but appear not very vocal or powerful
CHW without stipend	<ul style="list-style-type: none"> • Service implementation • Most withdrew their contribution when stipends were introduced and they were excluded • Used FGDs to voice their discontent
Community health council (CHC)	<ul style="list-style-type: none"> • Vocal and actively involved in one facility • Not involved in selection in any facility • No role in implementation

In the sub-district, both new policies arrived by way of communication (whether verbally or in writing remains unclear) from the provincial capital, stating that five CHWs per facility would in future receive a stipend from an NGO and a request to facilities to forward the names of five CHWs to the NGO. The sub-district itself did not have any direct role in selecting the CHWs who were to receive stipends, and passed the information on to facilities, together with instructions to involve CHCs in the selection process. As one manager noted:

We said that, since the community care workers are from the community, so the community should be involved in this structure, [which] is the link between the health services and the community; namely, the clinic committee. We said to them that you have to invite the clinic committee and all the community care workers must be there; both the ones who are getting stipends and the ones who are not. So, please, good people, make it a point that you don't take anyone who is not a volunteer here in a particular facility. Take within our whole of volunteers so that at least these people were here for such a long time. So they did that. So we were not involved as the managers (interview with HIV manager, sub-district).

None of the sub-district managers had seen either of the policies in writing or were familiar with their key concepts such as NQF levels, entry and training requirements, or scope of

activities. All they knew was that initially five, then seven, CHWs would receive stipends, that there were three categories of CHWs and that they should all be trained in the basic 59-day home-based care course. The sub-district managers' role in the policy implementation process was restricted to being an occasional conduit of information between the provincial government and health facilities, and taking some responsibility for the training of CHWs. One of the HIV/AIDS managers was formally responsible for the programme and specifically the training of CHWs, a task she found difficult to fulfil as training budgets were withheld by the provincial health department. In this 'vacuum' of activities at sub-district level, the new health promotion manager decided to hold monthly meetings with all CHWs in the sub-district, which were used, and continue to be used, for feedback, report-back and continuing education. They are run quite informally, with some input from various programme managers (such as those running programmes for HP, HIV/AIDS and TB) and discussions with CHWs. We were told that the meetings had initially been resisted and undermined by the other sub-district managers. Attendance had changed from well over a hundred participants in the beginning to under forty yet, as the HP manager persisted in her efforts, attendance began to pick up again. When we visited the sub-district, the meeting was well attended and all programme managers were eager to participate, which provided a rare opportunity to share information and receive feedback about activities in communities from the CHWs. The HP programme had persisted and was recognised as the host of these meetings.

Facility managers played a crucial role in the implementation of the programme. As a rule they were the ones most closely associated with the selection of CHWs for stipends, and they are responsible for the day-to-day supervision of CHWs. Formally, their only role was to confirm and pass on the selection of CHWs to receive stipends and to sign the CHWs' monthly log sheets. However, because they were a nodal point for information between sub-district, facilities and communities, they played quite powerful informal roles. As discussed above, in two out of three clinics, the facility managers *de facto* selected the CHWs who were to receive stipends. In the process they (intentionally or unintentionally) were unclear about how the qualifications and suitability of the CHWs factored into their selections. After a CHW's name had been passed on to the NGO, facility managers were evidently excluded from any communication regarding contracts and stipends, yet still had the very powerful (but limited) role of signing off the CHW's monthly reports (called 'log sheets'). Although facility managers were not given formal responsibility and resources to supervise CHWs, they were still expected to supervise them. None of them had received any instruction, training or resources to facilitate their supervisory role. As a result, it was left to facility managers to define their role and fill it to the best of their ability, given local circumstances. In all three facilities this meant that supervision was limited to receiving reports and being available for questions CHWs might bring to them.

Our insights into the role played by CHWs in their communities are limited because we did not have the opportunity to explore and observe them going about their daily activities. Given that there was no immediate supervision of their work in communities and accountability to CHCs was very limited, it is likely that CHWs shaped their role within communities in different ways. Within the formal organisation and hierarchy of policy implementation, they had limited roles. Like sub-district and facility managers, they had no say whatsoever in the shaping of the policies, decisions about categories of different CHWs and so on. In one clinic, CHWs were allowed to participate in decisions about who among them should receive a stipend, but not in the others. The activities of CHWs receiving stipends were defined by their designations, but the roles of all CHWs (with or without stipends) were considered similarly by provincial and sub-district authorities, namely as volunteers doing community service. It was mentioned before that these authorities themselves were aware that this role definition contradicted local realities, in that the assumption that stipends would supplement other income was known to be false. But none of the actors in authority suggested that the definition of the role of CHWs should therefore be changed.

According to the policies, CHCs are expected to play a key role in the initiation, running and supervision of the CHW programme. All three facilities we engaged with had a CHC, albeit of different lengths of existence and levels of activity. Shockingly, none of the CHCs had been involved in the selection of the CHWs on stipends or were actively involved in the running, co-ordination or supervision of the programme. Neither had they received any training to prepare them for their role as CHC members, although some had consulted previous members on the scope of their role. Furthermore, none of the CHCs had received information or briefs regarding the policies or their intended implementation in the province or the LSA.

3.3.2 Legal status of CHWs: Volunteers or employees?

The policies stipulate that CHWs should be 'employed' through NGOs and CBOs. However, the nature of this 'employment' relationship is ambiguous and a source of tension that permeated many of our discussions with study participants. The NGO representative emphasised that their relationship with CHWs was not an employer-employee relationship:

The Department of Health wanted to thank the community care workers for the valuable role that they are playing because they were not paid, they were just volunteers, so they gave them a stipend. [...] Now in Xhosa they call it 'isepi', just something small and it is basically for food during the day and basically transport money.

She also lamented the fact that "the spirit of volunteerism has been removed by there being a stipend. I'm sorry to say that, because for years and years and years volunteers have been volunteering." But while the NGO insisted that they were not an employer of CHWs and bemoaned the fact that the latter thought of themselves as employees rather than volunteers, they had put in place elaborate accountability and reporting mechanisms, typical of a normal job. For example, CHWs had to sign a service-level agreement, which specified details like their designation and minimum working hours (60 hours per month). They had to open a bank account in their own name and fill in a bank verification form to have their stipends transferred into an account. And they had to fill in and submit monthly log sheets, which needed to be signed by their facility manager. Failure to comply with any one of these provisions at any time led to non-payment of stipends. Given the amount of paperwork and ongoing bureaucracy CHWs encountered in this way, which formalised their relationship with the NGO, it is perhaps not surprising that they considered themselves employees rather than volunteers. There is no doubt that the bureaucratic culture of the provincial capital and its understanding of what does and does not constitute a volunteer were imposed on CHWs and, indeed, all key role players at sub-district level. Yet, although the NGO representative insisted on the voluntary nature of the work of CHWs, she also acknowledged that her conceptualisation did not quite fit the actual situation in which most CHWs find themselves:

They are not supposed to be actually living on it, but they have now found that the volunteers are having to live on this because they don't have any other source of income, hence the change of mindset and behaviour that you are now seeing in the clinics. So that is where it stems from, the fact that they are now looking at themselves as employees rather than volunteers in the true nature of volunteers.

For community health workers, the distinction between employee and volunteer was not so clear cut, as there had been promises of money in the past which sometimes did and mostly did not come true. They appeared to understand the present policy initiative as one of the many non-transparent and unpredictable ways in which government works. Two CHWs explained how they reached this understanding:

I was elected in 1995. I was elected by the residents to become the community worker. We started in 1995 with others who were elected just like me. A nurse trained us how to consult patients. We went also to rural areas as well. Some people say being a community worker offers one nothing much, when one looks

back. We were promised that the government will provide us with the soap [stipend]. We carried on until 2000/2001. Round about 2004 we received the soap [stipend]. In 2003 we were asked to sign every day to receive the soap each month, a stipend worth R500. In the meantime it was said that five people should be home-based care workers. These people were to be trained [yet] some of us did not receive training. We waited in 2003; only in 2004 did we receive the stipend. It is the payment for all of us, whereas others have quitted already. [...] Some of us could not bear it anymore but we persevered (CHW, clinic C).

I joined the health workers programme in 1983. I received some training on First Aid, which was taught by a person from Umtata. There were eight of us in that group. We were later joined by two nurses, who also came for this First Aid training. We got our certificates at the end but only four people had passed. The nurses needed assistants at the clinic and they asked for help from the four people who had passed their First Aid course. We helped the nurses without pay. We had never even heard the word 'volunteer' yet; we learnt about it later (CHW, clinic B).

CHWs evidently had a fairly clear sense of their role as assisting government to bring health services closer to their communities, but they struggled with the concept of volunteerism, which was new to them and only recently introduced to describe an already long-established practice.

3.3.3 Recruitment and training of CHWs: Qualifications

The EPWP's Social Sector Plan distinguishes three levels of CHWs, with different entry qualifications and training requirements. Volunteers with no or little formal schooling should be trained at National Qualifications Framework (NQF) level 1. Workers with NQF level 1/Grade 9 or an equivalent qualification should be trained at NQF level 3 to qualify as CHWs. On completion of accredited training and required work placements, they can progress to the next level. Training in the above two levels is the primary responsibility of the government, while the CHW at NQF level 4, or workers with Grade 11 or equivalent qualification, should be put through learnerships under the Health and Welfare Sector Education and Training Authority (SETA), hosted by the NGO. The national 59-day HCBC training programme forms the basis of all training. This implies that CHWs at all levels should have completed this course and any other training should build on this foundation programme.

Provincial practice was somewhat different: all three categories of carers were considered level 1, single purpose 'community care workers'. When asked whether CHWs in the province were pitched against NQF levels, the NGO representative said, somewhat in despair, "Don't even go there yet. They haven't even got to number 0, let alone number 1 yet, they are still working on the plan."

There was an enormous amount of confusion around the question of entry qualifications. While educational qualifications as an entry criterion undoubtedly played a role in CHW selection, provincial and sub-district managers all insisted that they had not requested specific school qualifications:

Now it is very difficult for us to say when they select the people out there to say, "Please, the criteria must be standard 10," because we don't decide on that. It is the people down there in the sub-districts and the districts who selected these people according to their experiences or according to the situation at that moment. For instance, [...] there are those who are already skilled without standard 10; we don't chase them away (interview with provincial HP manager).

We were not able to unravel how the suggestion of a grade 10, 11 or 12 qualification had entered the conversation. It would appear that suggestions regarding minimum qualifications were made up 'along the way', and as different managers saw the need arising:

There are minimum requirements, but then what happens in an area [...] where some of them only got standard 3, yet they are volunteers and they are providing a wonderful service in the community? There is a minimum criterion for things like lay counselling where a certain amount of perceptive skills is required and interpretation skills are required. [...] But somebody with only a standard 3 can be a home-based carer because it is a hands-on thing. You just need to have a kind heart, have a pair of eyes to check out if there are any children running around that have got no mom and dad at home, you know that sort of thing (interview with NGO representative).

We asked them [provincial management] what are we going to do because the people working down there as community care workers have standard 2, standard 6 and standard 7. We don't have the people with standard 8, standard 9 and standard 10. [...] After some of the facilities chose people with standard 6, who had already been volunteering for a long time, [this] caused a bit of a misunderstanding between the facility and the community because there were so many complaints (interview with sub-district HIV manager).

It is also possible, although this cannot be proven, that some facility managers used the minimum educational qualification as an instrument to facilitate the selection of a small number of CHWs from a large pool, a process that held enormous potential for serious tension between facility staff, CHWs and communities. This is what the facility manager of clinic A may have done when she 'passed on' an instruction from the province that CHWs would have to select those with standard 10 themselves.

CHWs and community members held different views about the (implicit) suggestion to appoint younger, better educated CHWs, as can be seen from the two very different quotes below:

The reason why this lady was not chosen is that only people with a bit of education were selected. She had mentioned that she does not meet the criteria. The government actually disappointed her by requiring a certain standard of education, and yet she couldn't reach that standard. She was disillusioned by this because she had been a volunteer for a long time already. We also have that same problem in the committee, of the government taking only the educated people, whereas we have volunteers who have sacrificed for many years. The committee does have a serious problem. The volunteer who has worked for 10 years is a good example and yet the one who has volunteered for just one year or a few months gets first preference just because she is educated (CHC member, clinic A).

[They] needed children with standard 10. The reason? She said there will be books that will be delivered and we would not be able to read them. We were obviously 'substandard products' who would find difficulty in dealing with those books. We then decided to bring one child from our village and asked her to join us. [...] We were not against the standard 10 idea and we also thought of our old age. We searched for these children in the village and said to them, "Please, children, come and join us because only standard 10 education is being recognised now and we will not be able to read the books that will be coming." It was then that we resigned. We did come back last year though, and reported to the nurse, but we realised that because there are these young people with standard 10, we will not cope. We brought our child from our village and just stood back. (CHW, clinic B).

While many clearly resented the fact that their many years of voluntary work remained unrewarded, some felt that the new initiative would provide much-needed employment and career opportunities for some of the youth of the area.

3.3.4 How are CHWs selected to receive stipends?

The selection of CHWs to receive stipends was meant to be a collaborative effort between facility managers and CHCs and they were to be drawn from the pool of existing volunteers in each facility. According to the NGO representative, the sub-district office was only a conduit of information between the facility and the NGO. In practice, however, things were somewhat different.

All three facilities selected CHWs who had volunteered before. In Clinic A, the manager had called a meeting of all (32) CHWs and had asked them to select five CHWs who were to receive stipends from among themselves. The CHC was involved in selecting CHWs insofar as many of the CHWs were CHC members and had therefore been involved in their own selection. In Clinic B, the facility manager reported that, due to the short notice for the submission of names for stipends to the sub-district, the clinic staff had to take executive decisions regarding who was to be selected for what. This report was confirmed by the CHWs in the same clinic who said that the sister in charge of the clinic's HIV/AIDS programme had single-handedly chosen them to be in the programme. There had been no involvement of the CHC, which at the time of the selection had been largely defunct. In Clinic C, CHWs were selected by the facility manager, although there appears to have been some communication with communities (not the CHC), who were encouraged to submit the names of volunteers and the facility manager.

It is evident that facility managers played a crucial role in the selection process. As they were the only recipients of information coming from the sub-district office, they had the liberty to interpret the instructions from 'above' as they liked and to pass on information selectively. There is little doubt that there had been a fairly explicit instruction to involve community structures and to choose from among active CHWs. While it would appear that the latter instruction was followed in all clinics, the former was ignored in clinics B and C and somewhat misinterpreted in clinic A. In each case, the facility manager provided a weak rationale for their action, for example in clinic A, where the manager claimed that the CHC was involved by virtue of the fact that CHWs were CHC members in clinic A and clinic B's claim that there wasn't enough time to get communities involved. The facility manager and a CHW of clinic A describe the process in their own words:

We had about 36, or 34, community health workers; all of them, at the time, were not on the stipend. And then we got too 'big'; we had to select five from those 32 community health workers with a standard 10, so that they could go on a stipend. And then what we did was call them all together with the clinic committee when we made our selection. So these five were elected. (facility manager, clinic A).

A meeting was called and it was decided that only five health workers were to be elected. The meeting was called and sister said [...] this meeting was for all health workers who had volunteered. We were called to meet here at the clinic. When we arrived, we were given our own room as health workers, but sister was not present. We, the five health workers, were elected by all the other health workers who were present at that meeting (CHW, clinic A).

Interestingly, the facility manager argued that the reason for selecting only five CHWs was that 'we got too big'. This implies a perception that the government intended to provide stipends for all CHWs, but that there were too many. This argument was accompanied by a carefully nurtured implicit suggestion that there would be more stipends in future – a suggestion that was used as an incentive for volunteers to remain active and reinforced by the fact that two stipends were added to the original five at a later stage:

As the time went on, some of the community workers were asked to offer their voluntary work, so that when there are the next elections, there will only be selections from the group of voluntary community workers. In case there is a shortage of community workers, then their recruitment of new community workers will take place (CHW, clinic C).

3.3.5 Training and 'trainability' of CHWs

The question of educational qualifications discussed above had another controversial twist: when we asked various actors what they thought the reason behind the need for a grade 12 qualification was, many of them answered that the reason was that the selected CHWs would have to be 'trainable'. This term was interpreted as not only being able to 'deal with books', as mentioned above, but also and more importantly, to be able to follow training in English, as most of the organisations offering training only had English-speaking trainers:

I think the language which is used is English, so they don't understand English. [...] I think that is the main problem (interview with HIV manager, sub-district).

At the start, there was nothing about qualifications. As the time went by, there was a mention about standard 10 or 9, but times have changed now. The workshops and training are in English. Community care workers need to be trained and they must be somebody who is trainable. So, with most of the community care workers, there was a feeling that the community care workers will be unable to understand the training because of the language that is being used (facility manager, clinic C).

Again, however, it is not clear where this supposed requirement originated, and again it is likely that the need to be able to distinguish and select among a large number of CHWs, coupled with some rumours about educational requirements, led to the creation of a rule through practice. At the same time, the rationale for the rule was at least partly negated by practices around training. The same HIV manager quoted above, who was in charge of training, pointed out that the training of CHWs had so far been patchy:

You'll find that home-based carers are not usually trained. Some have done two weeks. You see the home-based care course takes 59 days to finish up. [...] So you will find that most have two weeks of home-based care, another group has a week; most of them haven't started yet.

There was agreement among all respondents that there was no merit in favouring those with higher qualifications. Most managers felt that there was no difference in the quality of service being rendered between the more educated and the less educated; in fact, the older and less educated CHWs often substantially outdid their more educated counterparts in commitment and experience – experience that was being lost as most older CHWs were abandoning their activities.

While it would appear that most CHWs had received some basic HIV training (five to 10 days of basic training and some training in VCT in some cases), the co-ordination, ownership and resourcing of training was one of the most controversial issues in the policy implementation process. At provincial level, the NGO denied any responsibility for training and confirmed that they had not received a budget for training from the provincial government:

The Department of Health is responsible for their training. We report on the training done, but we don't [...] do the training. [...] The HIV/AIDS Programme manager and the TB Programme manager are supposed to liaise with the clinic sisters and find out what training is required. Based on that information, the volunteers are then supposed to go on training.

The HIV manager in the sub-district confirmed that she was in charge of training, but emphasised that she had no resources to conduct training:

The problem was that the budget was centralised to the province. We have to do our logistics here, like finding the codes with the service providers and for the accommodation. Then, with the facilitators, we were using our clinic nurses who have been trained as trainers of home-based care. So we have to do all those logistics and send them to [the provincial capital]. [The provincial capital] will stay and stay and stay and perhaps after three weeks they will tell you there is no money. And if I can say it clearly, last year they only did one training [course] for me. When I came here, I found that there was a group of 20 community care workers who had done 40 days' training in home-based care. I wished to take them up so that at least they could finish their 59 days [of training], but because of the long wait some got jobs somewhere else, so of that 20 who had been trained, only 14 were left. So I pushed the 14 to finish up the 59 days. That is the only group presently who has finished the 59 days.

Not only did the unreliability of budget allocations make planning for training impossible, the HIV manager had also received neither training information nor the relevant training materials to conduct the basic 59-day training course, a key responsibility in her role:

I don't have the policy. So I might be leaving out some of the things because I don't know, I don't have the policy. Even with the curriculum I'm talking about, I only said to one of the trainers, somebody who was trained as a trainer of home-based care, "Just give me the book [training manual] so that I know." Otherwise, I, as the person on top, don't have anything but I'm still expected to see that the training is going [well]. [...] Province keep on promising, promising, promising because I have been asking for those things from [name deleted], who is responsible, up till now. How am I expected to do the correct job?

With all the uncertainty surrounding qualification requirements and training, the practice that seems to have emerged in the sub-district is that lay counsellors, whose educational activities in the clinic are considered to be of a higher standard than those of workers in home-based care and TB support, are prioritised for training and are expected to have higher (matric) qualifications. Training is provided as the opportunity arises. CHWs are also invited to the regular monthly meetings, which provide some continuing education. It must be noted, however, that CHWs have to cover all their own costs to attend these meetings, most importantly, transport costs. When no formal training courses are provided, clinic sisters are expected to offer on-the-job training.

It is noteworthy that none of the training stipulations contained in either of the two CHW policies are being implemented or even discussed. None of the CHWs are receiving systematic and continuous training. And matriculants, who were supposed to be earmarked for rapid training and learnerships leading to NQF level 4 qualifications, are pitched at level 1 and have not received any information about the possibility of learnerships.

3.3.6 Supervision of CHWs

Apart from providing ongoing education, facility managers are furthermore expected to supervise CHWs. The NGO assumed the managers were responsible for supervision:

We take it that they are being supervised by the clinic sister because the clinic sister is signing off the log sheet.

However, the sub-district HIV manager and the facility managers all acknowledged that supervision was limited, as no direct on-the-job supervision was taking place. Supervision consisted of discussion at occasional meetings and of responding when CHWs came with queries:

The problems we experience, we take them to the clinic (CHW, clinic C).

If there is something I want to know, I go to the clinic and ask the sister (CHW, clinic C).

We report our problems to the sister-in-charge just as we do when reporting our patients' progress, so we take our problems to the clinic. The sister will advise you on what to do and if she is not able to, she will consult her seniors (CHW, clinic A).

But the facility manager at clinic C reported that even this informal form of supervision did not work, as the staff in the facility was too busy during working hours to attend to the queries of CHWs:

The community care workers, at times, they arrive here and try and try and try to reach the nurse, but in vain. So we have tried to solve this thing, asking what if we meet on Saturdays?

They eventually solved this problem by instituting regular Saturday meetings for feedback and discussions.

3.3.7 Implementing the CHW policies in the daily activities of CHWs

Prior to 2003, CHWs in the sub-district had worked largely as generalists, in close collaboration with clinic staff. The CHW policies contradict one another regarding the scope of activities because the EPWP implies that different categories of single-purpose workers should work throughout the system, while the NCHWPF emphasises the need for generalist CHWs with a wide range of basic activities. The provincial government, together with the NGO, evidently decided to follow the EPWP suggestions and to identify three categories of single-purpose workers to work in rural clinics, namely home-based carers, lay counsellors and TB DOT supporters. Implementers in the sub-district were aware of this categorisation, yet found it difficult to implement provincial directives. CHWs in the area had historically always worked as generalists. More importantly, after the introduction of stipend and the subsequent 'resignation' of most volunteer CHWs, facilities struggled to provide coverage within their catchment areas. Areas previously covered by 15 to 32 generalist CHWs now had to be covered by five CHWs, three home-based carers and two TB DOT supporters. There was general agreement among actors at the sub-district that the provincial policy directives could not be implemented literally, but some adaptation was needed:

So, the five CHWs, the two DOT supporters and the three [home-based] care workers have to share the areas. Each one may not have one area to look after. They may have two to three, which is very much difficult for them because those areas are too vast and they are too far. One cannot walk to that area on foot. She will have to use transport. [...] Yes, this is what I say to them: 'Look, people, you must not say that I am going to look after the TB people only, we have to share the duties. If you are a home-based carer, you have to look also for the TB clients. And even if you are a TB DOT supporter, you have to help the clients who don't have TB because our people outside are sick and some of the areas are not covered since there are no community workers or DOT supporters in that area. So you have to share the duties' (interview with HIV manager, sub-district).

The descriptions of CHW activities, as provided by CHWs, support the HIV manager's account:

As a community worker, I was handling everything because I was working with TB patients, and if somebody had TB, I would take that individual for DOT so that the patient will receive and start taking treatment. There are many people who recovered from TB after I made it a point that they take their treatment until they are discharged from the hospital. As I speak, I do have people with TB who are within my care. I also look at the welfare of the grannies who are pensioners. I look at the conditions in their homes. I will also look at the person who looks after them. If I see

that this person is very old and the condition she lives under is not good for her, and the person who stays with her is not taking care of her and does not clean the house, I tell them that an old person should not live like this. The old person should be bathed and be taken to the clinic. [...] People with bedsores – I deal with them. I dress them and the nurses will give the instructions on what to do and they will give me the kit, which includes the gloves. I take care of the patient until she gets better (CHW, clinic C).

I am a community health worker who proclaims a message to people in the rural areas. I heal people by talking, and advising mothers and children. I motivate them to take their children for immunisation. Everything that is supposed to be done by a health worker, I do (CHW, clinic C).

There are three of us and we are home-based carers. Our job is to go around the community. We look after TB patients and fetch their treatment from the clinic as frequently as required. We then take this treatment from door to door to the owners. In the mornings we check if they have had breakfast. We have to make sure of this because it is important to eat before they take pills. If the patient has had nothing to eat, you try your best to find something here in the house or cook porridge for him. If there is nothing to cook in his home we then supply him with the porridge we get from the clinic for such purposes. You prepare this porridge and feed your patient, and after 30 minutes you can then give him his treatment (CHW, clinic A).

The NGO representative appeared to be aware of a disjuncture between the intentions of provincial policy regarding the activities of CHWs and actual practice, but she saw it in a different and rather negative light:

It doesn't happen everywhere, but in some areas these volunteers are abused, abused in the sense that they are not doing pure volunteer work, as in being the extended arms of the clinic sisters. Sometimes they are expected to cook the clinic sisters' food or clean the halls and walls or mop the floors or whatever. Basically being a 'skivvy' [a type of informal slave] where we found that out in some of the areas.

Facility managers and CHWs did not report such activities, although one of the lay counsellors in clinic A reported that lay counsellors were doing some cleaning duties:

Lay counsellors report to the clinic in the morning and [...] because we cannot just start working in a dirty environment, we start by sweeping the floor if that is not done yet and dust the furniture. We do damp dusting after the usual morning prayers; one lay counsellor goes to work at the waiting room. There she gives the patients her daily speech. She will tell the people what the topic of the day is going to be and then start talking and answering questions. A good example of one of the topics is a speech on HIV/AIDS. For instance I would stand there and talk and try to explain everything about HIV to the community. Then, whoever suspects something about himself from listening to the signs and symptoms will ask to speak to me or my colleague in private.

We know from previous work in rural facilities, however, that since few clinics have cleaners or general workers, facility staff, whether nurses, nursing assistants or CHWs often have to clean their own facility out of sheer necessity. Clearly, while the NGO representative had some insight into discrepancies between their stipulations and local practice, she did not have sufficient understanding of local contexts or indeed practices to contextualise the limited information she had received.

3.4 Community participation in selecting, managing and co-ordinating CHWs

Like anywhere else in the world, the South African CHW policies emphasise the importance of community participation particularly in the selection of CHWs, but also in their management and co-ordination. The discourse of community participation, unlike other aspects of the policies, is well established in the implementation process, with virtually all actors buying into the principle. However, despite the unequivocal support, practice in the sub-district involved little community participation. All facilities had CHCs, although some had been established very recently, made up of representatives of different stakeholder groups within a facility's catchment area (youth, women, the headman, the ward councillor etc) and charged with supervising clinic activities. But community involvement in the CHCs was limited.

In clinic A, the facility manager considered that the requirement for the participation of the CHC in the selection of CHWs was met by virtue of the fact that several CHWs were in fact members of the CHC. However, a member of the CHC for clinic A had a different view of what happened:

The committee was not there, but the report was given to them by the sister-in-charge. The selection was authorised by other health workers and given to the sister-in-charge, who passed it on to the committee. She reported that the health workers had done the selection and she was not there either.

In clinic B, the CHC had not been established by the time CHWs were selected for stipends, so there had been no community participation and no involvement in activities of the CHWs subsequently. In clinic C, the situation was somewhat different. This facility had a very active CHC, which took a lively interest in the clinic's activities. Its members confirmed that they had not been involved in selecting CHWs, but were the only ones who expressed displeasure and frustration about this fact and pointed to the consequences of this lack of involvement:

We do have a problem here. The committee does not get involved when it is time to choose health workers. We just see health [workers] around, and that is the first problem. Even when training resumes, the committee is not aware, we are only told that so-and-so is a trained health worker. That makes the committee not [want] to support health workers.

The CHC members of clinic C had a strong sense of their role as community representatives. They emphasised their mandate to call facility staff to order and to oversee the smooth running of the facility and repeatedly made the point that a lack of involvement resulted in lack of support for the clinic and its activities. Their strong sense of purpose and direction was in stark contrast to the other two CHCs.

None of the members of the CHCs had received any form of induction, guidance or training for their roles:

From the beginning, it looks like these ladies never knew what the committee is supposed to do. [Yet] according to expectations, the health workers must rely on the clinic committee for guidance, and the committee should know what is going on (CHW, clinic A).

In contrast, the chairperson of clinic C's CHC had previously been part of a very active CHC and had received substantial political training in a neighbouring district, and he brought the necessary insight and skills to his new job.

Community participation in the implementation process was hampered by three factors:

- In two of the three clinics, CHCs had little understanding of their role. None of them had been properly inducted and had to rely on what their predecessors, most of them equally untrained, had told them.
- CHCs had not received any direct communication from either the sub-district or the province with regard to their specific role in the selection and supervision of the new CHW programme. As with the CHWs, most CHC members did not recognise the programme as anything other than a continuation of erratic government policies.
- Facility managers, who constitute an informational nodal point between management and communities, had not considered it as necessary or in their best interests to involve the CHC in CHW selection or other processes. (It was mentioned earlier that they had different justifications for this omission.)

3.5 Impact of the CHW policies on service delivery

There is no doubt about the intent of both policies to improve accessibility and coverage of health service in rural and under-served areas. The scope of this study did not involve an investigation of statistical information regarding coverage or health outcomes. We did, however, ask all actors what they felt the outcome of the new policies on service delivery in the sub-district had been.

We would first like to make three points. First, it must be emphasised again that the policies were not considered 'new', particularly by actors at facility and community level, but rather a continuation of previous CHW initiatives. Second, all respondents in this study viewed the policies as little more than the introduction of stipends to selectively reward CHWs and to regularise the activities of CHWs in certain categories. Third, the NGO representative's complaint that the stipend had 'destroyed' volunteerism in the area was repeated to us many times by sub-district managers, facility managers and members of CHCs. Most astonishing, however, was the fact that even some of the CHWs were uneasy about the impact that the introduction of the stipend had on their work and life:

We are getting money now and we never used to bother about it before when we just worked with dedication. We were not waiting for anything. But when this money issue started, we started to have some difficulties. It is the first thing that comes to our heads. You sometimes look and convince yourself that you are working for nothing. You compare your work to your electricity bill. We get so stressed towards month-end and when you look at your colleague you imagine her neck twisted to the other side because of financial stress, and immediately feel my own neck twisting as well. The money we get is extremely stressful. [We] should compare the time when we got absolutely nothing and now, and we should be happy to manage to buy at least a pair of shoes to walk with from this R1,000 (CHW, clinic A).

This CHW, who received a stipend, argued that it has introduced an undue concern with money, which has caused stresses unknown to her before she received the stipend. This appears to be a peculiar perception in a situation where monetary income is precious and hard to come by, but it probably reflects a combination of conflicting feelings. First, while the monetary income is undoubtedly welcome, CHWs on stipends are, of course, keenly aware of the fact that many of their colleagues do not receive stipends. In fact, this issue was so sensitive that, in two of the three clinics, CHWs refused to discuss it at all. Second, since the stipend is predictably considered payment for work done, the money is inevitably considered insufficient ("you compare your work to your electricity bill"). Third, many of the older women clearly experienced a tension between pride in their voluntary work as a service to the community and resentment that government was now either paying too little (if they were on a stipend) or nothing at all (if they were not on a stipend).

When asked about the impact of the new policies, most role players recognised their good intent, but emphasised the considerable drawbacks in the form of reduced coverage of patients and increased divisions among CHWs. Here are some memorable quotes:

People are complaining a lot. They say this stipends thing came to divide them because it was a sort of pick and choose. It would be better if everybody was given at least a stipend (interview with HIV manager, sub-district).

The areas that were covered by those community care workers, those areas are suffering a lot because [the number of] the community care workers we have now is so insufficient because there were seven community care workers, and the two that we selected to be inside the clinic as lay counsellors. Already it's five community care workers; our area is so large for them but these community care workers are trying their best to reach those areas. Under that mountain, there are homes there that are using this clinic, far over there, there are those homes there, they are using this clinic, and those ones; but our community health workers that we have are trying to reach them, they are stretching their distances of visiting, and they are visiting them. Even if they reach those people, they feel that they are not reaching them the way they wish to. They are visiting them, but not to their satisfaction (facility manager, clinic C).

I will also comment on the health workers issue. There were quite a few health workers at first, before they were supplied with soap [stipend]. The number dwindled after some time till the remaining few started getting soap. We, as the committee, were present and just watched. The health workers now started complaining: "Why?" The number of the places they are supposed to visit is much bigger than the number of health workers. Because they are few, they find it very difficult to cover all these places, though they try their best (CHC member, clinic C).

Both sub-district managers and facility managers raised concerns about the acceptability and quality of the younger CHWs, who they said lacked experience and did not know how to 'conduct' themselves in communities. In particular, community members had complained about lack of confidentiality. We were not able to verify these complaints, but the perceptions were evidently not uncommon. It is possible, however, that such perceptions were also exaggerated, particularly by older managers and CHWs who were unhappy about the appointment of younger, better-educated CHWs. But, while managers at the sub-district office confirmed concerns with reduced coverage and quality of service, they also stressed the benefits of the new policies. In particular, they emphasised that the policies enabled them to put systems in place where previously there had been none. They argued that the stipends necessitated a reliable database and committed CHWs to report on a regular basis through log sheets and narrative reports in clinics, something they had not been able to enforce previously. Overall, there appeared to be a great deal of ambivalence about the impact of the 'stipend policy', which was reinforced by uncertainty about its reliability and predicted longevity.

4. Discussion of results

The story of the implementation of the two CHW policies in the sub-district is a story of policy changing shape and losing much of its initial essence and intent in the process of implementation, leading to a perceived deterioration in access to and coverage of health services in the area. The policies were intended to improve access and coverage in chronically underserved areas, to mobilise communities and improve community participation in health, and to provide work opportunities for the unemployed, while also equipping them with skills that could lead to a career path in health services. Sadly, the policies as they are currently being implemented in the sub-district only provide work

opportunities for a small number of unemployed, without offering any career path opportunities and with very limited training and supervision. Large numbers of volunteers with many years of experience have left in disgust.

In this section, we will try to understand where, how and why the policies were stripped of their essence during the implementation process. Note that we will not address possible issues and problems in the policy *formation* process, such as the fact that two policies were developed by different departments that hardly communicate with each other. Instead, we will focus on the shaping, reshaping and thinning out of the policies in the process of translating them into practice as they inform all levels, from provincial level to community level.

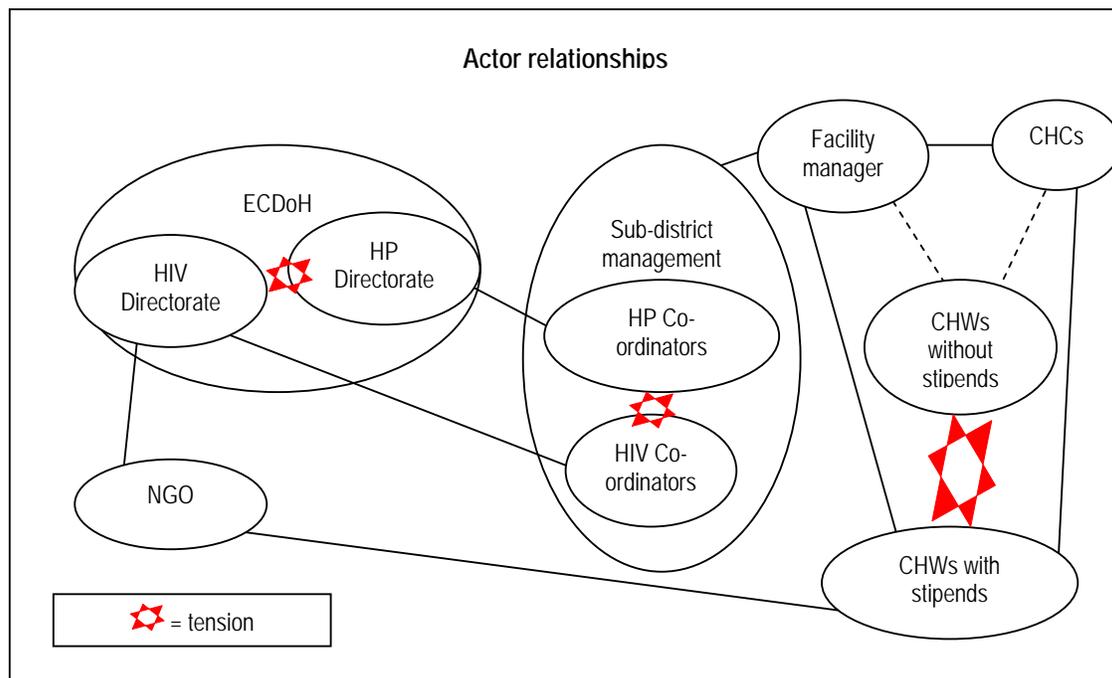
The key themes we identified were:

- the relationships between role players
- who has access to information and resources and who does not
- who participates in decision-making and who does not
- the use and abuse of power by role players.

4.1 Relationships between key role players

How different role players related to and worked with each other formed the basis of the entire implementation process. Table 1, which appeared earlier, summarised the different role players and their roles in the implementation process. The table indicates a distinct hierarchy in the ways in which role players had to play their roles. While at the provincial level, roles revolved primarily around control of resources (such as finances and information), sub-district and facility managers functioned primarily as information nodes, and CHWs played the role of recipients only in the process. However, hidden in this hierarchy are several points of tension and discordance, which found expression in relationships between role players at different levels (see *Figure 2*).

Figure 2: Power relationships between key role players



Competition for the programme's ownership and resources in the provincial health department led to tension within the DoH and meant that there was little or no collaboration between different Directorates within the DoH in running the programme. On the contrary, the CHW programme is considered an extension of the HIV/AIDS programme and its activities are understood to be focusing on HIV/AIDS activities. We were told by two managers that the fact that TB DOT supporters were being paid from the CHW budget was purely due to the generosity of the HIV Directorate. As a result, the implementation of a multi-faceted programme, and particularly the introduction of generalist CHWs as stipulated by the NCHWPF, was stifled. Arguably, the contestation and tension also contributed to a neglect of crucial policy elements, such as training and community participation, as the focus remained on securing budget ownership.

The power struggle within the province was largely mirrored in the sub-district, where considerable tension existed among the four managers, which revolved primarily around the new and very energetic HP manager coming into conflict with the old, powerful and not-so-energetic HIV programme manager. The sub-district manager had felt very vulnerable in her role, and was now making an effort to assert herself. In the conflict between the new HP manager and the old HIV manager, she appeared to be supporting the latter. It was clear from the tone of conversations and how we were directed to speak to whom that both felt exceedingly threatened by the HP manager. The new HIV manager, quite shy and withdrawn, appeared to be the least powerful of the main role players in the sub-district.

These tensions in the sub-district office clearly had an impact on policy implementation. Our impression was that both the HP and new HIV manager pursued their work with a real mission to improve health care delivery and make the best possible use of CHWs, while the two older managers did not have the energy or inclination to drive policies. Instead, they created stumbling blocks for any efforts, particularly by HP manager, to implement innovation. This problem is illustrated by conflict around access to transport - vital in a rural, spread-out district. The HP manager found it difficult to gain access to transport, which was controlled by the older HIV manager because she also held the transport portfolio:

HP manager: No, I have no problem [with travelling long distances]. I don't care whether it's far; I can reach it if you can just give me transport, I can reach it. Those are the places that health promotion should visit, those there. The problem is with the management.

Interviewer: You can't get the car?

HP manager: Yes, they do not see the way one can see. They prefer the transport to stay here [at the facility].

While tensions and contestation primarily took place within the province and the sub-district, alliances were mostly configured vertically in the provincial and sub-district HIV and HP programmes. Both HP and HIV managers had direct lines of communication to their provincial superiors, even though they reported to and were accountable to the sub-district manager. However, within these alliances, implicit tension existed, particularly between the provincial HIV Directorate and the young sub-district HIV manager. Although the manager was in charge of the programme, specifically training, she struggled to access resources that were controlled by the province, most specifically training budgets and materials. This substantially weakened her position in the sub-district and in the eyes of the CHWs.

Relationships between the sub-district office and facility managers and between facility managers and CHWs and CHCs around the CHW programme appeared cordial, although hidden tensions, particularly around the selection of CHWs, may well have existed which were not verbalised. There was obvious tension between CHWs who received stipends and those who did, yet this was never mentioned either. Most CHWs with stipends were younger and better educated but less experienced, but found themselves in the rural context, less respected, less vocal and less powerful. Most CHWs without stipends had withdrawn their

services to communities, but in our engagements they came across as vocal, extremely experienced and still very powerful in their communities. There is no question that their presence and their voice in the focus group discussions silenced most of the younger CHWs, yet within the policy framework they spoke from a position of powerlessness.

It is striking that tensions among role players existed primarily horizontally when two interest groups at the same level competed for authority and resources. There were no strong alliances forged to drive the implementation process, although vertical alliances did exist. As a result, the implementation process presented itself to us as marked by unease and apprehension, which in turn hindered rather than supported the process.

4.2 Communication and information flows during the implementation process

Communication and access to and use of information were crucial in shaping the CHW programme in the sub-district. In terms of information, two types relevant to the implementation process can be distinguished: information regarding policy intent, objectives, and rules and information regarding front-line policy practice. Access to the written policies (the actual documents) appears to have been confined to the Province's HIV Directorate and the NGO. Neither the staff members of the Provincial HP Directorate nor any of the role players at sub-district, facility and community levels had seen any of the policy texts. While the HP Directorate had been able to pick up information about the broad scope and intent of the policies, the only information provided at the other levels was that selected CHWs were to receive stipends and were to be trained in the 59-days home-based care course. No information about the intended scope and structure of the policies, training and career path opportunities, different levels of CHWs, supervision, and community governance had been shared with sub-district and facility managers or community members, including CHWs themselves. As a result, implementation action at the sub-district was taken around just one element of the policies, namely the administration of stipends.

The lack of comprehensive instruction and guidance also meant that front-line implementers were left to their own devices in interpreting and finding ways to make the one instruction they received work under local conditions. This became most obvious in the selection process, when facility managers used rumours about entry criteria to select five stipend recipients from a large number of volunteer CHWs and ignored instructions to involve CHCs. The lack of information about and resources for training also meant that the HIV manager's role and authority in training was undermined, while the HP manager used this vacuum to assert her role by instituting regular monthly meetings, which served a continuing education function for CHWs. Facility managers simply incorporated new practices into existing practices and continued with existing informal supervision practices. Managers who used selective communication and information, combined old and new practices and made up rules to fit the circumstances caused a serious lack of clarity at the sub-district and facility levels, while the situation at community level became even more opaque. In our engagements with CHWs and CHCs, we tried unsuccessfully to get them to distinguish clearly between old rules, requirements and practices and the new policies. They did not recognise the new policies as new, but rather a continuation of about 20 years of shifting official practices around community health work.

Communication and information flows from the province to the sub-district, facilities and communities were minimal and severely limited role-players' understanding of the scope of the policies along the communication chain. In addition, information about actual CHW practices only flowed up the information chain intermittently and selectively. Information about the tasks CHWs performed in communities was largely confined to CHWs themselves and the communities they worked in. Even facility managers had very limited insight into these activities, as they never accompanied CHWs on their rounds and relied on information from CHWs or community members, including patients visiting the facility and CHC

members. Similarly, local arrangements of task allocation, training and supervision were not known to any of the role players at provincial level:

The actual [daily] management and supervision of community health workers is better understood at this moment by the [sub-district] area manager, and the HIV/AIDS programme manager at that level (interview with HP manager, provincial level).

There was agreement among sub-district and facility managers that home-based carers and TB supporters should work as generalists to ensure improvement of much deteriorated coverage, a fact which was certainly not known by provincial managers. With regard to supervision, provincial authorities assumed that facility managers had taken on that responsibility, but there was no information or insight into whether and how supervision was taking place in facilities and communities. Furthermore, it appeared that provincial role players had not given any thought to nor been informed about the impact that the introduction of stipends had already had, particularly on coverage levels, as most volunteers withdrew their services.

Was the poor communication and withholding of information intentional? Our engagements with role players suggest that this may have been the case on a few occasions, especially where tension existed in organisational structures. There is little doubt that the HIV Directorates at provincial and sub-district levels intentionally kept their health promotion colleagues out of information loops (supposedly because the CHW programme was not a health promotion responsibility). However, indications are that, in the vertical channels, lack of communication and information was more the result of omission and poor management practice than of intent. Managers at all levels passed information down to their subordinates only on a 'need-to-know' basis. As a result, the flow of information became thinner and thinner until, by the time it got to community level, it had virtually dried up. None of the role players, with the possible exception of the sub-district health promotion manager, had any concept of the importance of communication or participatory and inclusive management practices.

4.3 The use and abuse of power by role players

It is evident that relationships, particularly tensions between actors, as well as management practices, had a deep impact on how CHW policies were introduced and implemented in facilities and communities. Tensions between government departments, in particular, led to a reduction in the scope of CHWs' activities and a focus on just one element of the policies as formulated at national level, namely the payment of stipends. Relationships and poor management practices also led to patchy and selective communication, which meant that role players below the provincial level had very little knowledge about the policies' scope and intent, while role players at the provincial level had little insight into practices 'on the ground'.

We mentioned in the introduction that the role of power in policy implementation processes is an under-researched, yet crucial, aspect of understanding policy implementation. In the webs of relationships and tensions described in this paper, role players exercised or attempted to exercise power in several ways. If we expand *Table 1* (on role players and their roles) to explore how they exercised power in their respective roles, we find a fairly clear hierarchy between those exercising power proactively (mainly at provincial and sub-district levels) and those who exercised power reactively (mainly and community and facility levels).

Table 2: Proactive vs reactive power: How role players exercise their power through roles

Role players	Roles	Power exercised proactively?	Power exercised reactively?
DoH/HIV Directorate	<ul style="list-style-type: none"> Control resources Influence policy 	x	
DoH/HP Directorate	<ul style="list-style-type: none"> Attempt to influence policy Attempt to access resources 		x
NGO	<ul style="list-style-type: none"> Controls funds and who receives salaries 	x	
Sub-district/HIV manager	<ul style="list-style-type: none"> Claims authority over CHWs because of budget location In charge of training 	x	
Sub-district/HP manager	<ul style="list-style-type: none"> Institute monthly meetings Organise training 	x	x
Sub-district manager	<ul style="list-style-type: none"> Little involvement, but appears to be supporting HIV manager over HP manager 		
Facility manager	<ul style="list-style-type: none"> Information node between sub-district, CHC and CHWs Ultimately controls appointment of CHWs Day-to-day supervision 	x	x
CHW with stipend	<ul style="list-style-type: none"> Chosen by virtue of their education qualifications Receive stipends, but appear not very vocal or powerful 		
CHW without stipend	<ul style="list-style-type: none"> Most withdrew their services when stipends were introduced and they were excluded Used FGD to voice their discontent 		x
CHC	<ul style="list-style-type: none"> Vocal and actively involved in one facility Not involved in selection in any facility 		x

In the next three sections, we will explore in more detail the sources and bases of power in relationships between actors, as well as the way in which power was exercised. We will focus on three aspects specifically which stand out in the implementation 'story':

- the abuse of power that led to the thinning out or reduction of policy scope and objectives;
- the power that reshaped policy practice in communities; and
- the health promotion manager in the sub-district, who used her discretionary power to strengthen implementation.

With regard to the first aspect, we will discuss how proactive and authoritative power was used to provide or withhold key resources in the implementation process, while in the latter two we will focus on different uses of discretionary power, both proactively and reactively. In this context, discretionary power is defined as the 'scope of action' that front-line operatives use to resist, cope with or shape policies (Barrett, 2004).

4.3.1 How role players abused their power to reduce policy scope and objectives

A significant outcome of the policy implementation process has been the reduction or thinning out of very complex policy intents and objectives to a single outcome, namely the payment of stipends to a small number of CHWs. It was mentioned earlier that role players were only informed selectively about the content of the policy. But further than that role players in all likelihood were also mainly informed about that which they understood and were comfortable with, leaving out that which was too complex to understand or difficult to

implement. Their power to decide (consciously or unconsciously) what information to pass on and what information to withhold was gained by virtue of their status in the implementation hierarchy and the authority this gave them.

As the main agency charged with implementation by the national DoH, the provincial HIV/AIDS Directorate, together with the commissioned NGO, had access to the greatest amount of information. We were told that they had been invited to workshops where the policies had been discussed, and they evidently had most relevant documentation in their possession. The NGO representative was the only role player we met who knew about the policies' stipulations regarding training and NQF levels. The placement of the budget and authority in the HIV Directorate allowed the latter to focus all other role players' attention primarily on the HIV activities of CHWs. Not only did they play down or omit CHWs' stipulated roles as generalists or specialists in different fields – a stipulation that would have called for collaboration with other Directorates, and particularly the HP Directorate, which was intentionally left out of the implementation loop. Their monopoly on information also allowed them to disregard the complexities of the policy and focus on the fairly simple payment of salaries, thus also simplifying their own responsibilities.

The process of simplification and further reduction is repeated particularly at the facility level where facility managers used their monopoly over information flowing from the sub-district into communities to manage particularly the CHW selection process more easily. Because all information from the sub-district office passed through them, they had the power to withhold the crucial information that communities were meant to play an important role in the selection and management of CHWs and to misinform CHWs about entry qualifications. While it would appear that the omission of the communities' role was quite deliberate, the spreading of misinformation was less deliberate and more a lack of clear understanding on the part of facility managers. However, because they were imbued with authority at this level of implementation, they had the power to interpret (misinterpret) the policy as they came to understand it and to pass this interpretation on as fact.

Why did managers use their authoritative power to resort to misinformation and omission? Undoubtedly, a lack of understanding and inability to fully understand the complexities of the policy were part of the reason, particularly with regard to facility managers. This raises questions about the level of complexity of policies and implementers' ability to grasp these and translate them into practice. Would less-complex policies have a better chance of being implemented in line with their original intent? A comparative analysis of different policy implementation process would be of interest here.

Another explanation for the thinning out of policy may lie in Barrett's observation regarding the role of organisation culture in the policy process. Arguing that policy change "very often involved bit organisational and cultural change", she asserts that "policy is only implemented when it has become encultured in the 'normal' way of doing things" (Barrett, 2004). CHWs were and are undoubtedly not considered part of the health system by provincial Directorates, and in fact are explicitly organisationally excluded by outsourcing their management. It is not very surprising therefore that their management was not part of the organisational culture and therefore reduced to the minimum, the payment of stipends. At facility level, CHWs were very much part of the organisation, but according to locally established rules and cultures. The new rules and guidelines did not fit established practices and complicated the lives of facility managers who utilised their power to circumvent them.

4.3.2 Use of reactive discretionary power in the communities

Communities had no authoritative power in the implementation process, but made use of discretionary power at their disposal to shape certain aspects of the policy. Two instances of the use of discretionary power can be specifically identified.

In the first instance, managers at sub-district and facility level and CHWs jointly agreed that it was impractical to have CHWs in communities do specialised tasks, namely TB support and home-based care. They therefore decided, against provincial government's specification, to ask all CHWs in communities to work as generalists and support each other. Their scope of action or power emanated from the fact that all role players at this level agreed that this was the only sensible way to make the policy work under local conditions, and they had knowledge of local conditions to do so. Furthermore, the authoritative power of the provincial government was far away and had neither insight into frontline practices nor the ability to control these. It is ironic that the process of reshaping the policy to fit local circumstances, role players in this case re-introduced an important element of the policies' original intent, namely the use of CHWs as generalists.

The second instance of the use of discretionary power is by CHWs who withdrew their services after they learnt that they would not be receiving stipends. These CHWs acted from a position of 'weakness', and made use of the only form of power they had at their disposal (short of open revolt) – the removal of their contribution as CHWs. This action did not constitute open resistance, and these CHWs, if asked, undoubtedly would not have considered themselves in a position of power. They used the only leverage they had at their disposal – withdrawal. The result of their action was the reduced coverage of health services in the sub-district and deteriorating accessibility for community members. However, this impact was felt only by communities themselves. Managers at provincial level appeared to not even be aware of the fact that services had deteriorated as a result of the introduction of stipends.

4.3.3 Use of proactive discretionary power by the health promotion manager

Lastly, we want to discuss a special instance of the use of discretionary power by the health promotion manager in the sub-district. It was mentioned before that the sub-district manager played a largely passive role (but supporting the HIV manager), and the HIV managers controlled access to resources and to policy-related information and was imbued with official authority and responsibility for the programme. Like the provincial HP managers, she had no official function in the programme, and thus did not have any authoritative power in the implementation of the programme. Like her provincial colleagues, she felt strongly that the CHW programme should fall under the health promotion manager, as it should cut across all programme and health promotion staff worked closely with community structures. But, in contrast to the provincial managers, she had successfully fought for a position for her programme. Several factors contributed to this success. Firstly, and importantly, she stood out as an exceptionally energetic and optimistic personality, with a deep commitment and drive to improve service delivery in the area. Secondly, she had come into her post well qualified, with some relevant experience in the new HP portfolio and with a very clear vision of what she wanted to achieve in this portfolio. While she met resistance and was undermined by colleagues in the sub-district office, she nurtured relationships with facility managers and CHWs, which allowed her to build somewhat of a constituency in the communities of the sub-district. This allowed her to eventually succeed to instituting a regular monthly feedback and continuing education meeting which, from our own observation, proved highly popular with all CHWs. The idea was initially resisted by her colleagues, but she had persisted and had initially experienced sharply dwindling numbers, but by the time of our visit had succeeded not only to entice over 100 CHWs to attend these meetings at their own expense, but also to convince her colleagues to actively participate. As the HP manager noted:

I was around but I was not involved; they didn't involve me. In fact, it was not acceptable for a health promoter to be involved in community health workers here at Emahleni, but I still keep on doing these monthly meetings because now, without community health workers, my job will not exist. [...]The HIV/AIDS manager and I

were fighting when I started to work here, about the community health workers. I sat down and I explained why I need the community health workers, and without them I cannot succeed. Then they've seen that this [meeting] is working. Now when there's a meeting for community health workers, I say "I'm busy doing an agenda, who wants to go?" Everybody is going to slot for their programme; this side, things are going very smooth now; they can even disseminate their own issues in the meetings.

In the process of using her discretionary power through knowledge, persistence and continuing positive discourse with all role players in the sub-district, the HP manager contributed enormously to strengthening the CHW programme. She provided training, albeit informal, where the HIV managers did not manage to organise formal training, she consulted with and advised facility managers regarding various activities of CHWs and their support and supervision. And she ensured that the CHWs and their activities were firmly within the vision and on the agenda of the sub-district's planning and management activities, and that managers were eager to interact with them.

The above examples reflect very different uses of power in the policy implementation process. It is disappointing that, in all but the last example, power, whether authoritative or discretionary, was used to narrow down and thin out the scope of the policy from its initial intent. The last example, on the other hand, highlights the productive impact of the use of discretionary power against those in authority to strengthen and be true to the underlying values and the mission of the policy. While the HP manager did not 'conform' with policy processes, as set out by authority, she undoubtedly enhanced the 'performance' of the policy through her actions (Barrett, 2004).

5. Conclusion and recommendations

In this study, we set out to explore how two community health worker policies, namely the Extended Public Works Programme (EPWP) and the National Community Health Worker Policy Framework (NCHWPF), were shaped and transformed in the process of being implemented in one sub-district in South Africa. More specifically, we wanted to investigate how role players at different levels of the implementation process interacted with each other and the policy and how they used power at their disposal in this process.

We found that selective communication and lack of information, particularly from the provincial to the sub-district level, led to a reduction of the scope of the policies to the payment of stipends. As role players at the district and community levels did not have information to understand the content and scope of the policy, their actions were shaped by what they were informed about: the need to pay stipends to selected CHWs and to have them work in specialised fields. While they did not have the power to change the stipend rules, which were set and implemented by the provincial NGO, they did use their knowledge of local conditions, control over local knowledge and distance from the provincial capital to continue to use CHWs as generalist health workers.

Information, communication and knowledge turned out to be the most crucial elements impacting on how the policies were translated into practice. Access to information allowed the provincial HIV Directorate and the facility managers to select which aspects of the policy they wanted to see implemented: the provincial Directorate chose to focus on stipends and HIV/AIDS, conveniently choosing the narrowest possible interpretation of the policies. Their concern, at provincial and sub-district level, was primarily with 'conformance' rather than 'performance' (Barrett, 2004). The district managers similarly chose to omit the need for community participation from the implementation process. In both cases, it can be assumed

that the reductions are caused by role players' inability or unwillingness to conceive of the implementation process in more complex ways.

In contrast, the sub-district health promotion manager, although not informed of the full scope of the policy, saw its potential for the improvement of quality of care and pursued it vigorously. She had had appropriate training, experience in another sub-district, and she had the confidence and skills to follow her goals against significant resistance. It is worth speculating a little bit what might have been different if relationships had been more cooperative and information had been accessible and flowed freely. Most important is the question, whether a reduction in coverage and the almost total neglect of training, supervision, and career development could have been avoided.

I am not sure whether we could have avoided the key contradiction in wanting to pay CHWs but having a limited budget available and so having to choose who will get the stipend. Evidently all role players had in one way or other battled with this contradiction; all felt the unease, but few had alternative solutions. One suggestion made was the full decentralisation of the budget to sub-district and community level and a more equal distribution among a larger number of CHWs. Quite likely a negotiated process which had included genuine engagement with community actors could have avoided the build-up of tension in communities and the embittered withdrawal of many of the experienced CHWs. The unquestioned exercise of authoritative power by the province and the NGO had no scope for negotiation and rendered CHWs powerless in this context, except for their ability to withdraw their input – which many of them did at the expense of coverage and access. Had communication and information about the full scope of the policy been better, there possibly might have had to be more negotiation around issues of qualifications, training and supervision. That this did not take place would simply have been due to the fact that most role players did not know about the content of the policy and those in authority who did know chose (purposefully or not) to withhold this crucial information. Barrett argues that 'policy is only implemented when it has become encultured into the 'normal' way of doing things'. In our case study the only aspect that could easily become part of 'the normal way of doing things' was the payment of stipends within a set and agreed-upon structure. The health system appears to know nothing about integrating and caring for CHWs. In fact, it has so far taken great care to keep CHWs out of the system, despite increasing reliance on them. It therefore is hardly surprising that complex training and career-pathing arrangements do not easily become part of the daily running of health services. It would need local champions who persist in advocating and driving these aspects of policy implementation.

But beyond the difficulties of implementing these particular policies, the case study reflects more general concerns with policy implementation processes. As long as it is not acknowledged by role players in these processes that "implementation should be regarded as an integral and continuing part of the political policy process rather than an administrative follow-on" (Barrett, 2004: 253), we are likely to find vast divergence between policy formulation and policy outcome. Those in charge of policy formulation should surely accompany the implementation process. Their activity ought to begin with a careful assessment of the status quo (patently absent in our case study) and possibly result in less complete and more flexible policy documents that are suited for negotiation and learning aimed at reshaping in the implementation process.

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Acknowledgements

The authors gratefully acknowledge the assistance and input from the following organisations and individuals: the staff and community members of the district and province who shared their experiences and insights with us, EQUINET and IDRC (who supported and funded this project), the Centre for Health Policy, Lucy Gilson, Ermin Erasmus and Helen Schneider.

Acronyms

CHC	Community health committee
CHW	Community health worker
DoH	Department of Health
EPWP	Extended Public Works Programme
FGD	Focus group discussion
HCBC	Home community-based care
HP	Health promotion
NCHWPF	National Community Health Worker Policy Framework
NGO	Non-governmental organisation
NQF	National Qualifications Framework
TB DOT	Tuberculosis – Directly observed treatment
UWC	University of the Western Cape
WHO	World Health Organisation

Equity in health implies addressing differences in health status that are unnecessary, avoidable and unfair. In southern Africa, these typically relate to disparities across racial groups, rural/urban status, socio-economic status, gender, age and geographical region. EQUINET is primarily concerned with equity motivated interventions that seek to allocate resources preferentially to those with the worst health status (vertical equity). EQUINET seeks to understand and influence the redistribution of social and economic resources for equity oriented interventions, EQUINET also seeks to understand and inform the power and ability people (and social groups) have to make choices over health inputs and their capacity to use these choices towards health.

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