

Practice and power: a review and interpretive synthesis focused on the exercise of discretionary power in policy implementation by front-line providers and managers

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Tackling the implementation gap is a health policy concern in low- and middle-income countries (LMICs). Limited attention has so far been paid to the influence of power relations over this gap. This article presents, therefore, an interpretive synthesis of qualitative health policy articles addressing the question: how do actors at the front line of health policy implementation exercise discretionary power, with what consequences and why? The article also demonstrates the particular approach of thematic synthesis and contributes to discussion of how such work can inform future health policy research. The synthesis drew from a broader review of published research on any aspect of policy implementation in LMICs for the period 1994–2009. From an initial set of 50 articles identified as relevant to the specific review question, a sample of 16 articles were included in this review. Nine report experience around decentralization, a system-level change, and seven present experience of implementing a range of reproductive health (RH) policies (new forms of service delivery). Three reviewers were involved in a systematic process of data extraction, coding, analysis, synthesis and article writing. The review findings identify: the practices of power exercised by front-line health workers and their managers; their consequences for policy implementation and health system performance; the sources of this power and health workers' reasons for exercising power. These findings also provide the basis for an overarching synthesis of experience, highlighting the importance of actors, power relations and multiple, embedded contextual elements as dimensions of health system complexity. The significance of this synthesis lies in its insights about: the micropractices of power exercised by front-line providers; how to manage this power through local level strategies both to influence and empower providers to act in support of policy goals; and the focus and nature of future research on these issues.

Keywords Front-line providers, interpretive synthesis, local managers, LMICs, policy implementation, power, thematic synthesis

KEY MESSAGES

- Interpretive synthesis of existing, qualitative health policy analysis literature generates policy-relevant insights about the processes and practices of policy change.
- The micropractices of power exercised by front-line providers influence the experience and consequences of policy implementation, helping to explain the policy implementation gap; and also represent a core element of health system complexity.
- Local managers play a critical role in managing front-line providers' discretionary power, and must combine efforts to influence providers by aligning resources and organizational environments with policy goals, with efforts to influence the discourses and mindsets, beliefs and values and levels of motivation that underlie providers' tangible practices of power.
- Further research about power in implementation could test the conclusions of this synthesis, drawing on interpretive policy analysis approaches to access local, practice knowledge around the values and meanings that influence micropractices of power.

Introduction

The 'know-do' gap, between technical knowledge of how to address critical health problems and the practice of health system delivery in low- and middle-income countries (LMICs), underpins the current concern about implementation failure in global health debates (Sanders and Haines 2006). Theory on policy implementation, drawn from political science, public administration and organizational studies, suggests that an important dynamic influencing this gap is likely to be the exercise of power. This theory suggests that whilst formal bureaucratic power runs from top to bottom, the informal power necessary for problem solving to support successful policy implementation is widely dispersed in any organization (Elmore 1978; Barrett 2004). Although 'top-down' theoretical perspectives focus on the power of co-ordination and control held by those at higher levels of the public sector bureaucracy, who establish policy goals and frameworks, 'bottom-up' theorists see implementation as '...an interactive and negotiative process [that] is taking place over time, between those seeking to put policy into effect and those upon whom action depends' (Barrett and Fudge 1981, p. 25). Only limited attention has so far been paid in LMIC health policy and systems research to understanding how the exercise of power by 'those upon whom action depends' influences implementation of policies, programmes and interventions (Gilson and Raphaely 2008).

Using a thematic synthesis approach (Thomas and Harden 2008), this article presents, therefore, an interpretive synthesis that addresses the question 'How do actors at the front line of health policy implementation exercise discretionary power, with what consequences and why?' It draws on a set of articles reporting qualitative research addressing the dynamics of policy implementation, paying particular attention to policy actors and influences over them (Gilson and Raphaely 2008), a body of work that is particularly relevant to the synthesis question. Rather than seeking to establish or test an overarching theory of policy implementation, the synthesis simply sought, first, to identify whether and what discretionary power is exercised by front-line health system actors and with what consequences for policy implementation. We understand these actors to be those working in direct interface with, or close to, patients and citizens, who exercise discretionary power '...wherever the effective limits on [their] power leave [them] free to make a

choice among possible courses of action and inaction' (Davis 1969, p. 4). Although working within policy frameworks and rules, these actors may not always work in alignment with them. Second, we sought to tease out some understanding of what drives and shapes the use of these micropractices of power¹—as a basis, ultimately, for considering management strategies that might address the implementation gap. As an interpretive synthesis the intention was to draw out conceptual insights from a purposeful sample of relevant articles, rather than to aggregate findings across a comprehensive set of articles (Pope *et al.* 2007).

We have three equally important goals in this article: first, to address the synthesis question; second, to explore an approach to interpretive synthesis for qualitative, policy analysis research; and third, to consider how such synthesis can inform future policy and research debates. As policy analysis is still developing as an area of health policy and systems research (HPSR) we were interested both in exploring the role of thematic synthesis in generating further knowledge from the available work, and in developing the research agenda for the area. This is one of five articles with similar goals.

In the next sections we outline, first, the approach we used in this work. Then we present both a systematic review of evidence drawn from the articles linked to our synthesis question, and an overarching interpretive synthesis of this evidence. Finally, we consider the significance and implications of the synthesis for the management of, and research on, policy implementation.

Methods: systematic review and synthesis approach

The first task in any review is to select articles following a systematic search of appropriate databases using relevant key words. For this article, however, we were able to draw from the first, comprehensive review of LMIC health policy analysis literature ever undertaken (Gilson and Raphaely 2008), which had been subsequently updated to support a mapping of published LMIC health policy implementation work for the period 1994–2009 (see Erasmus *et al.* this edition). The initial review identified empirical analyses that 'integrate politics, process and power into the study of health policy' through searches of both PubMed and the International Bibliography of the Social Sciences, selected to allow relevant work from public

health and broader social science fields to be identified (Gilson and Raphaely 2008, p. 295). Selection of the articles included in the mapping review combined assessment of specific relevance (empirical analyses of health policy implementation experience) with quality, using a quality assessment checklist adapted from Wallace *et al.*, 2006 together with review of the richness of the implementation description (a common marker of quality in qualitative work: Popay *et al.* 1998; Roen *et al.* 2006). The availability of this broader pool of implementation articles provided, therefore, an appropriate basis for the review reported here (see Figure 1).

Guided by Thomas and Harden (2008), we adopted a thematic synthesis approach to this review. In the first step, 50 articles were identified as relevant to our synthesis question from the 167 articles included in the implementation mapping review. The 50 articles were categorized by policy focus and the two largest sets of articles (9 articles addressing decentralization and 7 articles addressing RH), were then selected for inclusion in this review (see Annexes 1 and 2). Purposeful and heterogenous sampling is recommended for framework synthesis, to support interpretive analysis (Thomas and Harden 2008). These sets of articles also reflect the two leading edges of health system development worldwide (system-level change and new forms of service delivery: Travis *et al.* 2004), and allowed us specifically to consider the acknowledged influence of policy type or characteristics on implementation (Hill and Hupe 2009).

Although all the articles addressed experience relevant to this review (this was a central element of our inclusion criteria), none report studies that explicitly set out to examine power in implementation. This reflects a recognized gap in the broader health policy analysis field (Gilson and Raphaely 2008). However, interpretive synthesis often draws on articles that did not themselves consider the review question (Thomas and Harden 2008) and, by definition, entails going beyond the original studies to generate fresh interpretations of the phenomena of focus (Pope *et al.* 2007). The review team, therefore, prepared for their work by reading three articles addressing key, relevant concepts in order to develop a common basis for the inductive judgements necessary in data extraction and coding (Thomas and Harden 2008). The concepts considered were: the nature of discretionary power in policy implementation; the consequences that can result from such power, including the public value of managerial action; and the possible sources of, and reasons for, exercising power (Moore 1995; Barrett 2004; Erasmus and Gilson 2008). Drawing on these conceptual insights, and having conducted an initial coding test, we then identified four code families linked to our overarching synthesis question: instances of exercising discretionary power (power practices); consequences of exercising power; sources of power; and reasons for the exercise of power.

In step 3, each article was coded by three reviewers. Using specialized computer software (Atlas.ti) to allow systematic analysis, each reviewer coded the relevant data in each article for each code family separately, using free codes that aimed to retain the specifics of the data. In coding, we considered data from all parts of a article, recognizing that relevant material is not only presented in the findings sections, and also author judgement (that is, authorial insights into reported data, which

we coded using the notation 'AJ'). Identifying and coding instances of discretionary power was relatively straightforward, but more inductive judgement was needed to identify and code their consequences, as well as the sources and reasons for exercising power. These judgements drew on the common understandings initially developed through shared reading, and were also sometimes based on authorial judgement as these context-rich insights were valuable in teasing out understandings around power embedded in the data. In addition, although each reviewer initially coded each article independently, we subsequently came together as a group to share ideas and develop coding consistency across people and articles.

Step 4 entailed several elements. Each team member reviewed all of the free codes by code family for each of the two sets of articles, and, using an axial coding process (Thomas and Harden 2008), identified the descriptive themes (or natural groupings) within the codes. Through a consensus process of team discussion we then agreed a final list of descriptive themes by code family. During this process, we noted that experience differed across the three groups of front-line health staff considered in the articles: community-based workers, facility-based health professionals and local managers. Following recommended practice in interpretive synthesis, we then used matrices to allow systematic comparison and contrast of the themes both across policy area and staff group, that is, to allow examination of evidential variation across these two dimensions of context (Pope *et al.* 2007).

Analysis of the evidence presented in the matrices also provided the basis for developing an overarching synthesis that also goes beyond that evidence (step 5). Following initial discussions, one researcher led the task of writing up the preliminary synthesis for final agreement among the team members. Finally, the reviewers developed interpretive judgements (step 6) about the implications of this synthesis for managers, based on the articles, discussion and wider experience.

As is usual in thematic synthesis, we present below both the systematic review of evidence relevant to our question and the syntheses and interpretations derived from that evidence (Barnett-Page and Thomas 2009). This synthesis is inevitably constrained by the limits of the articles included. The articles only represent two policy areas, and cover a range of geographical settings. Perhaps more importantly, the articles do not offer a comprehensive picture of the discretionary power used in implementation, and they do not always allow practices of power to be clearly linked to consequences, sources or reasons. The evidence in these articles cannot, therefore, be seen as fully representing experience—as an absence of evidence is not necessarily an absence of experience. That few examples of the positive use of discretionary are presented in these articles cannot, therefore, be taken to indicate that front-line providers generally work to resist policy implementation; positive examples may just not be well represented or identified from these articles. Nonetheless, drawing on the principle of analytic generalization, we argue that the comparison and contrast of these experiences, all of which address the process of policy implementation in the common context of public health care systems, does generate broad conceptual insights of relevance across policy areas and geographical settings.

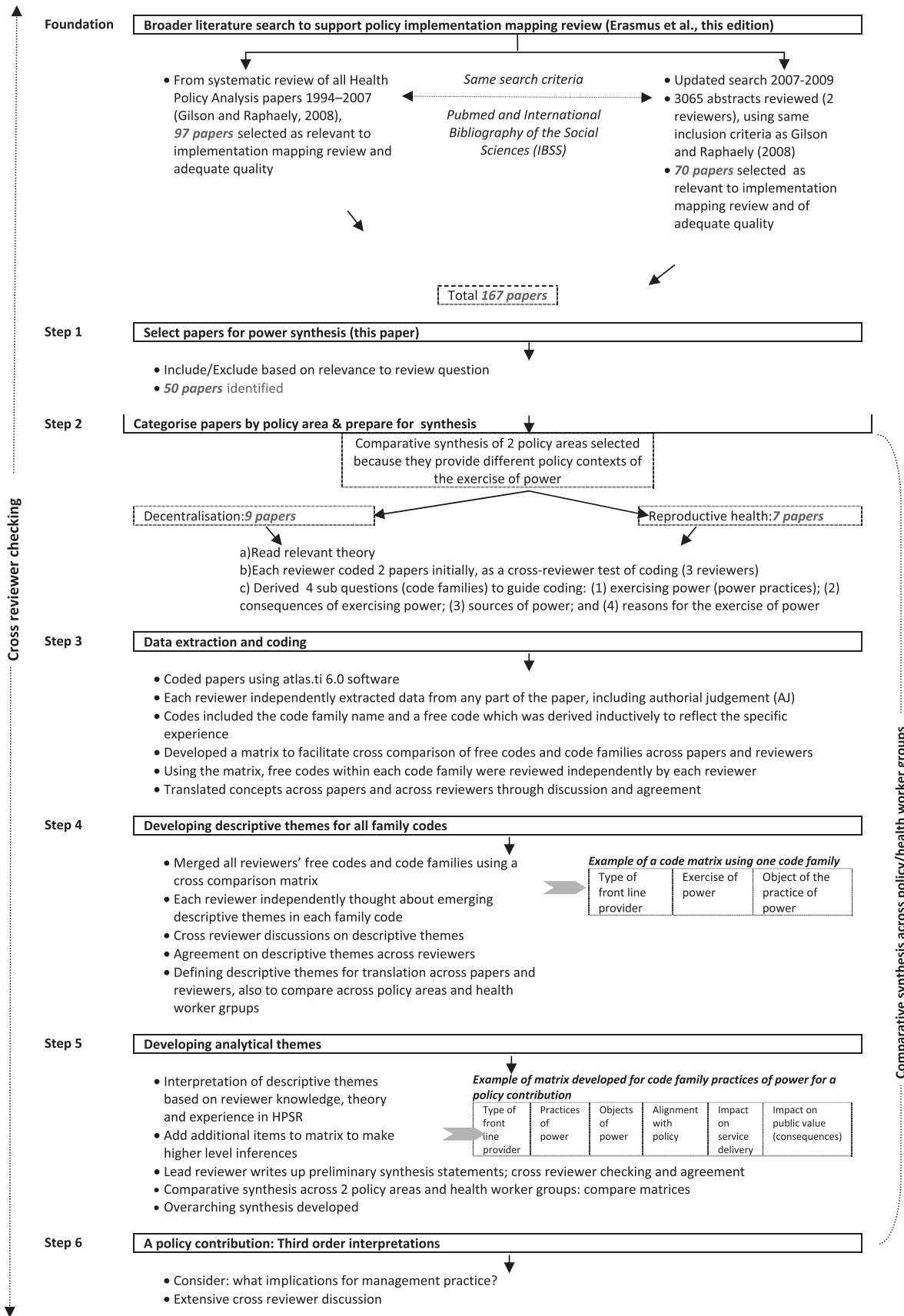


Figure 1 Steps in synthesis (drawing on Thomas and Harden 2008)

Table 1 Categories of discretionary power

Object	Decentralization articles	Reproductive health articles
Patient consultation processes (i.e. actions and inactions taken within the provider–patient consultation)	✓	✓✓
Citizen engagement processes (i.e. involving, or not, the community in decision-making and responding to expressed community need)	✓✓	None
Service delivery processes and organization (i.e. the delivery or not of specific types of services, the adaptation of service delivery guidelines and/or interventions that address the organization of service delivery)	✓✓	✓✓
Management processes (including staff and activity management)	✓✓	✓
Personal workplace decisions (i.e. decisions about whether and where to work, attitudes towards work)	✓✓	✓✓
Other policy actors (such as patients, community members, providers and politicians)	✓✓	✓✓
Policy (i.e. policy implementation processes)	✓	✓

Notes: Ticks indicate the presence of the practice category in the set of articles, with fewer ticks indicating fewer examples.

Interpretive synthesis may include an element of aggregating evidence but is ultimately about generating conceptual insights (Pope *et al.* 2007).

Overview of articles reviewed

Annexes 1 and 2 present the full list of articles included in this review. Together the articles report on implementation experience from 11 different countries, and 1 article (Palmer *et al.* 1999) focuses on emergency relief settings in several countries' experiences.

All the articles report studies which primarily use qualitative data collection methods such as in-depth interviews, focus group discussions, observation and semi-structured questionnaires (sometimes combined with documentary material). One article reports on an action research project (Khresheh and Barclay 2008), and one draws on several years of experience within an operations research project (Haaga and Maaru 1996). Four of the nine decentralization articles have the same first author, though the articles report different studies in different contexts.

Although grouped by policy area, there is considerable variation in the specific policies considered within each set of articles. The RH policies considered included: family planning, abortion, the provision of treatment services for sexually transmitted infections, and implementation of a new hospital birth record. Although all decentralization experiences focused on the primary or district level, with specific consideration of community participation in decision-making, these articles also considered a wider set of policies affecting service delivery: strengthening health promotion and prevention services, environmental health, abortion and public–private partnerships for environmental health service delivery. Therefore, whereas policy implementation can be equated with service delivery development for the RH articles, the decentralization articles encompass implementation both of new decentralization policies and service delivery changes. In addition, user fee removal or implementation was considered in both sets of articles, but particularly within the decentralization set.

The RH articles offer evidence around the power exercised by community-based workers, nurses and doctors working within

primary care facilities, health professionals in hospitals, and health professionals working for humanitarian organizations in emergency relief settings (one article). Managers working at the lower levels of the health system are rarely considered in these articles. The decentralization articles, meanwhile, provide evidence on the power practices of primary care health workers, with one article examining a cadre of community-oriented workers (environmental health officers), as well as local managers working, primarily, at a district, or equivalent, level.

A systematic review of the practice of discretionary power within health systems

The two inter-related sub-questions embedded in our primary question are:

- (1) What practices of discretionary power do front-line providers and local managers exercise in policy implementation, and with what consequences?
- (2) What power sources do front-line providers and local managers draw on in exercising discretionary power, and why do they exercise such power?

Question 1: What practices of discretionary power do front-line health system actors exercise in policy implementation, and with what consequences?

Table 1 summarizes the seven categories of discretionary power identified from the articles reviewed, categorized by the primary object targeted by the practice. These categories show that front-line actors exercised discretionary power over other policy actors—both at a personal level (other policy actors, see below for more details) and through key processes (i.e. patient consultation, citizen engagement and management processes). Practices of power also targeted the workplace, meso-level service delivery organization and processes and policy itself. Key differences between the two sets of articles reviewed reflected the policy focus, showing the more common targeting of citizen engagement and management processes in decentralization experience, and of patient consultation processes, in experiences of RH service delivery. Discretionary power was also quite

Box 1 FLP practices of power over the patient consultation process

Decentralization articles

Action:

- Senegalese hospital doctors and nurses demanded bribes and sell drugs against policy rules (Foley 2001)
- Primary care nurses waived fees for family members, against policy rules in Zambia (Atkinson 1997; Mogenson and Ngulube 2001) and Senegal (Foley 2001)

Failure to act:

- Zambian primary care nurses did not give patients drugs to take home as is expected, assuming they will be used improperly (Mogenson and Ngulube 2001)
- Nurses withheld or delayed care in Senegal (Foley 2001—until paid) and Zambia (Atkinson 1997)
- South African nurses refused to provide abortion services (McIntyre and Klugman 2003)

Reproductive health articles

Action:

- *Kenyan CHWs were sometimes proactive in offering appropriate family planning services to clients, sometimes secretly (to avoid community concern, or as the husband has not consented)* (Kaler and Watkins 2001)
- Kenyan CHWs used their own decision-making rules, rather than policy prescription, in deciding what family planning services to offer to specific groups of clients, e.g. no contraceptive pills were offered if a mother had no children or they were offered contraceptive pills only if they had more than three children (Kaler and Watkins 2001); and in Bangladesh, CHWs placed other pressures on clients regarding contraceptive choices (Haaga and Maaru 1996)
- Kenyan nurses restricted contraceptive choices made available to clients (Kaler and Watkins 2001)
- In Tanzania, primary care nurses tried to persuade women to use family planning against their own preferences, arguing that there would be negative consequences for their families, or, against policy, tried to persuade women with large numbers of children to be sterilised (Richey 1999)
- Ghanaian primary care nurses only provided STI services when senior staff were on site, though expected to provide them at all times, and encouraged patients in traditional beliefs to avoid discussing the reasons for STIs (Mayhew 2000)
- Ghanaian primary care nurses gave treatment secretly (Mayhew 2000)
- Primary care nurses waived fees for family members in Ghana (Mayhew 2000)

Failure to act:

- CHWs failed to ask prescribed questions of client in consultation in Bangladesh (Haaga and Maru 1996) and Kenya (Kaler and Watkins 2001)
- CHWs did not follow new algorithms as expected or do not offer any family planning choices to clients in Bangladesh (Haaga and Maru 1996)
- Primary care nurses and doctors failed to offer STI treatment in Ghana – did not follow treatment guidance and make necessary treatment decisions, especially when no senior staff available in facilities (Mayhew 2000)

Note: Italicized items are aligned with policy objectives and/or address client needs.

commonly exercised through formal and informal fee charging practices (see Box 1 and discussion of managers below).

A full listing of the identified front-line providers' (FLP) practices of power are presented in Boxes 1–3. These show that FLPs' exercise of discretionary power mostly influenced patients or community members, and that it took the form both of action and of inaction, or the failure to act. These practices also mostly entailed going against formal policy rules and expectations.

Working at one remove from the beneficiaries of new policies, managers, meanwhile, commonly exercised power by directly supporting or opposing new policy rules, influencing the process of implementation, innovating within policy rules or by influencing how others work with those rules. The more limited evidence extracted about local managers from the articles suggests that they too exercised power both in alignment with, and contrary to, policy expectations, but the balance of practice seems tilted in favour of alignment. Thus, in relation to:

- citizen engagement processes, managers assisted community members to participate in decision-making, but sometimes also coerced them into this role (Brazil, Atkinson *et al.* 2005);
- service delivery organization and processes, managers supported the integration of promotion and prevention services

into daily practice within the health system in Brazil (Atkinson *et al.* 2005) and introduced a new maternal and child health (MCH) booklet to track health and immunization status and developed comprehensive primary health care (PHC) services to respond to local need (Mexico, Birn 1999); but refused to support the provision of new abortion services in South Africa (McIntyre and Klugman 2003);

- Policy in general, made choices about whether or not, or to what extent; implemented policy guidelines in their jurisdictions for decentralization (Zambia, Atkinson 1997; Brazil and Chile, Atkinson *et al.* 2000; Atkinson *et al.* 2008), fee or fee removal policies (Mexico, Birn 1999) and preventive and promotive services (Brazil, Atkinson *et al.* 2005); as well as about the pacing of implementation (South Africa, McIntyre and Klugman 2003).

Managers also seemed more likely to exercise discretionary power over a wider range of policy actors than FLPs. These included: (a) providers themselves, through their management practices (exploiting subordinates: Haaga and Maaru 1996) and the way they engaged their staff in decision making (Atkinson *et al.* 2000; Crook and Ayee 2006); (b) programme managers (McIntyre and Klugman 2003) and (c) the politicians whose support they needed to implement policies or who seek

Box 2 FLP practices of power over service delivery organization and processes

Decentralization articles

Action:

- *Providers chose to offer new preventive and promotive services, as required by policy, integrating them into their routine activities in Chile* (Atkinson et al. 2008)
- *Environmental health officers chose to implement new environmental health regulations in Ghana* (Crook & Aye 2006)
- *Providers initiated new ways of working in support of service delivery: developing multidisciplinary teams responsible for family health in defined geographical areas in Brazil* (Atkinson et al. 2000) *and innovative service delivery models in Mexico* (Birn 1999)
- CHWs distributed medicines unofficially in Brazil (Atkinson et al. 2000)
- Providers made irregular referrals to their own private clinics or keep drugs at home to offer services from own homes in Brazil (Atkinson et al. 2000)

Reproductive health articles

Action:

- *Kenyan CHWs adopted flexible responses better to meet clients' family planning needs, sometimes going beyond policy expectations, including redefining roles, accompanying clients to clinics* (Kaler and Watkins 2001)
- *Jordanian hospital staff chose to support a new hospital information system that greatly improved reporting* (Khreshah and Barclay 2008)

Failure to act:

- CHWs in Bangladesh failed to provide outreach clinics as expected (Haaga and Maru 1996)
- South African primary care nurses refused to provide a newly legislated abortion service—sometimes to any woman or sometimes to particular groups of women (Harrison et al. 2000)
- Primary care nurses failed to conduct STI outreach services in Ghana, as required in policy (Mayhew 2000)
- Providers failed to offer expected reproductive health services in refugee camps (Palmer et al. 1999)

Note: *Italicized items are aligned with policy objectives and/or address client needs.*

Box 3 Other FLP practices of power

Citizen engagement processes

- *In Brazil, providers acted to support newly decentralized participation processes* (Atkinson et al. 2000; 2005), *and clearly acted in response to local population health demands* (Atkinson et al. 2008)
- Providers decided role of community committees, prevented them from taking action and did not consult them in Zambia (Atkinson 1997; Mogenson and Ngulube 2001), or acted with hostility towards them in Senegal (Foley 2001) or coerced their participation in Brazil (Atkinson et al. 2005)

Other policy actors

- Primary care nurses excluded individual community members from newly established facility decision making structures and processes in Senegal, particularly women (Foley 2001)
- Primary care nurses exercised favouritism in appointing particular people to such structures in Zambia or penalised specific community members for not participating in facility-related community projects agreed by new structures (Mogenson and Ngulube 2001)
- Primary care nurses were embroiled in conflictual personal relationships with community members in Senegal (Foley 2001)

Personal workplace decisions

- Providers chose to be absent from work without permission in Brazil (Atkinson et al. 2000) and in Ghana, so preventing STI service delivery (and sometimes in response to broader family and social demands: Mayhew 2000)
- CHWs in Bangladesh stopped work when not compensated as expected (Haaga and Maru 1996)
- After decentralization, providers chose to remain in or leave current workplaces, or not work in underserved areas (Mexico, Birn 1999; Brazil and Chile, Atkinson et al. 2005)
- *Against rules, primary care nurses used fee income to improve their own motivation* (Zambia, Atkinson 1997)

Note: *Italicized items are aligned with policy objectives and/or address client needs.*

themselves to shape policy implementation (Crook and Aye 2006). Finally, like FLPs, managers' personal workplace decisions also influenced implementation—by choosing to stay in their jobs after decentralization (Brazil: Atkinson *et al.* 2000), challenging policy rules and protesting to superiors (Senegal: Foley 2001) or by corrupt acts (Zambia: Atkinson 1997).

Across all three staff groups, we also identified some instances where personal thoughts and attitudes underpinned practices of power (as recognized in theory: Fischer 2003). These instances came largely from articles reporting studies that

had explicitly sought implementors' views or from authorial interpretations of evidence. FLP practices of power targeting citizen engagement and patient consultation processes were, thus, sometimes shown to be underpinned by: attitudes about the policy of focus, both positive and negative (abortion: Harrison *et al.* 2000; decentralization: Atkinson 1997; user fees: [AJ] Atkinson 1997; McIntyre and Klugman 2003); and negative attitudes towards (groups of) clients and the community at large (Harrison *et al.* 2000; Mayhew 2000; Mogenson and Ngulube 2001; [AJ] McIntyre and Klugman 2003;

Crook and Ayee 2006). Ghanaian environmental health officers' positive attitudes towards their job, meanwhile, allowed them to work constructively in new roles (Crook and Ayee 2006).

In a few instances, thoughts and attitudes were also found to be important in making meaning of policy, and so shaping other exercises of power. A South African nurse's re-framing of abortion as acceptable after rape, allowed her to provide abortion in those particular circumstances although she would refuse to provide the service to other women (Harrison *et al.* 2000). Similarly, Brazilian providers' awareness of health promotion concepts underpinned their acceptance of their new roles in providing these services (Atkinson *et al.* 2005). Managers' acceptance, or not, of democratization discourse, moreover, influenced their approach to implementing decentralization policies (Zambia: [AJ] Atkinson 1997; Brazil: Atkinson *et al.* 2000), whilst negative views of abortion and user fees led some South African managers to work against implementation of these policies ([AJ] McIntyre and Klugman 2003).

These experiences point to one other managerial exercise of power: managers' influence over other actors' understanding of policies. The three instances identified were:

- Framing health care as a technical rather than political issue, managers supported the implementation of decentralization in Brazil by reducing the potential for conflict with local government ([AJ] Atkinson *et al.* 2000);
- Offering visionary leadership around meeting the needs of the uninsured in Mexico, managers were able to develop a model programme despite budgetary and other constraints (Birn 1999);
- Locating family planning in an approach to maternal and child health care, rather than population control, managers secured support from some FLPs for family planning policies in Tanzania (Richey 1999).

Finally, we assessed the consequences of discretionary power for public value, that is their value to society at large. Drawing on Moore (1995), we judged that those power practices influencing service delivery (including user fee implementation) were likely to undermine public value when they impacted negatively on patients personally and restricted their access to service (see Boxes 1–3). However, public value was enhanced when power practices improved relationships with patients (hospital information system, Khresheh and Barclay 2008) or expanded patient access to services (family planning referrals, Kaler and Watkins 2001; abortion and family planning re-framing, Richey 1999; Harrison *et al.* 2000). Power practices influencing decentralization, meanwhile, had wider public value impacts linked to their potential to build or undermine community trust in the health system (e.g. via provider attitudes towards the community, by inclusive or exclusive approaches to community engagement and by staff (non)availability in newly decentralized local systems (Foley 2001; Birn 1999; Atkinson *et al.* 2000; Mogenson and Ngulube 2001). Managerial corruption was also likely to impact negatively on public value and undermine public trust in the health system (Atkinson 1997).

In summary: in acting against policy rules when exercising discretionary power, FLPs and managers may generate negative

consequences for patients and citizens in terms both of access to services and their experience of the health system and so, ultimately, the health system's value to society. Nonetheless, some experiences suggest that the exercise of discretionary power has positive potential for policy implementation. First, we identified a few instances of FLP discretionary power going beyond, and even against, policy, but offering enhanced public value. In Kenya, e.g. community-based health workers sometimes acted in ways that supported the uptake of family planning services, with benefits for women and families as well as generating the wider benefit of greater trust in the health system to which these workers were linked (Kaler and Watkins 2001). Second, the evidence shows that managers did sometimes, and perhaps more often than FLPs, act in alignment with policy rules and support policy implementation for public value. For example, where managers and primary care providers adopted innovative approaches to service delivery organization, such as in Brazil, multidisciplinary teams responsible for family health in defined geographical areas, they also promoted access and public value (Atkinson *et al.* 2000).

Question 2: How and why do front-line providers and managers exercise power?

Through an inductive process, drawing on prior theoretical reading, we extracted, coded and categorized evidence from the articles to identify, first, the different sources of power underpinning the exercise of power by providers and managers (the how question) and, second, the reasons why providers and managers exercised power in these ways (the triggers for exercising power).

Table 2 presents the full set of personal factors (attitudes, motivation, behaviours and value judgements, as well as knowledge and skills) identified as sources of power for FLPs' actions and inactions, across the two policy areas considered (RH and decentralization). Summarizing from the table, personal factors that triggered exercises of power were whether or not the policy was aligned with an FLP's values, there was personal commitment to the policy or the policy offered personal guidance and incentives for FLP actions. At an organizational level, the policy itself, as well as the organizational and managerial environment, sometimes acted as sources of power for actions supporting service delivery/policy implementation; however, it was the processes of policy implementation and management that were more likely to trigger their exercise of power (Table 3). The reverse also holds. Specific elements of the organizational environment (discourse and weak lines of accountability) sometimes provided a source of power for actions that constrained implementation, and weak policy and management processes triggered such actions. Resource availability also acted as both a source and reason for exercising power, and was found to underpin support and resistance to implementation. Organizational and staff–community relationships, finally, only served as triggers for these exercises of power.

The identified sources and/or triggers for the thoughts and attitudes that underpinned FLP practices of power were: personal values (Atkinson *et al.* 2000; Crook and Ayee 2006); the extent of communication and consultation in policy development (McIntyre and Klugman 2003; Atkinson *et al.* 2005; Crook and Ayee 2006); the spread of ideas within the wider system

Table 2 Personal factors acting as sources or reasons for the practice of power for front-line providers

	Supporting service delivery/implementation	Constraining service delivery/implementation
Sources	Value judgements (RH, abortion policy: Harrison <i>et al.</i> 2000) Intrinsic motivation (EHOs: Crook and Ayee 2006) Positive personal behaviours, such as: <ul style="list-style-type: none"> • Championing of patients by CHWs (family planning: Kaler and Watkins 2001), • Forging good relationships with citizens by EHOs (Crook and Ayee 2006) Knowledge and skills relevant to jobs generated by supportive training (family planning, CHWs: Kaler and Watkins 2001; EHOs: Crook and Ayee 2006)	Value judgements (RH, abortion policy: Harrison <i>et al.</i> 2000) Attitudes of professional superiority towards community members (decentralization, Mogenson and Ngulube 2005) The absence of professional status (EHOs: Crook and Ayee 2006) The absence of knowledge/skills relevant to jobs, resulting from weak training (EHOs: Crook and Ayee 2006)
Reasons	Alignment of personal values with policy (RH: Kaler and Watkins 2001, CHWs; Richey 1999; decentralization: Birn 1999) Personal commitment and motivation in relation to a policy, including to: <ul style="list-style-type: none"> • A new RH health information system policy (Khreshneh and Barclay 2008); • Stay in a local area after decentralization (Atkinson <i>et al.</i> 2000); • Provide preventive and promotion services within newly decentralized structures (Atkinson <i>et al.</i> 2008); Positive guidance and incentives for provider action offered by the new policy, such as the: <ul style="list-style-type: none"> • Value of a new RH health information system policy for clinical practice (Khreshneh and Barclay 2008); • Financial, career and status rewards of the policy (decentralization: Atkinson <i>et al.</i> 2000; 2008; Crook and Ayee 2006, EHOs; RH: Kaler and Watkins 2001, CHWs); • Performance targets, CHWs (Haaga and Maaru 1996); • New job descriptions, EHOs (Crook and Ayee 2006); • Vision and direction (RH: Haaga and Maaru 1996, CHWs; decentralization: Atkinson <i>et al.</i> 2005; 2008); • Transparency preventing bad practice, EHOs (Crook and Ayee 2006); • Integration of preventive and promotion services within newly decentralized structures into routine activities by front-line providers (Atkinson <i>et al.</i> 2008) 	Lack of alignment of personal values with policy (RH: Kaler and Watkins 2001, CHWs; Mayhew 2000; Palmer <i>et al.</i> 1999; decentralization: Foley 2001; McIntyre and Klugman 2003) Lack of commitment (EHOs, Crook and Ayee 2006), also linked to front-line providers': <ul style="list-style-type: none"> • Limited understanding of prevention (Atkinson <i>et al.</i> 2008) • Weak skills for RH (Palmer <i>et al.</i> 1999) • Limited/weak training relevant to STIs (Mayhew 2000) • Limited experience of decentralization (Atkinson <i>et al.</i> 2005) Lack of guidance and incentives for provider action offered by a new policy, including: <ul style="list-style-type: none"> • Policy confusion, family planning (Richey 1999) • Role confusion, STI disease treatment (Mayhew 2000) • Lack of RH service standardization (Palmer <i>et al.</i> 1999) • Lack of financial incentives (decentralization: Atkinson <i>et al.</i> 2008; Birn 1999; family planning: [AJ] Haaga and Maaru 1996, CHWs); • Lack of transparency (decentralization: McIntyre and Klugman 2003).

Note: Table identifies whether RH, and specific related policies, or decentralization, is the focus of the identified article, and also which articles focus specifically on community-based workers (CHWs, community health workers and EHOs, environmental health officers) as opposed to other front-line providers.

(Atkinson *et al.* 2005) and relationships with both colleagues and the community (Crook and Ayee 2006).

Finally, these experiences showed that sources of power (and to a more limited extent, the reasons for exercising power) were nested in and bolstered by three sets of contextual factors:

(a) Professional norms and practices:

- The professional culture of EHOs in Ghana supported positive practices of power (Crook and Ayee 2006); but
- medical hierarchy in Ghana underpinned nurses' refusal to provide STI services, deference to senior staff and their own lack of legitimacy (Mayhew 2000); professional discourse underpinned nurses' refusal to offer abortion services in South Africa (Harrison *et al.* 2000);

(b) Sociocultural values:

- The traditional role of older women in RH underpinned respect for CHWs in Kenya (Kaler and Watkins 2001); but

- Community traditions and preferences regarding drugs supported the practice of front-line providers keeping drugs at home in Brazil (Atkinson *et al.* 2000); community values and public discourse underpinned South African nurses' refusal to provide abortion (Harrison *et al.* 2000); traditional gender roles underpinned the failure to offer STI services by female nurses to male clients in Ghana (Mayhew 2000); social and Islamic norms lead women to be excluded from decentralized decision-making structures in Senegal (Foley 2001);

(c) Wider political and economic factors:

- Political support for decentralization in Brazil and Chile (Atkinson *et al.* 2000; 2005); the broader economic situation underpinned community receptiveness for family planning in Tanzania (Foley 2001); but
- A lack of trust in government underpinned the power practices of Kenyan CHWs (Kaler and Watkins 2001),

Table 3 Other sources and reasons for the practice of power for front-line providers

	Supporting service delivery/implementation	Constraining service delivery/implementation
Sources	<p>Policy itself:</p> <ul style="list-style-type: none"> • Gives providers credibility (RH: Kaler and Watkins 2001, CHWs) • Gives providers the discretionary space to engage with clients (RH: Kaler and Watkins 2001, CHWs; Haaga and Maaru 1996, CHWs; Richey 1999), or general discretionary space (decentralization: Atkinson 1997; McIntyre and Klugman 2003; Atkinson <i>et al.</i> 2008) • Underpins the new roles and activities of decentralized units (Atkinson 1997; Birn 1999; Atkinson <i>et al.</i> 2000; Foley 2001), • Can, when framed ambiguously, be discussed in ways that act as a source of support (although this can also allow for opposition for policy implementation: RH, Richey 1999). <p>The organizational and management environment:</p> <ul style="list-style-type: none"> • Front-line providers' professional roles in the health system (decentralization, Atkinson 1997; RH: Mayhew 2000; Foley 2001) • Clear job descriptions and the back-up of regulatory instruments and legislation (decentralization, Crook and Ayee 2006, EHOs) • Managerial support for front-line providers (RH: Khresheh and Barclay 2008); • Access to the resources of the wider health care system (RH: Kaler and Watkins 2001, CHWs). <p>Resource availability</p> <ul style="list-style-type: none"> • RH, donor funding (Richey 1999) • Decentralization and related service delivery, Brazil and Chile (Atkinson <i>et al.</i> 2000; 2008) 	<p>Organizational discourse about or <i>linked</i> to policies (about nurses' rights, <i>linked</i> to RH, abortion policy: Harrison <i>et al.</i> 2000)</p> <p>Weak and conflicting lines of accountability (decentralization: McIntyre and Klugman 2003)</p> <p>Lack of resource availability</p> <ul style="list-style-type: none"> • RH, refugee camp settings (Palmer <i>et al.</i> 1999)
Reasons	<p>Policy and management processes that</p> <ul style="list-style-type: none"> • Include FLPs (RH: Haaga and Maaru 1996, CHWs; Khresheh and Barclay 2008; decentralization: Crook and Ayee 2006, EHOs; Atkinson <i>et al.</i> 2005) • Work with the hierarchical structures of the health system (decentralization: Atkinson <i>et al.</i> 2008) <p>Organizational relationships:</p> <ul style="list-style-type: none"> • The support of colleagues (decentralization: Atkinson <i>et al.</i> 2008; Crook and Ayee 2006, EHOs) • Supportive networks between health sector staff and other sectors and civil society organizations (decentralization: Atkinson <i>et al.</i> 2005; 2008) <p>Staff–Community relationships</p> <ul style="list-style-type: none"> • Where positive, trigger virtuous cycles of interaction and provider exercise of power and service delivery/policy implementation (decentralization: Atkinson <i>et al.</i> 2005; 2008; Crook and Ayee 2006, EHOs) • The fear of negative community responses triggers positive power practices (RH: Kaler and Watkins 2001, CHWs) <p>Resource availability supports</p> <ul style="list-style-type: none"> • RH services (donor funding: Richey 1999) • Decentralization and related service delivery (Atkinson <i>et al.</i> 2000; 2008) 	<p>Policy and management processes that</p> <ul style="list-style-type: none"> • are weak or exclusive (decentralization: Atkinson <i>et al.</i> 2005([AJ]; RH: Haaga and Maaru 1996, CHWs; Palmer <i>et al.</i> 1999; Mayhew 2000). • <i>encompass multiple policy changes</i> (decentralization: McIntyre and Klugman 2003). <p>Organizational relationships:</p> <ul style="list-style-type: none"> • The threat of colleagues (decentralization: McIntyre and Klugman 2003); • Limited decentralized authority for resource use (Atkinson <i>et al.</i> 2005; 2008) • Constraining networks between health sector staff and other sectors and civil society organizations (decentralization: Atkinson <i>et al.</i> 2008); • Generally weak relationships after decentralization between health staff and local government (Foley 2001; Atkinson <i>et al.</i> 2008), regions (Atkinson <i>et al.</i> 2008) <i>and between area and programme managers</i> (McIntyre and Klugman 2003) <p>Staff–Community relationships</p> <ul style="list-style-type: none"> • Where negative, trigger vicious cycles of interaction, provider exercise of power and service delivery/policy implementation (decentralization: Crook and Ayee 2006, EHOs; Foley 2001) • The fear of negative community responses triggers negative power practices (RH: Kaler and Watkins 2001, CHWs; Harrison <i>et al.</i> 2000; Palmer <i>et al.</i> 1999; decentralization: Atkinson <i>et al.</i> 2000) <p>Lack of resource availability</p> <ul style="list-style-type: none"> • Generally, for RH services (Palmer <i>et al.</i> 1999; Mayhew 2000) • Led senior staff to be absent from facilities and so junior staff not provide RH services (STI treatment: Mayhew 2000); • Generated perceptions of high staff workloads and poor working conditions, leading to refusal to provide abortion services (Harrison <i>et al.</i> 2000) or poor staff behaviours (decentralization: Mogensen and Ngulube 2001)

Notes: (1) Table identifies whether RH, and specific related policies, or decentralization is the focus of the identified article, and also which articles focus specifically on community based workers (CHWs, community health workers and EHOs, environmental health officers) as opposed to other front-line providers. (2) Factors italicized work exclusively to constrain service delivery/policy implementation.

and Ghanaian EHOs (Crook and Ayece 2006); traditions of personalized leadership (Atkinson *et al.* 2000), political instability (Atkinson *et al.* 2005) and networks of patronage (Atkinson *et al.* 2008) in Brazil underpinned practices of power that undermined decentralization as did political interference in Ghana (Crook and Ayece 2006), and networks of patronage in Senegal (Foley 2001).

Tables 2 and 3 also show that the differences between sources and reasons were often quite subtle, and in practice, there were also, commonly, complex interactions among these factors. For example, in South Africa (Harrison *et al.* 2000; McIntyre and Klugman 2003), nurses' value judgements about which client groups were and were not 'deserving' provided a source of power (i.e. the justification and confidence) to provide or refuse to provide abortion services. Their policy role as the provider of these services then gave them the additional power to put these judgements into practice. In addition, the alignment of the 1996 Termination of Pregnancy Act with value judgements was the reason why some nurses provided services to women who had been raped or who had suffered incomplete abortions, whilst the contradiction between the policy and other value judgements also led some nurses to refuse abortion to young girls or to a blanket refusal to offer abortion services. At the same time, although their policy role as providers of abortion services was a source of their power, their lack of involvement in policy development and poor communication with them about the policy triggered these practices of power.

Comparison among FLPs highlights differences between the experiences of community-based workers and that of formal health professionals (nurses/doctors). Community-based providers work outside a facility base, offering preventive and promotive care which sometimes involves local inter-sectoral collaboration. As a result, CHWs essentially relied on the co-operation, good will and buy-in of communities as power sources for their work, but were also far more likely to encounter community power structures, norms and local political cultures, and had to rely more on informal sources of power, than formal health professionals (Haaga and Maaru 1996; Kaler and Watkins 2001; Crook and Ayece 2006). Not surprisingly, therefore, their exercise of discretionary power included actions to build their status within the community's eyes—such as, in Kenya, wearing uniforms, building relationships with the local clinic, using their role as community-based workers to gain social recognition and championing patients in the face of harsher nurse attitudes (Kaler and Watkins 2001). Community relationships were also largely, though not exclusively, identified as a trigger of CHW power practices (Kaler and Watkins 2001; Crook and Ayece 2006; see Table 4). One article, reporting experiences around RH services in refugee camps, reported similar experiences (Palmer *et al.* 1999). In contrast, formal health professionals were more able to rely on traditional professional authority in relation to clients and citizens, as well as being more firmly embedded within organizational and professional hierarchies and influenced by those norms.

Managerial experience was largely derived from the decentralization articles. Compared to FLPs, wider political relationships, particularly with local government, were more likely to be both sources, and reasons for their exercise, of power

(Atkinson *et al.* 2005, 2008). However, other sources of manager power were similar to those for FLPs and included personal capacities and resources (Atkinson *et al.* 2000; 2005; 2008), personal convictions and values (Birn 1999), clear policy roles (Birn 1999; Atkinson *et al.* 2000), levels of resource availability and the degree of coherence in the organizational and managerial environment (Atkinson *et al.* 2000; McIntyre and Klugman 2003). Managerial exercise of power in support of decentralization was triggered by commitment and motivation (Atkinson *et al.* 2000), and philosophical convictions (Birn 1999); whilst power practices constraining implementation were triggered by interference from other managers (McIntyre and Klugman 2003), and weak leadership and engagement in policy processes (Birn 1999; Atkinson *et al.* 2000; McIntyre and Klugman 2003). The presence or absence of popular demand was another identified trigger (Birn 1999). These factors were, again, nested within wider contextual factors. Community contexts with strong traditions of participation or social movements, local histories of collective action, clearly defined and non-conflictual centre-local political and administrative processes and local inter-sectoral processes provided sources of power for actions in support of decentralization (Birn 1999; Atkinson *et al.* 2000; 2005), whilst actions constraining decentralization were underpinned by sociopolitical traditions of exclusion (Foley 2001), personalized leadership and weak community participation (Foley 2001; Atkinson *et al.* 2000; 2005).

Comparison across policy areas, finally, shows the influence of different combinations of factors. On balance, the RH articles, addressing value-sensitive policy issues, demonstrate that personal factors can influence policy acceptance and implementation (see Table 3)—and were underpinned by social and professional norms. In contrast, the decentralization articles highlight the influence of broader organizational factors and community relationships (see Table 4)—and were underpinned by wider economic and political factors.

Overall synthesis: How and why do front-line providers and local managers exercise power in policy implementation, and with what consequences?

Figure 2 outlines our overall synthesis, which builds on but, as is usual practice in interpretive synthesis (Pope *et al.* 2007), also goes beyond the systematically generated and summarized evidence. It highlights key insights derived from this evidence that, given their level of abstraction, are judged to be relevant in public sector environments across geographical settings, whilst also taking account of the identified differences among policy types and provider groups.

FLPs and local managers exercise power in implementation around a set of objects, and related actors, and through both their actions and inactions. FLPs exercise personal power in their individual engagements with patients and citizens, particularly when offering advice and treatment. Managers work at one remove from health system beneficiaries and so tend to exercise personal power in relation to FLPs and other health system actors, rather than individual citizens. Both sets of front-line actors also exercise power over their own workplace behaviours. An organizational level, both groups, but

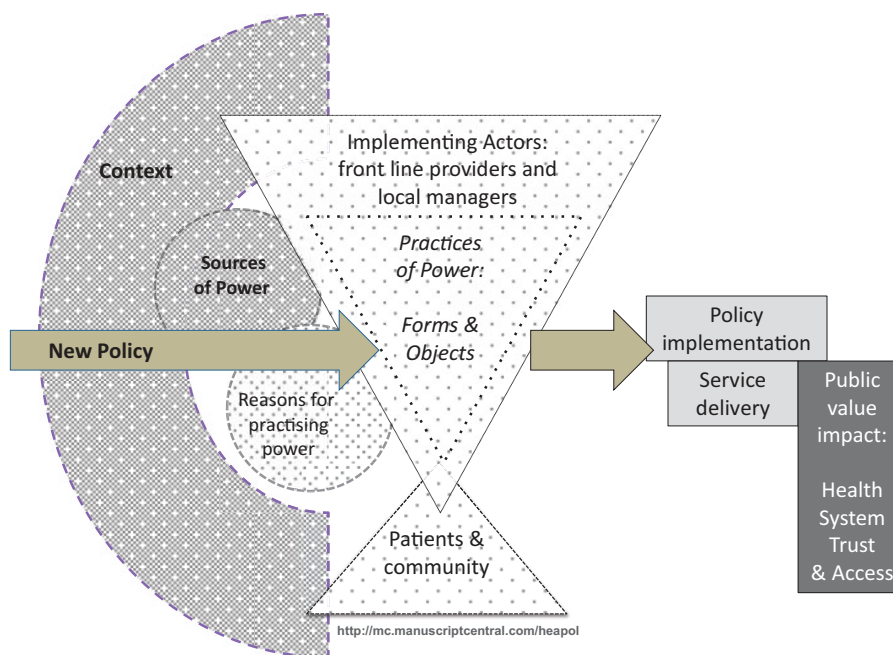


Figure 2 An outline of how micro-practices of power play out in policy implementation

especially managers, exercise power over service delivery organization and processes, citizen engagement processes, policy itself and, for managers only, in managerial processes. Finally, the personal meaning these actors give to particular policies may influence their own practices of power; and managers may also shape the actions of other actors through the policy meanings they present to them.

The sources of power underpinning these practices are largely drawn from the personal, local and organizational context in which FLPs and managers are situated. This context comprises a web of relationships and a set of norms that can be traced up the health system hierarchy and outwards to the community and society, and are themselves located within a history of experience and reputation. Personal and professional values, personal knowledge and skills, and personal motivation are all examples of possible sources of power for implementation support, as are professional roles within the broader health system, organizational coherence and resourcing, sociocultural values and the political and economic context. The nature, extent or absence of any of these factors may, however, act as a source of power for resistance. Community-based workers tend, moreover, to draw on community sources of power, whereas facility-based workers draw more on professional and organizational sources of power, and local managers, on sociopolitical and administrative traditions.

The introduction of a new policy into this context may provide additional sources of power for, and/or trigger responses of, implementation support or resistance. Newly defined roles and responsibilities might represent a power source, e.g. as might the enhanced provider credibility, additional resources or new spaces of engagement with beneficiaries that a new policy might bring. Power for resistance, meanwhile, might be generated by new, confusing lines of

accountability, inadequate resource levels or discourses that run counter to the policy. The introduction of a new policy may, in addition, trigger front-line actor support or resistance through the extent of its alignment with pre-existing personal or professional values or beliefs, or expectations of personal gain, or through the manner in which they are engaged in, and supported to, implement it. The degree of resource availability for the policy and its organizational fit are other possible triggers, as is the nature of local and higher level leadership for policy change. The impact of policy implementation on local and community relationships may also trigger vicious cycles of negative interaction and resistance, or virtuous cycles of positive interaction and support—e.g. a new policy may either encourage or undermine collegial networks, or may open providers to undue community pressures or enhance their local reputation. The mix of ripple effects stimulated by a new policy vary across policies in response to their impact on provider values and organizational and community contexts, e.g. and to whether community or facility-based providers are key implementing actors. These effects also vary between contexts, given differences in professional, political and social norms, systems and histories.

The evidence presented suggests that FLPs' practices of power commonly work to obstruct policy implementation and undermine service delivery. Longer term negative public value impacts are the likely consequence, given the knock-on effects on patient access to health care or citizen trust in the health system, for example. Local managers also quite often exercise power in ways that limit or constrain policy implementation, service delivery and the achievement of public value—such as through the direct exercise of power in their engagements with citizens or the mis-use of management authority; or indirectly, through their exercise of power over their staff or

the way they shape policy decision-making practices and the organization of service delivery. However, there are also some instances of more positive experiences—even in the exercise of discretionary power outside the formal structures and processes of the health system and beyond policy mandates. Community-based workers may, thus, take independent initiatives to build their relationships with their clients, other FLPs may be motivated to work effectively or allowed to innovate in service delivery, and local managers may provide support for such actions. As noted earlier, the absence of evidence on such positive experiences in this set of articles should not be taken to imply that they are not more common.

What is the significance of this systematic review and synthesis?

This review and synthesis makes three main contributions to the broader health policy and systems field. First, it provides systematically generated evidence from existing literature that illuminates the discretionary power of front-line health providers and local managers in low and middle income countries, how it is exercised in daily decision making, routine activities and through local relationships. The consequences of these micropractices of power in terms of the implementation of policy goals—as well as access to services or public trust in the health system—demonstrate their significance for understanding the oft-cited implementation gap. In addition, the review adds to the emerging literature on health systems as complex adaptive systems (Paina and Peters 2012), pointing out the importance of actors, power relations and multiple, embedded contextual elements as dimensions of that complexity. Although few in number, the diversity of the articles reviewed—in disciplinary perspective, as well as policy, country and time contexts—enriches the synthesis and the analytic generalizations it presents.

Second, the review suggests that tackling the ‘implementation gap’ requires consideration of how to manage the discretionary power exercised by front-line actors, and points to strategies that could be used by their managers. As a starting point, the experiences suggest that these managers (perhaps located at district or local area level) must recognize that every policy has its own peculiarities and influences, and they must also be aware of the different behavioural drivers of providers working in communities, compared to those working in facilities. Management strategies must, therefore, be tailored to particular policies and providers.

Managers must also be aware of the scope of their own discretionary power. Although varying between contexts, they generally have, e.g. some positional and organizational power. In line with top-down perspectives on implementation (see also Hudson and Lowe 2004; Hill and Hupe 2009), the synthesis suggests that they might influence FLPs by aligning resources and organizational environments to support them to work towards policy goals (see Table 4). For example, it might be possible for these managers to: link policy implementation to incentives; revise job descriptions to establish clear roles and responsibilities in line with policy goals; allocate resources to support implementation; delegate decision-making authority to support implementation; or hold providers to account for

negative practices, perhaps through disciplinary procedures. They may also be able to authorise formal training and learning activities that can help to build the FLP knowledge, understanding and confidence that sustain actions supportive of policy (see Table 3).

However, and in line with bottom-up perspectives on implementation (e.g. Barrett 2004), the synthesis shows that rules and incentives are not the only influences over FLP behaviour. FLPs’ attitudes towards new policies (see Table 3), as well as towards patient and community groups, are an important foundation for their other practices of power. A related element of local manager power identified in this synthesis is, therefore, their potential to influence the provider discourses and mindsets, beliefs and values, and levels of motivation, that underlie the more tangible practices of provider power. Values clarification workshops are, for example, widely proposed as a way of offsetting provider concerns about abortion policies (e.g. Turner *et al.* 2008). Supportive supervision is also widely seen as important, if difficult, in low resource settings (Bosch-Capblanch and Garner 2008). However, by encouraging regular reflection and deliberation and engaging staff in fine tuning and strengthening policy implementation it could provide opportunities to build the personal and organizational meanings that sustain implementation, as well as generating practical, innovative ideas with positive policy outcomes (Walker and Gilson 2004). Performance management and appraisal systems, meanwhile, offer general opportunities for sustaining staff motivation and managers might also devote attention to developing and managing the team work that is commonly recognized as important within health care (Franco *et al.* 2002). Finally, given that providers are always embedded in a web of local relationships (see Table 4), strengthening structures of mutual, local accountability is an important potential influence over provider behaviour (Molyneux *et al.* 2012).

The third and final dimension of this review’s significance is for health policy and systems research. On the one hand, the review demonstrates the possibility of generating policy-relevant theoretical insights about aspects of the process and practice of policy change through systematic synthesis of existing, relevant empirical literature. It specifically demonstrates the approach of thematic synthesis for such work, highlighting the use of conceptual reading and authorial judgement as a basis for inductive judgement as additions to current practice (Thomas and Harden 2008). Building on this article, further power syntheses could also, for example, consider experience from a wider range of health policy areas, compare LMIC and higher income country experiences, and/or draw in non-health literature. On the other hand, this review itself provides a foundation for future primary, empirical research that could test and extend the framework represented in Figure 2, or address identified gaps in the existing knowledge base—e.g. about the use of power in successful policy implementation, or in management practice. The still limited understanding of values and meanings as influences over micropractices of power also suggest that policy implementation work would be deepened and enriched through wider use of interpretive policy analysis approaches to access local, practice knowledge (Yanow 2003).

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¹ We use the term ‘micropractices of power’, to denote our focus on the use of power by individuals within the health system—recognizing their agency within the broader institutional structures shaping their behaviours and actions (see also Lipsky, 2010; Rice, 2013).

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Annex 1 Decentralization articles

Title	Policy area	Methods	Geographical location and location within the health system	Brief overview	Providers/managers of focus
Atkinson <i>et al.</i> 2000 Going down to the local: incorporating social organization and political culture into assessments of decentralized health care	Decentralization of health care provision to the local district government	Case study approach, three cases of district health systems, employing observation, informal conversations (researchers lived in the districts for 14 months) and formal open interviews. Included multiple stakeholders representing the health system and the community	Northeast Brazil District level, including facilities in the local health system (e.g. public health centres)	The article explores three cases of district health systems in Northeast Brazil to identify aspects of local social organization and political culture in order to examine their potential influence on health-care quality provided within a decentralized health system	Health care providers and local managers
Atkinson <i>et al.</i> 2005 Prevention and promotion in decentralized rural health systems: a comparative study from northeast Brazil	Decentralization, promotion and prevention	Case study approach, two rural local health systems, employing document analysis, interviews, conversations and observations	Ceara State, Northeast Brazil Municipal level	Within a decentralized health system, the study compares two rural local health systems in order to understand local factors affecting the implementation of policies for prevention and promotion. The study compares why the two sites perform differently in adopting prevention and promotion activities into their local health systems. Local factors such as levels of community participation and political continuity are found to be relevant	Health staff and managers in the local health system
Atkinson <i>et al.</i> 2008 Promotion and prevention within a decentralized framework: changing health care in Brazil and Chile	Decentralization, promotion and prevention	Case study approach, eight local health systems in rural and urban Brazil and Chile, employing interviews, secondary sources, policy documentation and observations	Brazil and Chile National, regional and local	Within decentralized health systems the article looks at factors from local, regional and national levels that impact on the implementation of the health care models of promotion and disease prevention. The article draws comparisons at three levels: (1) between similar local health systems within a national health system, (2) between rural and urban local health systems within a national health system and (3) between the local health systems of two different countries. The article speaks to factors that affect delivery on the ground	Health care providers such as physicians and family health care teams; local managers
Atkinson 1997 From vision to reality: implementing health reforms in Lusaka, Zambia	Decentralization, cost-sharing and increased popular involvement as part of the implementation of the National Strategic Health Plan (1994)	Case study of Lusaka, employing open interviews with multiple actors (health sector and community) and discourse analysis	Lusaka, Zambia National level, district level, local level and local population	The article examines the intentions of health reform policy, the interpretations of the policy at all levels of the system and considers the experience of the health reforms by health staff and potential users. The article also demonstrates the use of two conceptual tools in studying health sector reform: Lukes' three dimensional definition of power (1974) and Wildavsky's concept of veto points (1973)	Clinical health centre staff and the facility managers; local managers
Birn 1999 Federalist Filtrations: The Politics and Execution of Health Services Decentralization for the Uninsured Population in Mexico 1985–1995	Health services decentralization	Case study approach, three Mexican States employing interviews with the federal level actors in Mexico City	Sub-national levels of government, including state and local levels. Also a community component	Examines the rise and fall of the decentralization of health services for the uninsured population in Mexico for the period 1985–1990. Of particular interest was the examination of the effects of these on the delivery of service at the local level, often affecting the quality of services provided as well as provider behaviour	Health care providers such as specialists and physicians; managers

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Annex 1 Continued

Title	Policy area	Methods	Geographical location and location within the health system	Brief overview	Providers/managers of focus
Crook and Ayece 2006 Urban Service Partnerships, 'Street-Level Bureaucrats' and Environmental Sanitation in Kumasi and Accra, Ghana: Coping with Organizational change in the public bureaucracy	Privatization and public community-based participation in service provision and decentralization	Case Study of the public health departments in Kumasi and Accra, using participant observation, interviews and a questionnaire survey	Kumasi and Accra, Ghana Local government	As a result of various changes in the methods of the delivery of sanitary services, the article focuses on how Environmental Health Officers (EHOs) manage their new roles internally in the bureaucracy and with other external delivery agents in delivering sanitary services. This includes studying relationships within communities as community-based participation was one of the policy changes. EHO's were originally located within a division which was part of the National Ministry of Health; however, as a result of decentralization they were placed under local government authority and many changes in their roles and jobs functions are discussed	Environmental health officers working in local communities
Foley 2001 No money, no care: women and health sector reform in Senegal	Decentralization, privatization of the health sector and the institutionalization of participatory management structures. Power was devolved from central to regional and local levels	Case study approach, one city with a focus on one neighbourhood, using interviews, participant observation and focus groups with multiple stakeholders representative of the health system and the community	The neighbourhood of Pikine in the City of Saint Louis, Senegal Regional level, clinics and the community	Focuses on three elements of parallel change within the public health sector in Saint Louis, Senegal: decentralization, privatization and the implementation of participatory management structures at each health facility. Policies from the top are modified and adapted at the ground level where they are implemented; the article examines local level dynamics affecting implementation of these policies and reflects on the position of women in relation to the health system as a result of these policies. The article also reflects on the behaviours and positions of front-line health providers as a result of policy changes	Doctors and nurses
McIntyre and Klugman 2003 The human face of decentralization and integration of health services: experience from South Africa	Devolution of authority from the centre to the provincial and local authorities. Also deconcentration within provincial department to health districts. Primary health care approach	Qualitative study employing structured open ended telephonic questionnaire with multiple role players in the health system. Also key informant triangulation of findings	South Africa, three Provinces Considered all levels of government, national, regional, district and facility level	Discusses health manager experiences of decentralization in different levels of government in three provinces focusing on the processes of policy-making, budgeting and service implementation. The article focuses on the decentralization of policies related to the adoption of the primary health care approach in South Africa in 1994	Facility managers and health care providers (doctors and nurses) in local facilities; mid-level managers
Mogensen and Ngulube 2001 Whose ownership? Which stakes? Communities and health workers participating in the Zambian Health Reform	Decentralization of management and financing to the district level and to the level of local communities. Local communities are expected to participate through community health committees and user fees	Qualitative study, four provinces with more detailed sampling within each province employing focus groups and interviews in the health system as well as within the community	Zambia. Provincial, district and rural health facility level	The study aimed to understand people's experiences of health care reform, particularly looking at whether decentralization does foster engagement between government and communities at the local level. The study placed particular emphasis on understanding the experience of community participation amongst health care workers and community members	Health workers in the local health centres; local managers

Annex 2 Reproductive health articles

Title	Policy area	Methods	Geographical location and location within the health system	Brief overview	Providers/managers of relevance to synthesis
Haaga and Maru (1996) The effect of operations research on changes in Bangladesh	National family planning programme	Applied research, first two rural sites (thanas), then further testing in eight thanas. Project design includes (1) field offices used as 'policy laboratories'; (2) collaboration with government officers at both central and field levels; (3) demographic surveillance and periodic surveys at project sites, including qualitative research and (4) a focus on implementation issues. This particular article focused on understanding factors affecting implementation	Abhaynagar thana and Sirajganj sadar thana, Bangladesh. Delivery of Maternal and Child Health Family Planning services in communities using outreach services.	The article focuses on an operations research project in Bangladesh called the Maternal and Child Health-Family Planning Extension Project in Bangladesh which provided testable innovations in service delivery. The article does not only explore the research results of the project, but relevant to this synthesis explores the relationships between supervisors and family planning officers and discusses the training, behaviours, motivations and attitudes of family welfare assistants in implementing family planning in communities	Family welfare assistants, family welfare visitors and their supervisors
Harrison <i>et al.</i> (2000)	Termination of Pregnancy Act	Mixed methods study using a community survey, a survey among primary care nurses and open ended in depth interviews with primary care nurses and community women	South Africa, The Province of KwaZulu/Natal, Hlabisi District	The study explores the attitudes and beliefs of primary care nurses and community members regarding abortion and the new Termination of Pregnancy Act which took effect in 1997 in South Africa. The article highlights the effects of these attitudes and beliefs on the implementation of abortion services	Doctors and primary care nurses in the district hospital
Barriers to implementing South Africa's Pregnancy Act in rural KwaZulu/Natal.	Implementation of family planning programmes	Qualitative study using interviews and focus group discussions. Providers interviewed were active in two sub locations in the Oyugis district of South Nyanza	Western Kenya, South Nyanza.	The study investigates the needs, desires and agendas of community-based distributors who are responsible for implementing family planning programmes in communities in Western Kenya	Community-based distributors and nurse supervisors.
Kaler and Watkins (2001) Disobedient distributors: Street-level bureaucrats and would-be patrons in community-based family planning programmes in Rural Kenya.	Clinical information management relating to antenatal, birth and post-natal care for women.	Exploratory descriptive design, and an action research approach; practice-research engagement. Commitment of qualitative data to compare baseline data with implementation data produced from the new record system. The Jordanian Ministry of Health, three nearby Mother and Child Health Centres	Jordan. Ministry of Health, Hospital level and Maternal and Child Health Centres	The study tested the implementation of a new integrated clinical record where there had been no clinical reporting linking antenatal, birth and post-natal care for women. The researchers engaged practitioners in the research. The study investigated and reported on the process of change to improve and implement the birth record	Hospital managers, clinicians, midwives and Maternal and Child Health Centre staff

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Annex 2 Continued

Title	Policy area	Methods	Geographical location and location within the health system	Brief overview	Providers/managers of relevance to synthesis
Mayhew (2000) Integration of STI services into FP/MCH Services: Health Service and Social Contexts in Rural Ghana	STI and FP/MCH services	Multi-level case study, qualitative analysis of the processes and contexts of implementation employing policy analysis, documentary analysis, key-informant and semi-structured interviews, informal conversations and focus groups	Rural upper east region of Northern Ghana, district and sub-district level	The article focuses on the integration of STI and FP/MCH services at the local level. The article deals with the rural context and the realities of the implementation of an integrated STI service focusing on health system and service delivery factors and the social context within which implementation occurs	Doctors and nurses
Palmer <i>et al.</i> (1999) The emerging international policy agenda for reproductive health services in conflict settings	Reproductive health services	Extensive review of the grey and published literature, document analyses, informal interviews and a structured survey	Wide range of organizations chosen to represent field, country and head-quarter perspectives. Synthesis focuses particularly on interview data with NGO service providers involved in implementation in the field	The article focuses on the policy development of reproductive health (RH) services at an international level; the article also considers whether RH is on the relief agenda and the strength of its position within organizations. The article discusses this in relation to the implementation of reproductive health services in the field, in conflict-affected populations. The constraints to implementation are discussed from the perspective of those implementing RH services in the field	NGO service providers working in conflict affected populations
Richey (1999) Family planning and the politics of population in Tanzania: International to local discourse	Population policy	Qualitative study employing discourse analysis, documentary analysis, observation, interviews with multiple role players and participant observation at family planning clinics. The synthesis primarily used data from interviews with people responsible for implementing the National Family Planning Programme	Tanzania National level in Dar es Salaam and local level in one primary region (Morogoro) and two satellite regions (Ruvuma and Kilimanjaro)	The study looks at the competing 'positive' and 'negative' approaches to the population 'problem' in Tanzania. Looking at actual cases of formulation and implementation of the National Population Policy the article discusses the ambiguities and conflicts present in the multiple interpretations of the National Population Policy in Tanzania	Maternal and child health/family planning service providers in clinics at regional hospitals and at the village level. District level co-ordinators. Regional and district medical officers