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Actor interfaces and practices of power in a community health worker programme: a South African study of unintended policy outcomes

Uta Lehmann[1]* and Lucy Gilson[2,3]

[1]School of Public Health, University of the Western Cape, Bellville, South Africa, [2]School of Public Health and Family Medicine, University of Cape Town, Observatory, South Africa, [3]Department of Global Health and Development, London School of Hygiene and Tropical Medicine, London, UK

*Corresponding author. School of Public Health, University of the Western Cape, P Bag X 17, Bellville 7535, South Africa. Tel: +27-21-9592809. Fax: +27-21-9592872. E-mail: ulehmann@uwc.ac.za

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This paper makes a contribution to a much-neglected aspect of policy analysis: the practice of power in implementation. Practices of power are at the heart of every policy process, yet are rarely explicitly explored in the health policy literature. This paper provides a detailed study of micro-practices of power by those at the frontline of service delivery in the implementation of a national community health worker policy in one rural South African sub-district.

The paper is based on a small-scale qualitative study which collected data through observations, interviews and focus group discussions with health services and facility managers, community health workers and community members.

Practices of power were analysed using VeneKlasen and Miller's categorization of multiple dimensions of power, as power *over*, power *with,* power *to* and power *within*. Furthermore, the concept of 'actor interface analysis' allowed exploration of different actors' experience, interests and their specific location in the landscape of local health system governance.

The study revealed that almost all policy actors exercised some form of power, from authoritative power, derived from hierarchy and budget control, to the discretionary power of those working at lower levels to withhold labour or organize in-service training. Each of these practices of power had their rationale in different actors' efforts to make the intervention 'fit' their understandings of local reality. While each had a limited impact on policy outcomes, their cumulative effect produced a significant thinning down of the policy's intent. However, discretionary power was not always used to undermine policy. One manager's use of discretionary power in fact led to a partial reconstruction of the original policy intent.

The paper concludes that understanding and being responsive to the complexity of local realities, interests and contexts and the multi-layered practices of power may allow managers to adopt more appropriate management strategies.

Keywords Implementation, power practices, actor interfaces, South Africa

KEY MESSAGES

- Policies are translated and reshaped in the process of implementation, sometimes with negative consequences for the achievement of their goals.
- Policy translation and reshaping arises from contestation and negotiation among implementing actors, who are often thought to be relatively powerless.
- In the contested process of implementation, diverse practices of power are exercised by all actors.
- In practice, implementing actors with informal authority can exercise power in ways that assist implementation towards policy goals, whilst those with formal authority sometimes use their power to undermine the achievement of policy goals.

Introduction

This paper makes a contribution to a much-neglected aspect of policy analysis: the practice of power in implementation. It is widely acknowledged that practices of power are 'at the heart of every policy process' (Erasmus and Gilson 2008: 361). Lipsky's seminal work on street-level bureaucracy (Lipsky 1980), for example, demonstrated that frontline providers in large bureaucracies exercise discretionary power in policy implementation. Rather than simply complying with the organizational rules established by central actors, such providers routinely exercise power in their everyday decision-making in ways that influence, mostly negatively, client access to services and resources. Although these insights have informed a few health policy papers (e.g. Crook and Ayee 2006), there remain few examinations of power in the general health policy literature for low- and middle-income countries (Gilson and Raphaely 2008). Detailed, nuanced studies of the micro-level practices of power of the diverse frontline actors engaged in policy implementation processes are even rarer.

This paper aims to address this gap by exploring how practices of power shaped the implementation of a community health worker (CHW) strategy in a rural South African sub-district, in ways that thinned down and subverted complex and multi-faceted policy intentions and generated unintended policy outcomes. It examines how the experiences, understandings and interests of provincial and local managers, and CHWs, their differential access to information and their specific location in the landscape of local health system governance translated into a diverse use of authoritative and discretionary power in making sense of, negotiating and reshaping a national policy initiative. By exploring the different uses of power and how these converge and interact with each other, the paper aims to provide an in-depth look at what happens to policy 'at the coal-face' of implementation, and how policy is re-negotiated and re-shaped in the process of implementation. In addition, as the policy of focus is of current relevance across many African settings, the paper offers particular insights to those charged with implementing such programmes.

Methodology

The paper is based on a small-scale qualitative study aimed at understanding in as much detail as possible why and how the South African 2003 CHW policy was negotiated and changed shape as it was being implemented at the local level. The question emanated from previous work the first author (UL) and a researcher had conducted in the study area, which had found policy outcomes which seemed squarely to contradict policy intentions. We decided to return to the area, in 2007, to understand better what had happened in the course of implementing an apparently uncontroversial policy. Ethical approval for this study was obtained from the University of the Western Cape Ethics Committee.

Knowing colleagues working within the local departments of health provided us access into and substantial prior knowledge of the local policy implementation context. To get as detailed a story and as 'thick' a description as possible, we then conducted interviews with key actors in the provincial Department of Health and the sub-district. Three in-depth interviews were held with key actors in the provincial capital and four with colleagues in the sub-district (local management) office. We then looked at three local clinics of different sizes and located at different distances from the sub-district office, as well as their surrounding communities, to map the implementation of the policy at community level. Interviews were held with five nursing sisters, including facility managers, in all three clinics. Focus group discussions (FGDs) were held with a total of 80 CHWs who were attached to these clinics as well as eight representatives of clinic health committees, community governance structures charged by the policy with overseeing clinic and CHW activities. We also observed a monthly meeting between CHWs and programme managers at the sub-district office which was attended by over 100 CHWs and which simultaneously served a continuing education and report-back function. In addition both researchers kept ethnographic field notes and wrote analytic memos after each interview and FGD.

While most interviews were conducted in English, FGDs were conducted in the local language and subsequently transcribed and translated. As is common in qualitative research studies, data analysis was conducted concurrently with the data collection process. After each interview or FGD, the researchers would compare notes, discuss insights and findings, generate additional questions and develop themes for analysis.

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 were validated telephonically with study participants. Researcher and thematic triangulation occurred on an ongoing basis and systematically in the data analysis process, using the five-stage framework approach recommended by Pope *et al.* (2000) for analysing applied or policy-relevant qualitative data.

Given the layers of experiences revealed through these inductive stages of analysis, in the analysis presented here we seek to move beyond the idea inherent in street-level bureaucracy, i.e. that the use of power by street-level bureaucrats is primarily a control problem for central level actors (policy makers and senior managers). In analysing practices of power for this paper we have, therefore, drawn on VeneKlasen and Miller's conceptualization of the different expressions and sources of power. They argue against monolithic views of power as a negative and sinister force. Instead they suggest that 'power is both dynamic and multidimensional, changing according to context, circumstance and interest. Its expressions and forms can range from domination and resistance to collaboration and transformation' (VeneKlasen and Miller 2002: 39). Such a more relational and contextual understanding of power allows for a more nuanced understanding of roles and influences of multiple actors in the policy process. Table 1 sets out their conceptualization of four expressions and sources of power which are drawn on in the following analysis.

In addition, this analysis makes use of the sociologist Norman Long's approach of 'actor interface analysis' to understand better how different exercises of power in engagements between actors, and with policy implementation processes, renegotiated and reshaped policy outcomes (Long 2001). Interfaces are the point at which the different interests, relationships, modes of rationality and power of policy actors intersect. Their examination allows consideration of how '...processes of planned intervention enter the life worlds of the individuals and groups affected and come to form part of the resources and constraints of the social strategies they develop... In this way interface analysis helps to deconstruct the concept of planned intervention so that it is seen for what it is – namely, an ongoing, socially constructed and negotiated process, not simply the execution of an already-specified plan of action with expected outcomes' (Long 2001: 72).

Together these conceptual understandings allow us to investigate more clearly the multi-faceted practices of power at work in this experience, and their consequences for policy implementation.

Overview of the implementation process

The South African health system has changed dramatically since the election of the first post-apartheid government in 1994. Health care delivery in South Africa is now decentralized and organized through a district health system. The national and nine provincial Departments of Health hold responsibility for legislation, regulation and stewardship of health services. Fifty-two districts and in particular the country's over 200 sub-districts, each of which is equivalent to health districts in many other African countries, take responsibility for health services planning and implementation. The sub-district can be considered the implementation tier of health service delivery where vertical health programmes and policy intentions are translated into horizontal service delivery. Sub-district managers thus play an important mediating role between provincial and national policy makers and frontline service providers in facilities and communities.

Although South Africa has a long tradition and experience with CHW schemes, the first democratic governments did not initially move to develop a formal CHW programme for the country. Instead, a large number of essentially unregulated CHW projects developed, led by non-profit organizations (NPOs) (Friedman 2005; Friedman *et al*. 2007). The CHWs working in these programmes were predominantly mature women, most with very little formal education, who worked on a voluntary basis and often served their communities for many years. A national survey conducted in 2008 estimated there were 65 000 CHWs working across the country, but this figure remained contested. In the study sub-district the numbers fluctuated and varied: some facilities had as many as 32 CHWs working with them, others around 15, and some none at all.

Two policy initiatives, driven by separate political imperatives, converged in the early 2000s to be implemented as a new, government-led CHW programme. One was the national Department of Health's (DOH) *National Community Health Worker Policy Framework* which aimed at harmonizing and institutionalizing the existing CHW projects (Friedman 2005; Friedman *et al*. 2007). In parallel, the national government implemented a large-scale job-creation programme, which worked in the health and many other sectors of government. The main aim of this 'Extended Public Works Programme' (EPWP) was to alleviate and reduce unemployment through basic skills training.[1]

In practice, the two policies were implemented as one programme in the health sector, drawing on pooled funding (from the health and public works departments). Both programmes also shared an intention to create work opportunities linked to training and skills development, and introduced a stipendiary payment funded by government for those employed through them. For CHWs this was the first time a payment for services (coming from government funds) had been introduced

Table 1 Four expressions and sources of power

Form of power		Definition
Power over others	Authoritative power	'The most commonly recognised form of power, power over, (...) involves taking it from someone else, and then, using it to dominate and prevent others from gaining it.'
Power with others	Discretionary power	'finding common ground among different interests and building collective strength'
Power to act		'the unique potential of every person and social group to shape their life and world and create more equitable relations and structures of power'
Power within		'people's sense of self-worth, values and self-knowledge, central to individual and group understanding of being citizens with rights and responsibilities'

Source: VeneKlasen and Miller (2002: 43).

and the available budget inevitably restricted the number of CHWs that could be employed. However, beyond these shared features were significant differences that influenced implementation. A crucial issue in this experience was that the EPWP's primary intent was to develop career opportunities and formally accredited training for unemployed youth, whereas the DOH policy sought to bring uniformity across existing CHW projects which drew largely on mature women (as well as creating better interfaces between CHWs and the formal health services and developing a pool of generalist CHWs to support primary health care). The EPWP emphasis on unemployed youth underlay the use of criteria that gave preference to the selection of younger, more educated community members as the CHWs who would received stipends under the new policy, over the existing pool of mature women who had been working as volunteer CHWs.

Although there were some similarities across provinces, the details of the programme's governance and implementation arrangements were determined at provincial level. In the study province, the provincial health department's Health Promotion directorate vigorously but unsuccessfully contested for the CHW programme's ownership, arguing that generalist CHWs should work across all health programme areas and should have a strong focus on health promotion. However, the provincial HIV directorate was finally charged with implementing the CHW policy (which was primarily funded through the dedicated funding allocated to the HIV/AIDs programme), but contracted out the appointment and payment of CHWs to a local NPO. Yet, although this NPO was responsible for all contractual and financial relationships with CHWs, it did not consider itself responsible for other aspects of the programme, such as training, support and supervision of CHWs or training of the clinic health committees charged with formally selecting and supervising CHWs in their communities. Although CHWs were appointed and paid directly by the NPO, in practice this was only at the recommendation of facility managers. However, district and sub-district governance structures, fairly newly established and coming out of a pre-apartheid history of centralized and fragmented governance, were essentially by-passed in implementation decision-making. The sub-district managers' formal role was, therefore, largely confined to that of an information conduit between provincial actors and clinics.

At the time of the study none of the managers in the study sub-district who were most closely involved with the programme (overall manager, and those responsible for HIV/AIDS activities and health promotion) had seen the policy or were familiar with its key concepts such as CHW entry and training requirements, or scope of activities. Their information and insight was confined to the fact that a small number of CHWs would receive stipends, that there were different categories of CHWs and that they should all receive basic home-based care training which should be organized in the sub-district. What information was available to whom and how information was shared played a crucial role in the 'negotiation' of the implementation process and the shaping of policy outcomes. In addition, the implementation process was shaped by wider tensions among the four sub-district managers; between two older and two younger managers, between two responsible for HIV and one, for health promotion, and between three more reserved and cautious managers and the younger, energetic health promotion manager. For example, the older HIV manager was responsible for transport management in the sub-district and used this position to limit some of the younger managers' activities.

However, as noted above, facility managers played a formally limited, but in practice powerful, role in policy implementation. Their only formal role was to sign the CHWs' monthly log sheets, to allow them to be paid. However, because of their pivotal role in the flow of information between provincial policy managers and communities, they played important informal roles. In contradiction to policy guidelines, which allocated these roles to clinic health committees, they were very closely associated with CHW selection (and in two of the three study clinics essentially made the selection) as well as being responsible for their day-to-day supervision.

The provincial health department instructed that only seven CHWs per clinic would receive stipends, and that these CHWs should work as specialists offering (a) counselling services in clinics; (b) home-based care; and (c) tuberculosis support services in communities. No instruction was given regarding age or educational qualification, although rumours about such requirements became important drivers in the implementation process. While accepting the limitations on numbers which were dictated by budget availability, sub-district and clinic managers, as well as CHWs themselves, considered the distinctions among CHW activities as impractical in their large and very dispersed catchment areas. There was agreement among all implementers, therefore, that CHWs receiving stipends would continue to operate as generalists rather than specialists—a decision which contravened provincial instructions but conformed with the national department's policy intent.

As we did not observe CHWs as they worked in their communities we have few insights into their daily activities. However, as there was no direct supervision of their community work by facility managers or the clinic committees formally allocated this role, it is likely that CHWs shaped their work in negotiation with the communities they served and in accordance with their own skills and preferences. It is certain that neither CHWs nor their supervisors had been introduced to the intended scope of activities set out in the policy documents.

Although it seemed that most CHWs we interviewed had received some basic HIV training (5 to 10 days basic training and training in Voluntary Counseling and Testing in some cases), the co-ordination, ownership and resourcing of training was neither clearly designated nor co-ordinated. At provincial level, as noted, the NPO denied any responsibility for training and confirmed that they had not received a training budget from the provincial government. Although the HIV manager in the sub-district was formally responsible for training, she also had not received any resources from the provincial government to conduct training. It is noteworthy that none of the training stipulations contained in the CHW policy were being implemented or even discussed.

Policy outcomes

At the time of this study the most significant outcome of the policy implementation process had been the reduction or thinning of very complex policy intentions and objectives to

a single outcome, namely the payment of stipends to a small number of CHWs. Although small numbers of unemployed youth had received work opportunities, they had no apparent career path, and training and supervision were all but non-existent. Simultaneously, a large number of mostly older, experienced CHWs had withdrawn from the programme because they were not selected to be paid stipends and felt that their long-standing commitment and contribution had gone unacknowledged. Overall, therefore, all facilities had substantially fewer CHWs available than before the introduction of the national policy. Formally, as per guidelines, each facility had seven CHWs attached to it. The exact number of un-paid CHWs remained opaque and fluid, as the sub-district made every effort to retain unpaid CHWs, and several of them had formally withdrawn but were evidently still rendering services to their communities. Although we did not pursue quantitative information on CHW availability, there was unanimity in the sub-district that the policy had led to a reduction of health service coverage, particularly in the most remote areas, as it had resulted in fewer CHWs being available to render services.

These outcomes, which were not pursued deliberately by any of the implementing actors, bore no resemblance to, and in fact largely subverted, the policy's intentions.

In the rest of this paper we first explore how key actors' practices of both authoritative and discretionary power shaped their roles in the implementation process. We then examine how these power practices, at crucial interfaces of actor engagements in implementation, both subverted policy intent and yet allowed the realization of some positive local policy outcomes.

Practices of power

Table 1, presented earlier, introduces a conceptualization of power that allows identification of the different expressions and sources of power seen in this process of policy implementation.

Authoritative power, *power over*, flowed largely vertically *downwards*: the provincial HIV directorate over the sub-district HIV co-ordinator and the NPO and facility managers over CHWs who received stipends. Those holding authoritative power enjoyed control over funding for, and information about, the programme. By contrast, for example, the newly appointed sub-district HIV manager, supposedly in charge of the CHW programme in her area, held little real power. Her position was undermined by the province who denied her resources to 'do her job' and she demonstrated little *power within* to assert herself against the older sub-district managers or the energetic health promotion manager.

Power to act flowed in several different directions. All actors at sub-district, facility and community level used their knowledge of the local context to act against provincial authority by deciding to retain a largely generalist approach to the utilization of CHWs, despite provincial stipulations which introduced different categories of CHWs. The facility managers also used their knowledge of local context, as well as their location as nodal points for the flow of information, to manage the difficulties of CHW selection. For example, to assist in selecting a small number of CHWs from a large pool, they 'invented' selection criteria based on rumours about what the policy required (e.g. minimum of grade 10 education level and ability to be trained in English). They also used their power to act to offer some, albeit limited, supervision to CHWs in a situation where no provision for supervision had been made at all.

Many CHWs who did not receive stipends used their *power within*, meanwhile, to withdraw their services as CHWs. While this was largely an act of passive resistance, born out of anger and frustration, it is clear that these CHWs acted with a sense of agency and self-worth, using the discretionary power at their disposal. Indeed, although many withdrew their active service, making themselves unavailable to the facility and sub-district managers, they continued to attend monthly CHW training and feedback sessions. In these, by our own observations, they played a very active role, suggesting that they continued to be active in their communities. They also used the research process of this study to voice their dissatisfaction. We had asked facility managers to invite a small group of CHWs for focus group discussions. However, when word spread that researchers were coming to discuss the CHW programme in the sub-district, large numbers of inactive and active CHWs turned up at two of the three facilities, with the explicit aim of using the planned discussion to state their case (which, as a result, acquired the flavour of a community meeting).

But the most visible manifestation of *power within* was displayed by the sub-district's health promotion manager. Like the provincial health promotion managers, she had no official function in the programme or authoritative power, and was frequently undermined by other sub-district managers. Like her provincial colleagues, she also felt strongly that the CHW programme should fall under the health promotion manager, as it should cut across all programmes and health promotion staff worked closely with community structures. But in contrast to the provincial health promotion managers, she had successfully fought for a position for her programme in the sub-district (and thus some *power to* act).

Several factors contributed to her 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 (*power within*). Secondly, she had come into her post well-qualified, with relevant experience in the new health promotion portfolio and with a very clear vision of what she wanted to achieve in this portfolio. While she initially met resistance from her colleagues in the sub-district office, she was able to build a constituency and networks in the sub-district communities by nurturing relationships with facility managers and CHWs. From this base she was then able to set up and sustain monthly CHW meetings (*power to*) which functioned as both a report-back and continuing education opportunity and which, from our own observation, proved highly popular with all CHWs. By the time of our visit she had succeeded not only in enticing over 100 CHWs to attend at their own expense, but had also convinced her sub-district colleagues to participate actively in these meetings which were hosted by the health promotion programme. The space and interface of the monthly meetings and her engagements with facility staff and CHWs allowed for the local reconstruction of an otherwise quite destructive policy process: she retained some engagement with the disaffected

older CHWs and instituted a very constructive engagement between all actors in the sub-district. Her role and authority are illustrated in this excerpt from an interview with her:

> *In fact it was not accepted for a health promoter to be involved in community health workers here, but I keep on doing these monthly meetings because now without community health workers my job will not be; it cannot reach the villages, all the villages, if I cannot work together with community health workers. I keep on calling them for meetings, meetings - until everybody can see that this is very important because they go - now, like HIV and AIDS manager we were fighting,* ***fighting*** *when I started to work here, we were fighting for the community health workers. I sat down and I explained why I need the community health workers, and without them I cannot succeed.*

In using her discretionary power to 'negotiate policy modification in action' (Barrett 2004: 253), through knowledge, persistence and continuing positive discourse with all actors in the sub-district, the health promotion manager was the one implementing actor who consistently strengthened rather than undermined the programme through her use of power. She provided (informal, on-the-job) training, where the HIV managers did not manage to organize 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 on the agenda of the sub-district's planning and management activities, and that managers were eager to interact with them.

The fourth form of power, *power with*, was only used in small measure in this experience. While there were some alliances, most of these were tenuous. More clearly, although almost inadvertently, it emanated from the interaction between the health promotion manager and the CHWs without stipends. They strengthened each other through their respective organization and attendance of the monthly meetings.

How practices of power shaped policy outcomes

In this experience, CHWs, service providers and managers in the sub-district and the province used different forms of power to accommodate the opportunities and threats the policy presented in their life worlds: CHWs' understandings of and roles in previous CHW programmes and how these located them in their communities, managers' battles for authority and resources to give meaning to and support their roles and activities.

To understand how these power practices translated policy intentions into the outcomes as experienced, it is useful to identify and examine the key interfaces in which the processes of negotiation and contestation influencing outcomes occurred. As Figure 1 illustrates, we identified four distinct interfaces in the implementation continuum which led to a re-shaping and reduction of the policy's intent: (1) between two competing directorates in the provincial department of health, (2) between programme managers in the sub-district office, (3) between facility managers and CHWs, and (4) between old and new cadres of CHWs. In each of these, there was contestation over resources and negotiation to make the policy 'fit' local context. In some cases the contestation played out overtly and actively, and in others was hidden and passive.

The national policy framework had envisaged a programme supporting the introduction of generalist, multi-purpose CHWs. It had not stipulated governance arrangements and responsibilities for the implementation of the programme at provincial or sub-district level. In practice, however, the location in and flow of dedicated funding for the programme through the HIV/AIDS directorate resulted in the programme becoming an extension of the HIV/AIDS programme. In the first interface identified, the Health Promotion directorate contested for ownership or at least participation in the programme as it considered CHWs central to its activities. However, in an organizational environment where departmental bureaucracies are organized and operated in silos, and this manager could not access extra resources under their control CHWs, this contestation remained unsuccessful. Arguably, the focus on and contestation over budget ownership might have aggravated the neglect of other crucial policy elements, such as roles, skills development, supervision and community participation.

Contestation at provincial level was echoed in the sub-district. In this second interface, the considerable tension among the four main managers at this level revolved primarily around the older, long-serving and powerful HIV programme manager, who was close to retirement, feeling threatened by and resisting the energy, knowledge and assertiveness of the new health promotion manager. In this conflict the overall sub-district manager sided with the older HIV manager, forming a powerful 'old guard'. The second, younger and newly appointed HIV manager, who was in the process of taking over from the previous HIV manager, meanwhile appeared to be the least powerful in the sub-district constellation. She was further weakened by the fact that, although in charge of the programme as a whole and specifically of training, she did not get access to resources controlled by the provincial HIV/AIDS directorate, most specifically, training budgets and materials. In this setting, the health promotion manager successfully contested and negotiated the space to train and support both old and new CHWs as generalists. Her efforts to retain the old and disaffected CHWs and her training initiative partly mitigated the thinning effect on the policy of provincial policy decisions (towards a focus on HIV/AIDS activities and non-decisions—not making resources for training available to the sub-district), as well as the power struggles among provincial and sub-district managers.

The third interface, which significantly reshaped local policy outcomes, was one of negotiation, not contestation, between facility managers and CHWs. Faced with the task of having to select a small number of CHWs out of a much larger pool, facility managers certainly over-played (whether deliberately or not was unclear) rumours that there existed a minimum educational qualification for eligibility in receiving a stipend. These rumours were incorrect, but they assisted facility managers to navigate an interface which held enormous potential for serious tension between facility staff, CHWs and communities, by creating an understanding of externally imposed selection criteria. Although this practice of power resulted in much discontent among older, less formally qualified CHWs,

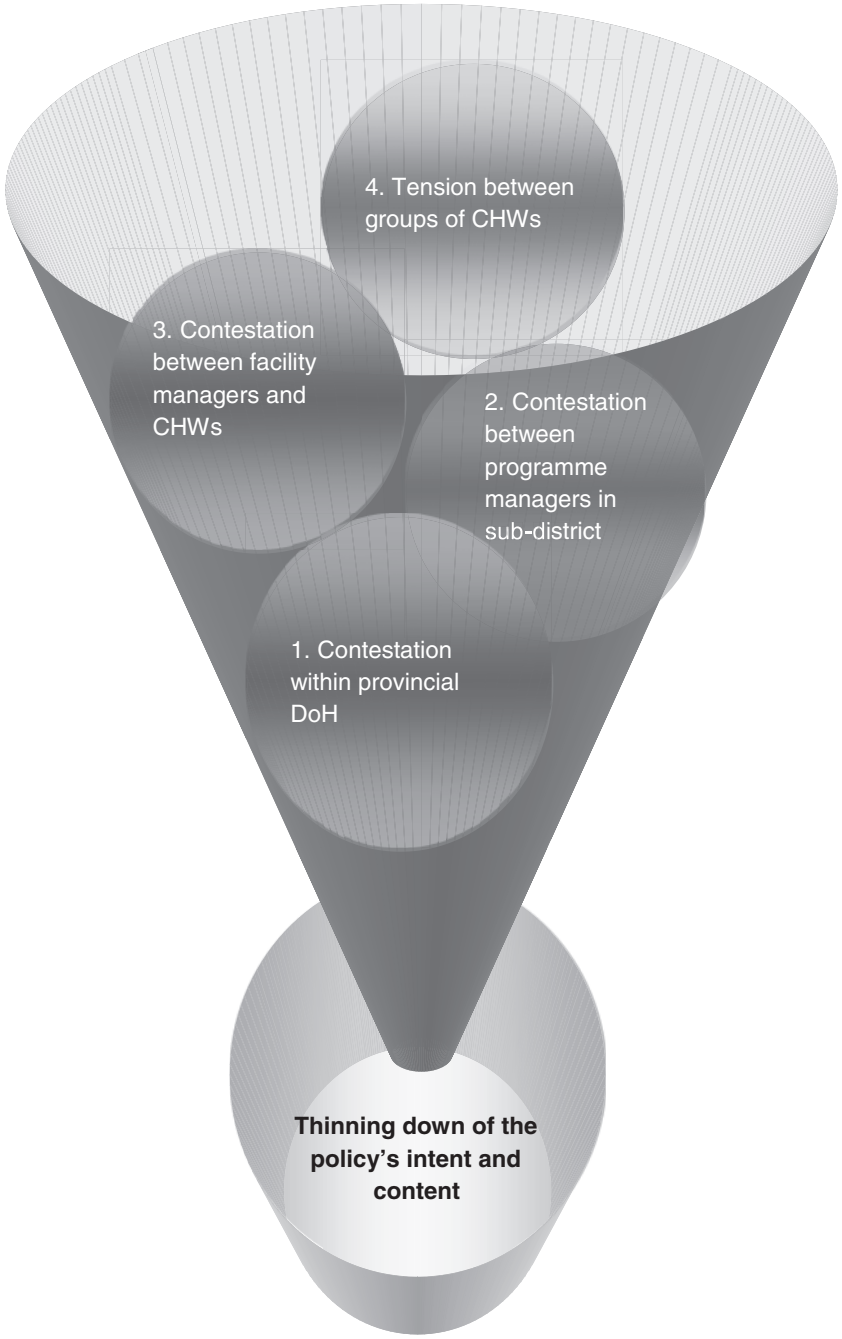

Figure 1 Key interfaces in the policy implementation continuum

and some withdrawal of their services, this discontent was directed beyond the local context, at provincial and national policy makers.

The final interface which was palpably important, yet never verbally articulated, was tension between those CHWs who received stipends and those who did not. These tensions, which resulted both in a reduction of coverage and in a lack of acceptance of the young CHWs by the communities they served, revolved around two issues. First, the stipends themselves, and second, the fact that most of the CHWs with stipends were younger, better educated, but less experienced, and within the rural context, less respected by the wider community, less vocal and less powerful. As a result of these tensions, most of the CHWs without stipends had withdrawn their services to communities by the time of this study. Nonetheless, in our engagements they came across as vocal, extremely experienced and very powerful within their communities. Indeed, in the focus group discussions their presence and voice silenced most of the younger CHWs, although within the policy framework they spoke from a position of powerlessness.

Conclusions

Health policy literature acknowledges the importance of power in implementation processes, but there are only a few empirical studies that explicitly explore power and implementation. A study of the implementation of patient fee policies in two South African hospitals revealed the use of discretionary power in the selective implementation of user fees and patient exemptions from fees (Nkosi *et al*. 2008), for example. Studies speaking to imbalances of power in engagements between the state and communities in implementation processes are more common, e.g. studies exploring state centralization of power as a barrier to social participation in policy processes (Cifuentes *et al*. 2010) and the continuing power imbalance between government and community structures in community participation schemes in Mexico (Zakus and Lysack 1998). However, few studies give a detailed view of the diverse practices of both authoritative and discretionary power by the range of implementing actors, or their cumulative effects on policy outcomes.

In this paper we have deliberately traced the implementation of a policy process and examined in detail the micro-level power practices of implementing actors to gain understanding of 'the dynamics and emergent negotiations inherent in processes of policy intervention' (Long and Jinlong 2009: 80). The policy of focus is of particular current relevance as many governments in Africa are again considering how best to utilize CHWs in support of their health services, given the dual crisis of public sector health worker shortages and mounting care needs generated by a growing disease burden. These programmes face numerous challenges that must be addressed in implementation: most importantly, as in South Africa, they invariably build on and attempt to bring uniformity to a multitude of long-standing practices and experiences.

For those responsible for implementing CHW and other programmes, four lessons stand out from this South African experience.

- Firstly, almost all policy actors exercised some form of power, from authoritative power to control budgets and appointments to the discretionary power to withhold labour or organize in-service training. Most notable was the range of practices of discretionary power, the power exercised by those at the frontline of service delivery whose actions cannot be fully controlled by central actors. It was used collectively by sub-district managers, facility managers and CHWs to circumvent provincial rules about the use of specialized CHWs. It was used by the older generation of CHWs, who were excluded from stipends, to withdraw their services, but they also used their standing in this very rural community to remain vocal participants in engagements with sub-district managers, and this study's researchers. And it was used by the sub-district health promotion manager, who, through persistence, knowledge and ongoing communication succeeded to get her 'version of the job' done.
- Secondly, each of these micro-practices of power had their rationale in different actors' efforts and desire to make the intervention 'fit' their reality. And while each may have had a limited impact on the policy outcome, their cumulative effect produced a significant policy outcome—in this case the dramatic reduction of the policy's intent and content. Use of Norman Long's notion of the importance of actor interfaces helps grasp the transformation of policy intent into policy outcome through the contestation and negotiation of actors engaging with each other and with policy content and process. As Long and Jinlong have stated (2009: 72), 'it is only by probing these relationships and processes that one comes to identify and understand the significance of specific sets of interlocking ''actor projects'' that, as it were, map out the topography of the political and social landscape in question. In short, actor interface analysis is better able to explain the emergent dynamics and outcomes of actor initiatives and changes in development scenarios, thus permitting more insightful interpretations of the different responses to seemingly similar structures and processes of intervention.' For health policy analysts, Long's work highlights the value of drawing on broader development studies literature to investigate and understand the practice of power in implementation, and how deliberate policy interventions are translated through practice.
- Thirdly, discretionary power was not always used to undermine and subvert policy, as sometimes seems to be the implication of street-level bureaucracy literature, for example. The sub-district health promotion manager shows how discretionary power can be used against authoritative power, but to support and give expression to the policy's intent. Her actions reflect Erasmus and Gilson's (2008: 363) observation that 'implementers' interpretations of policy also have a power of their own, to shape how policy is understood by others'. Her persistent building of networks and engagement of actors ensured a partial reconstruction, albeit driven by a different (local) imperative, of the original policy intent. Barrett (2004: 255) speaks of management practices which either expect *conformance* (with policy targets and standards) vs *performance* (which aim to 'encourage innovative courses of action within a framework of procedural rules'). This manager exemplifies the use of discretionary power to *per*form, against significant pressure from colleagues around her to *con*form.
- Fourthly, and linked to the previous point, it is interesting to observe that many practices of authoritative power did *not* serve to secure intended policy outcomes. The provincial and sub-district HIV managers, for example, used their access to, and control over, information and resources to reduce the scope of the policy. Instead, it can be argued that the strongest support for the policy's original intention lay in the most important exercise of discretionary power, by the sub-district health promotion manager.

These four insights are important to understanding implementation processes as an 'intricate series of socially constructed and negotiated transformations' (Long 2001: 91). They also have important managerial implications as they suggest that policy implementation strategies likely to support the achievement of policy goals must be responsive to the complexity of these processes, and the multi-layered power practices within them. Jack Chapman therefore suggests that whilst it is appropriate and important for governments to determine *what* the priorities and directions of policy should be, the '*how?*' of implementation should be left to those responsible

for implementation. He argues that 'the range of interconnections and feedback makes it impossible to predict, in advance, the detailed consequences of interventions. Indeed, the consequences are often counter-intuitive'' (Chapman 2002: 27). To reduce the risk of unintended outcomes, Chapman advocates participatory and inclusive processes of agenda setting, and for policy guidance which should be 'as unprescriptive about means as possible' (p.91). He suggests that effectively managing policy change entails, in essence, setting clear directions, encouraging ownership by implementers of policy visions and goals, clarifying what the boundaries of their actions are, allocating resources with time scales, but without specifying the details of their use, and specifying core evaluation requirements. Implementing actors must then be allowed, through negotiation with others, to translate and re-formulate policies in ways that support goal achievement within those boundaries, through innovation, learning and local adaptation. Encouraging policy ownership by implementors, meanwhile, is more a matter of establishing meanings and framings of policy action that they accept—and that limit the sort of policy thinning observed in this experience—than of instructing them what to do in implementation (Fischer 2003).

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Conflict of interest

None declared.

Endnotes

[1] 'The Extended Public Works Programme (EPWP) is one of the Government's short-to-medium term programmes aimed at the provision of additional work opportunities coupled with training. It is a national programme covering all spheres of government and state-owned enterprises' (Extended Public Works Programme, 2005: i).

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