Applying Policy Analysis in Tackling Implementation Gaps

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Introduction

Around the 2004 Global Health Forum there were strong calls for increased investment in health systems research based on recognition of the 'know-do' gap (Editorial, Lancet 2004: 1555). This gap represents the difference between our knowledge about the interventions that can cost-effectively improve public health and our knowledge about how to bring about their implementation. In tackling this gap a series of papers in the Lancet (e.g. Travis et al., 2004; Victora et al., 2004) pointed to the importance of addressing the health system factors that constrain delivery of effective interventions. The constraints identified include financial and human resources, organisation and delivery of services, governance, stewardship and knowledge management, and global influences (Task Force on Health Systems Research, 2004). All are important. However, there is a tendency in current debates about the know-do gap to suggest that the core problems are the weak use of available evidence on cost-effective interventions and the failure to hold health workers accountable for their actions; both are then sometimes linked to a lack of political will to improve implementation. To caricature this perspective, it seems to suggest that better investment decisions and more committed politicians would ensure that public health policies and interventions intended to benefit the poor, are implemented with expected outcomes. In this frame, implementation is essentially seen as a linear, top-down and centrally-directed process, in which those responsible for implementation simply follow the policy instructions that percolate down to them.

This perspective denies the importance of power and politics over policy change in general, and, in particular, over policies that seek to promote equity. Such policies are almost always subject to contestation as, in seeking to benefit powerless groups, they challenge the status quo and the associated vested interests (e.g. Reich, 1996; Nelson, 1989; Williams and Satoto, 1983). In addition, health systems themselves reflect the wider patterns of social inequality of any society (Mackintosh, 2001). Equity-promoting policies, thus, often challenge the norms, traditions and hierarchies within health systems that shape health professional practice, and influence who gets access to health services, as well as the treatment and nature of care offered to different social groups. Recent experience in Tanzania, for example, demonstrates how poor people's experience of abuse at the hands of providers is a key facet of their experience of impoverishment, of their social exclusion (Tibandebage and Mackintosh, 2005). In South Africa, meanwhile, nurses' critical attitudes towards groups such as teenager mothers and poor patients have been argued to reflect their own struggle to assert their professional and middle class identity and to have become the norm given a lack of alternative discourses of patient care (Jewkes et al., 1998). Policies promoting equity face resistance at every level.

The importance of power indicates that the analysis required to support the implementation of equity-promoting policies must move beyond delineating existing patterns of inequity or considering what interventions represent best buys. Instead, at one level, it must track and challenge the global and national forces that prevent the development of such policies or worsen existing inequity. At another level, it must enable better understanding of the people involved in policy implementation and the factors driving their actions in particular contexts. Together such analyses will provide the basis for determining the strategies that can sustain the complex process of implementing any change intended to benefit the poor and powerless. These are the roles for policy analysis.

Recognising the necessity of conducting work at both levels, in this paper we particularly focus on the second. Ultimately any policy or health system change, whether generated from within or outside national environments, has to work through

those responsible for service delivery, and their interactions with the intended beneficiaries of those changes. Yet we continue to know too little about the experiences of these groups, including how their words, actions and beliefs shape the practice of implementation.

Policy analysis perspectives highlight the complexity and messiness of real world policy-making - in which actors' decision-making is influenced by, among other factors, their beliefs and values, the practices and power of other actors, their networks with other actors, and the political space for debate and negotiation in specific contexts (Walt and Gilson, 1994). An important body of implementation analysts, who draw both on policy analysis and organisational management theory, are known as 'bottom-up' theorists. They emphasise that implementation represents a policy-action relationship that 'needs to be regarded as a process of interaction and negotiation, taking place over time, between those seeking to put policy into effect and those upon whom action depends' (Barrett and Fudge, 1981: 4). Rather than seeing implementation as the simple and mechanical transfer of policy intent into practice, these theorists focus attention on the role of policy implementors in shaping and re-shaping 'what develops between the establishment of an apparent intention on the part of government to do something, or stop doing something, and the ultimate impact in the world of policy action' (O'Toole, 2000: 266).

The theorists propose that actors such as local health managers and frontline health workers themselves directly influence the form that any policy takes within the routine practices of health care delivery systems, through their words and actions. Their views are, in turn, influenced by the culture of the organisation and society in which they work (Gilson and Erasmus, 2004). In public sector bureaucracies in particular, policies are also filtered through the ways in which these street level bureaucrats respond to and cope with the enormous pressures under which they work – such as high levels of demand, resource scarcity and uncertain job security (Lipsky, 1980). Attempts to control the actions of street level bureaucrats only serve to encourage resistance to these actions, and act to increase their tendency to stereotype and disregard the needs of clients (Hill and Hupe, 2002). Alternatively, implementation practice may reflect the compromises achieved amongst the networks of actors that are always involved in implementation and that are necessary to enable action by the network (Barrett and Fudge, 1981). Finally, acceptance of the legitimacy of policy changes initiated at central levels by health workers and managers, is vital to whether and how they implement them (Lane, 1987; Rothstein, 1998).

Recognising the importance of policy analysis perspectives in understanding the challenges to equity-oriented policy change, EQUINET, the Regional Network for Equity and Health in Southern Africa, initiated a programme of policy analysis work in 2003. EQUINET is a network of analysts, advocacy groups and policy makers working at regional and country level within Southern and Eastern Africa, which also has links to international partners. The policy analysis programme combined opportunities for capacity building, through training and mentoring, with support for undertaking a set of small scale research studies. This paper presents an overview of these studies. It demonstrates how examining the influence of process and power over policy implementation can aid understanding of how to support and manage the implementation of equity-promoting policy and practice. The four studies are:

- A policy analysis of the budget process for primary health care in Zambia (TJ Nguble, CHESSORE, Lusaka);
- Investigation of the factors influencing enrolment in the Tanzanian Community Health Fund (P. Kamuzora, University of Dar es Salaam);

- Addressing the constraints on implementing equitable service delivery policies at sub-district level (V. Scott and V. Mathews, University of Western Cape, Cape Town);
- A discourse analysis of policy documents concerning public-private interactions in South Africa (E. Erasmus, University of Witwatersrand, Johannesburg).

The first three analyses focus directly on the experiences influencing the implementation of a set of policies intended to generate equity gains. The fourth seeks rather to understand how the discourse of policy documents may influence implementation.

This paper presents the main findings of the studies and then discusses their implications for the task of managing implementation. Finally, building on these insights, it describes the new programme of policy analysis planned within EQUINET.

Investigating implementation experiences

The three studies that examined the experiences of implementing equity-oriented policies all involved case study work in purposively selected geographical areas, and collected information through some combination of in-depth interviews, group discussions, document reviews, observation and secondary data analysis.

All show the relevance of the bottom up theoretical insights to understanding implementation practice in African health systems. They demonstrate the:
- practice of power within these systems;
- types of conflict that can arise between the driving beliefs and views underpinning implementors' behaviour and the equity goals of policies;
- negative consequences of imposing policy change without taking account of current power relations and belief sets.

(1) Analysing experiences surrounding the introduction of bottom up priority-setting approaches in Zambia (Ngulube, 2005)

Zambia introduced a set of wide-ranging health system reforms in the 1990s. These were built around a programme of decentralising management authority to districts, and sought to re-orient the health system towards primary health care in order better to meet the health needs of the majority of the population. As part of the reform programme, guidelines for planning and budgeting were developed to encourage new processes of priority setting that would involve partnership with all stakeholders at the community level. Indeed, partnership was established as one of the three primary guiding principles of the Zambian reforms. The partners identified as relevant to local planning and budgeting activities were district health managers, health facility managers, health centre and local area committees that included community representatives, and non-governmental organisations and donors working in localities. In practice, however, the study shows that planning and budgeting continued to be bedevilled by a series of problems, and that intended improvements in primary health care delivery have not been realised.

Some of the problems were those that commonly undermine the delivery of care in Africa, such as financial resource constraints and staff shortages and attrition. Others represented weaknesses in planning and budgeting, such as a lack of transparency in determining overall budget guideline figures for districts and concerns about the accuracy of the population figures used in these decisions. However, the key problem faced in implementing a decentralised approach to priority setting was that,

despite the policy rhetoric, too much power was retained at the national level. Central guidance and direction is, of course, required in any budgeting process in order to bring together the inputs of many different areas and facilities and, in particular, to offset the potential resource allocation inequities that might result from a fully decentralised process. However, to support partnership in priority-setting at the local level, such guidance must allow for compromise and negotiation between actors across the system, rather than serving to constrain the influence of implementing actors over decision-making (Table 1).

Table 1: Indications of power by step of budgeting process and stakeholder

Steps of budgeting process	Level of power over step of budgeting process			
	National	District	Health centre	Community
1. develop indicative planning figure	yes	some	none	none
2. determine basic health care package for primary care	yes	none	none	none
3. prepare planning and budgeting guidelines	yes	some	none	none
4. PHC priority setting at district level orientation meeting	yes	yes	some	none
5. incorporate prioritized health issues in the district budget	yes	yes	some	none
6. PHC priority setting at health centre level orientation meeting	some	some	yes	none
7. incorporate prioritized health issues into health centre budget	some	yes	yes	none
8. PHC priority setting at community level	some	some	some	some
9. incorporate prioritized issues into community health budget	yes	yes	yes	none

Source: interview and documentary material, and observation

The centralised control of planning and budgeting was probably a response to the threat of losing power facing some central level bureaucrats. However, Ngulube argues that it was also re-inforced by two other interacting and at least equally as important influences.

First, initiated by a small group of reformers working at the national level, the reforms were both not well understood by local level implementors and yet, accepted just because they were associated with the political elite. Essentially, the primary obligation of implementors was (mis-)understood as being seen to support government policy, and so managers were concerned to ensure that implementation was problem free rather than directed at specific outcomes. Any efforts to identify local priorities linked to outcomes were generally overlooked in the attempts to ensure smooth implementation. Local managers often only sought community views from those already known to be associated to the party in power, and thus supportive of the policies, ignoring even influential local councillors associated with other political parties. *'As area councillor from the opposition I am heavily sidelined by the health centre committee. They have brought a lot of politics. They think and say that all programmes in this area must be initiated and run by the ruling party without looking at their abilities to perform. The HCC members here have closed against me. They don't consider me as their civic leader. I have always been open but they don't want to associate with me just because I am not from the ruling party'* (community key informant). Given the legacy of a one-party political system, few middle or lower level managers had the skills, experience or inclination to engage in a process of actively testing and critiquing new policies, and power continued to lie in the hands of key reform leaders.

Second, the pre-existing power relations within the health system and wider community underpinned resistance to changing accepted practices. The norms driving implementors' behaviour included both the bureaucratic compliance of lower levels to higher levels:

'We have never tried to advise higher authority before (on the situation at grassroots level)… We are being governed by (civil service) general orders. Our corresponding

role is compliance, which is all we can do. If you don't, then you are perceived as a wrong person, a mis-fit. All we are expected to do at the bottom is merely provide compliance because that is how communication channels have been designed in our government system' (health worker at facility level)

and a reluctance to question elders, superiors and officials:

'Our background is such that when government has sent us their officers to explain about new policy changes (which appear to be) somewhat to our advantage, our role as a community is to comply and not be antagonistic. Even the Holy Bible says that in order to be a good citizen, one must be loyal and obey the state. It is often this spirit of blind loyalty that has continued to kill us in terms of community development' (community leader).

As a result, community representatives often felt unable to engage district authorities or were rebuffed when they sought such engagement, and health facility staff who by-passed normal bureaucratic channels in order to present their views were accused of being trouble makers. District authorities also managed the budgeting and planning processes in ways that allowed them to retain their authority - such as by only releasing information to lower levels and the community that reflected their own views of how budgeting should occur. Although reluctant to even appear to challenge higher levels, health facility staff also continued to exert power over community members. Some community members, thus, reported continuing to sit on committees they judged as toothless for fear of being singled out for intimidation by health workers, whose professional roles continued to give them authority within the wider community. The authority of these community representatives was also undermined by their own lack of knowledge and skills and by their lack of legitimacy in the community's eyes (given that the selection process was driven by health workers).

The end result of these various forces was that there was barely any local level partnership in priority-setting to address the needs of the community. Instead lip-service was paid to this goal and implementors just got on with the business of self-preservation in the face of the top-down exercise of power.

<u>(2) Investigating the causes of low enrolment in the Tanzanian Community Health Fund (Kamuzora, 2005)</u>

The Community Health Fund (CHF) is a district-level, voluntary pre-payment scheme targeted at rural residents and those who are informally employed. It was initiated in 1995 in quite a top down manner - that is, with little active engagement between policy developers and those given the responsibility for implementation, after a process of policy design essentially involving only a few central-level actors. The guidelines for the CHF outline a management process in which the Council Health Service Board (comprised of local government and community representatives) has oversight of district level activities and local area (ward) committees are intended to support implementation. However, the primary responsibility for implementation lies in the hands of the Council (District) Health Management Team.

The CHF has so far only been implemented in some geographic areas, and like other community pre-payment schemes, suffers from low enrolment rates where introduced. Past evaluations of CHF experience show that this problem is linked to four main factors: the limited ability to pay for membership contributions among many poor households, the poor quality of care available, limited trust in CHF managers, and weak acceptance of the need to insure against health risks among the

population. Confirming these problems, this study also went further in investigating whether these problems affected households of different socio-economic groups differently, as well as how the practice of implementation contributed to them.

The findings summarised in Table 2 show, first, that despite recognising the risks of being ill, the poorest groups did not enrol largely because they just could not afford to pay the contributions. In contrast the more wealthy groups were deterred from enrolling by a range of management problems as well as their own judgement that they could manage the risks of being sick just by paying when ill.

Table 2: Unpicking the implementation problems of the CHF

Problem	Impact on different wealth groups	District managers' actions as influences over problem
Limited ability to pay for health care among poor people	Many, but especially poorest, do not enrol	Failed to • implement an effective exemption mechanism for the poorest • take seriously proposals for exemptions received from community level
Poor quality of care provided by health facilities	Slightly wealthier groups, in particular, do not see why should pay for poor health care, so do not enrol	Despite guidelines, failed to • improve general supervision of primary health care facilities; • respond quickly (or sometimes at all) to community level requests to use funds raised to improve quality. No allocation of funds to support CHF administrative activities and, in particular, to support work of community committees.
Lack of trust in managers of scheme	Slightly wealthier groups, in particular, do not think managers will ensure scheme works well so do not enrol	Pre-existing concerns about management among community were only exacerbated by district managers' failures to: • take action necessary to strengthen quality of care; • respond to community inputs on CHF; • make information on CHF available; • ensure transparency about CHF funds.
Limited acceptance of need to insure against health risks	Slightly wealthier groups, in particular, would rather pay fees at time of sickness than enrol	Despite guidelines, failed to: • sensitize communities before implementation • conduct continuing community mobilisation activities.

Second, the findings show how district managers' actions shape the practice of implementation and underpin each problem. Kamuzora argues that their actions, as outlined in the table, represent the four classical coping strategies of street level bureaucrats defined by Lipsky (1980):
• rule breaking and careless rule interpretation was shown by the managers' neglect of central government guidance that emphasised the need to develop exemption mechanisms, and their rejection of local committees' requests for exemptions;

- officious rule enforcement was shown, first, in the way they used the letter of one law, the CHF Act of 2001, to pass the buck of exemption implementation to these committees (despite guidelines requiring them to address the issue) and, second, in their failure to allocate funds for CHF administration which, although in accordance with CHF guidelines, clearly undermined implementation practice;
- the failure to provide information to beneficiaries was reflected in their failure to inform the population about the possibility of an exemption mechanism;
- delaying tactics were reflected in the failure to respond to requests from community committees to use funds to improve care or support exemptions mechanisms (even though allowed by guidelines).

Second, he suggests that district managers could have acted differently to strengthen CHF implementation even though central guidance was confusing (such as the potential contradiction between guidelines encouraging them to implement exemptions and the Law that gave this responsibility to local level governance structures). In particular, although district managers were allowed to use CHF funds for quality of care improvements and managed other funds (the district basket fund) that could have been used to support CHF administration or supervision activities, they rarely supported any activity linked to the CHF. Finally, Kamuzora argues that this reaction was a clear response to the top-down process of implementing the CHF, as well as other policy interventions. Taken to districts in a rushed manner, partly under pressure from the ruling party to speed up implementation, district managers did the minimum required to implement the programme – and essentially neglected to manage it actively. Weak management then further undermined community trust in the managers and, in turn, in the schemes.

<u>(3) Explaining resistance to a policy of re-allocating staff to promote equity in health care provision in Cape Town, South Africa (Scott and Mathews, 2005).</u>

Working to promote equity in health care provision in a very unequal setting, the research team involved in this study noted the ambivalent responses and generally strong resistance to policy proposals for the re-allocation of nursing staff between areas within Cape Town based on equitable resourcing objectives. As part of their continuing support to the city council's efforts to strengthen equity in service provision, the team sought to understand the reasons for this resistance.

Their analysis shows that the legitimacy of equity as a health policy goal was broadly accepted both by primary care nurses and district managers. District managers also recognised that promoting equity in a resource constrained environment would inevitably require staff re-allocations. However, both groups of implementors still resisted implementation of the policy of re-allocations, and so called into question the legitimacy of the specific policy proposed to achieve equity. Nurses felt so strongly that some even threatened to resign and leave the health service rather than accept the policy, even when they would not themselves have to move post. Managers responded to the particular context of their local area. *'It is amazing if you move a manager from a well-resourced area to an under-resourced area, how she changes overnight and all of a sudden sees the need, whilst he or she didn't see the need whilst she was in a well-resourced area'.*

At one level, the study team explain this resistance as a function of conflict between the policy and the two groups' assigned responsibilities within the health system. Two central tasks of district managers are ensuring the financial well-being of their districts and the general well-being of their staff. Nurses are particularly concerned to ensure the provision of good quality of care to their patients. But both groups,

particularly those who stood to lose from the policy, perceived that the new policy challenged their capacity to fulfil these responsibilities. For managers, financial well-being was clearly hard to maintain in poorly resourced districts and, in well-resourced districts, was threatened by resource re-allocation. They also felt completely unable to manage the resistance of nurses to the policy, and their broader morale problems, given lack of training and support for them in these roles. Nurses meanwhile argued that re-allocations would undermine the quality of care provided to the client and that, by emphasising re-allocations, management was placing greater emphasis on concern for workloads (the basis for re-allocations) over quality of care. *'We want to render quality but they don't want that. They want us to see increased patient numbers to meet the workload norms and you are like a robot to do this and then go, and that is not nursing. I didn't do nursing for this'*. There was particular concern that the increased workloads resulting from staff re-allocations would put the nurse-client relationship at risk.

At another level, these perceptions have to be seen in the wider context of health system transformation within South Africa. After ten years of almost continuous change, health workers are tired of new policies. Nurses feel that they have borne the brunt of health system reform and that their concerns are never considered by managers: *'we get much more appreciation from the patient than from anyone else. We don't get that (appreciation) from the managers'*. They complained about the lack of consultation with them, or other preparation, before implementing new policies and the assumption that they will just do as they are told: *'No consultation beforehand. Training afterwards. It had to be implemented first and then you go for training. Not the other way around. No feedback on how it is impacting on you. You will do it. That's it. No backchat'*. The experience of uncertainty and the stress associated with continuous change also made them sceptical about the benefits of new policies. Even staff in those districts which stood to benefit from re-allocations questioned whether the policy would really assist them, given past experience of problems in ensuring that new staff allocated to their areas remained in post. Overall, *'because they haven't replaced nurses again currently, even now so where will you get the additional equity-motivated nurses. I just don't trust that'*.

In the end, therefore, Scott and Mathews argue that a lack of trust between managers and nurses threatened implementation of the staff re-allocation policy. This trust break-down resulted from poor communication and consultation, a perceived failure to take nurses' concerns seriously, managers' own inability to respond to nurses' worries and the past experience of promises not being kept. As a result, the legitimacy of equity as an overall policy goal was just not enough by itself to ensure support for the implementation of this particular policy for promoting health system equity. The breakdown of trust between managers and nurses resulting means that managers no longer have adequate authority to bring about implementation of the policy through the exercise of top down bureaucratic authority. Ultimately, Scott and Mathews conclude that new approaches to implementation are required to sustain implementation of new policies – approaches that take account of the pre-existing state of relationships among the network of implementing actors.

Understanding the influence of discourse in PPI policy implementation

The final study supported by EQUINET was quite different in its orientation, involving a detailed analysis of the discourse used in a set of South African policy documents about public private interactions (PPIs). Focussing specifically on documents associated with two key actors in these policy debates, the national Treasury (Ministry of Finance) and the national Department of Health, this analysis highlights

the ways in which policy is constructed in the language used to present policy and how this discourse may itself be used to shape the practice of implementation.

First, the analysis demonstrates the persuasive power of language: how, in this instance, language is used to encourage support for the policy. Focussing specifically on the Treasury manual on PPIs, Erasmus (2005) argues that the manual sets up an expert-lay relationship between the authors (policy developers) and the readers (policy implementors) that serves to discourage critique of the policy and encourage acceptance of the steps of implementation practice laid out in the manual. The expert-lay relationship is established by the very form of the document as a manual. Expert power is then re-inforced by various aspects of the manual contents, such as offering the lay-reader a series of technical abbreviations and terms that serve to demonstrate the expert's greater knowledge in the field. In addition, the manual puts forward a series of guidelines for action, a set of behavioural templates, that can just be followed in implementing PPIs, just like following a recipe book. Finally, the discourse, and even the pictures, used in the manual try to link PPIs to what are presented as new and more progressive way of managing service delivery than the traditional and outdated approaches of the public sector. In particular, the manual puts PPIs forward as a better way of managing the risks associated with service delivery (and borne by public sector managers), than traditional forms of public sector financing. Overall, although some of these presentations, such as guidelines, might seem like sensible approaches to support implementation, they must be read against the context of the unequal power relationship between expert and lay person. In this context, they serve to re-inforce the expert's power over the lay person and so seek to persuade the reader/implementor just to accept the guidance offered without too much reflection.

Second, the analysis demonstrates that despite the Treasury manual's efforts to persuade its audience that PPIs are a commonly accepted, good practice, available policy documents give evidence of continuing contestation within government about their role. By comparing the Treasury manual with a Department of Health-approved paper on PPIs, Erasmus shows how these different government actors hold different perspectives on the relative merits of this policy. According to the PPI manual, any PPI must meet three crucial criteria to be implemented: they must be affordable, provide value for money and transfer technical, operational and financial risk to the private sector. Although equity is not specifically mentioned, value for money might incorporate the equity gain of delivering more services that benefit a comparatively disadvantaged group. However, financial sustainability is a central underpinning concern. In contrast, the DOH-approved document places equity centre stage in decision-making and proposes that it, with health system sustainability, should have at least equal weight with financial sustainability in deciding whether to implement a PPI. The DOH-approved document also seeks to steer discussion about PPIs to the level of principle and away from the more nuts-and-bolts approach of the Manual. In these ways, therefore, it acts to question the manual by signalling that the time has not yet come just to establish behavioural templates for implementation. Instead, it signals that work remains to be done at the level of principle, in determining whether, and not just when, to go ahead with implementation.

Overall, therefore, this analysis indicates that differences in the discourses used in presenting the same policy may reflect continuing debates at the level of principle about that policy and may demonstrate resistance to it. At the same time the persuasive power of language may be used to support its implementation. Studying discourse gives important clues about the status of policy debates and about the ways in which policy documents act to re-inforce or challenge the power balances underpinning policy change.

Supporting the complex task of managing implementation

Taken together these studies emphasise the importance of actively constructing the support required to sustain the implementation of policies. A good evidence base will not by itself bring about implementation and political will is neither a personality characteristic nor an inherent feature of some types of states. Instead, support for equity-promoting policy change has to be built among the range of actors influencing health policy implementation.

The studies, and wider reflection on relevant theoretical perspectives, also provide support for three specific suggestions about how to build this support.

First, a key task appears to be that of developing the values, understandings and meanings that can sustain support for equity-oriented policies within the health sector (Gilson and Erasmus, 2004; Walker and Gilson, 2004). Although equity goals are, generally, supported by health workers and local managers, policy resistance can result from the perceived conflict between their understandings of their jobs and roles in the health system and specific equity-promoting policies. Implementation strategies have to address these actors' concerns by actively working with their worldviews, either demonstrating how policies are aligned with these views or encouraging their adaptation. The discourse used in policy documents and debates can itself serve to persuade health workers of the value and role of specific policies.

Second, efforts must also be made to enhance the legitimacy of new interventions and policies in the eyes of those responsible for implementation. The top-down imposition of policies on these actors may only re-inforce the pre-existing hierarchy of many bureaucracies and breed resistance. It does not encourage the active, local management that is required to support effective policy implementation and, specifically, promote equity. Where managers simply pay lip-service to new policies to keep the powers that be at bay, as in Zambia, they do not develop the problem-solving and learning skills that are required to adapt policies to implementation realities. Nor do they build the co-ordinated local level action required to sustain implementation over time. The studies presented here, as well as theoretical perspectives, emphasise that instead of imposing change and expecting implementation, health system leaders must always pay attention to the importance of consultation, communication and engagement among the network of actors responsible for implementation. They must build the trust in them required to enhance policy legitimacy and the trust among the range of implementation actors that underpins co-ordinated action (Lane, 1987; Rothstein, 1998).

Third, attention must be paid to building the combination of software and hardware that sustains equity-promoting health systems. Software elements include items such as the values, understandings, meanings, discourse and legitimacy that, as discussed, can promote resistance to, or underpin support for, policy change. Hardware elements, meanwhile, encompass the legal frameworks, financing mechanisms and organisational structures that frame service delivery practices. Hardware has importance in its own right because, for example, service provision will always be constrained without adequate resources; but hardware is also important because of its interactions with software. Changing the hardware can, for example, contribute to re-framing power relations within health systems (as with decentralisation) or signal value (as with the removal of fees or financing mechanisms that allow cross-subsidy). But, as the Zambian study discussed here shows, hardware interventions cannot achieve these goals by themselves; attention must also be paid to the software shaping implementation practice. Moreover,

hardware interventions can, when implemented without due consideration, undermine the health system's software. For example, the ways in which system reforms are implemented can undermine trust between key actors, as in South Africa (managers and health workers) and Tanzania (managers and community members), and so undermine policy change. The impacts of actions to strengthen the system's hardware are, therefore, mediated by its interactions with the system's software. Sustaining equity-promoting policy change not only requires recognition of this interaction but also, deliberate efforts to develop the combination of hardware and software that embeds inclusion within the routine practices of health policy implementors (Mackintosh and Gilson, 2002).

Overall, the complex work of managing rather than imposing policy change cannot be avoided, a task that implementation theorists increasingly refer to as the task of governance (Hill and Hupe, 2002).

Taking forward policy analysis work within EQUINET

There is only a relatively small group of researchers applying policy analysis approaches in their work in Africa. In part this is because only a few health policy and systems researchers have had exposure to, and obtain funding for, such work. In addition, there is some scepticism in health policy and research circles about whether this type of analysis can be classified as research or management.

EQUINET has no such qualms, seeing the need for a wide range of research and action to support equity. It is, therefore, planning to build on this foundation by supporting a policy analysis programme combining research, action and capacity building over the next five years.

One important analytical focus of this programme will be the identification of strategies through which the central level can support and enable sustained policy implementation at local levels, rather than imposing policy change across the health system. Building on the analysis presented in this paper, this work will involve wider consideration of:
- how local level policy actors experience the implementation of policy change initiated and driven by national (or international) actors, and the local level impacts of such processes;
- what drives the actions and approaches of national level actors and the responses of local level actors;
- what ideas and approaches for better implementation practice can be derived from innovative experiences within and outside the health sector.

It will include detailed investigation of the problems associated with top-down implementation in specific country contexts – as well as processes of deliberative engagement between government officials, civil society organisation and researchers to identify new strategies and practices for implementation.

This analytical work will be complemented by training and mentoring activities aimed at building and extending the pool of those applying policy analysis in Africa. These activities will include support for the implementation of small-scale research projects in a learning-by-doing approach to training, as well as for Master's level training in the field. In addition, those who have already been involved in EQUINET-supported policy analysis work will be encouraged to continue their involvement in the new analytical or training activities, building a network of Africa-based health policy analysts.

Finally, the policy analysis programme will also feed into and be complemented by work in EQUINET's other theme areas – including Trade and Health, Fair Financing, Human Resources, Human Rights and Governance. It will both seek to identify opportunities and entry points through which EQUINET can influence regional policy developments in these theme areas, as well as to extend the work done in these areas through the application of policy analysis frameworks.

On behalf of EQUINET, I welcome discussion of all our work.

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