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Constraints to implementing an equity-promoting staff allocation policy: understanding mid-level managers' and nurses' perspectives affecting implementation in South Africa

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Abstract

Much of current research on issues of equity in low- and middle-income countries focuses on uncovering and describing the extent of inequities in health status and health service provision. In terms of policy responses to inequity, there is a growing body of work on resource reallocation strategies. However, little published work exists on the challenges of implementing new policies intended to improve equity in health status or health service delivery. While the appropriateness of the technical content of policies clearly influences whether or not they promote equity, policy analysis theory suggests that it is important to consider how the processes of policy development and implementation influence policy achievements. Drawing on actor analysis and implementation theory, we seek to understand some of the dynamics surrounding the proposed implementation of one set of South African staff allocation strategies responding to broader equity-oriented policy mandates. These proposals were developed by a team of researchers and mid-level managers in 2003 and called for the reallocation of staff between better- and lesser-resourced districts in the Cape Town Metropolitan region to reduce broader resource allocation inequities. This was felt necessary because up to 70% of public health expenditure was on staff, and new financing for health care was unavailable. We focus on the views and reactions of the two sets of implementing actors most directly influenced by the proposed staff reallocation strategies: district health managers and clinic nurses. One strength of this analysis is that it gives voice to the experience of the district level—the key but much neglected implementation arena in a decentralized health system. The paper's findings unpack differences in these actors' positions on the proposed strategies, and explore the factors influencing their positions. Ultimately, we show how a lack of trust in the relationships between mid-level managers and nurse service providers influenced the potential to implement a specific set of equity-oriented strategies.

Introduction

Initial research on issues of equity in developing countries focused on uncovering and describing the extent of inequities in health status and health service provision (Equinet Steering Committee 1998; Leon and Walt 2000; Leon et al. 2001; Whitehead et al. 2001). In the last decade the work has expanded considerably and covers inequities in

social determinants of health (Popay et al. 2008; Bull 2009) and governance and participation (Musuka and Chingombe 2007; Loewenson et al. 2009). There is also a considerable body of work in the health care financing literature on, for example, resource allocation strategies (Bossert et al. 2003; McIntyre et al. 2007; Zikusooka et al. 2009). In contrast, few papers specifically consider the factors influencing the process of implementing policy changes intended to improve equity in health status or health service delivery (Gilson and Raphaely 2008; see for example, McCoy et al. 2003). This article seeks to understand the experience of implementing a policy with equity goals from the perspective of implementing actors working at district level, with specific focus on the factors driving their support and resistance to the policy.

Much policy work in the health sector focuses on the technical aspects of policy design—the 'content' of policy. The policy analysis framework proposed by Walt and Gilson (1994) emphasizes that in addition to content, actors, processes and context need to be considered. The importance of actors (ranging from individual users of health services, to civil society groups, to health workers and professional associations, to bureaucrats and politicians, to donors) is emphasized as an influence over any policy's implementation (Walt and Gilson 1994; Buse et al. 2005). The literature on implementation theory suggests two main understandings: the top-down approach and the bottom-up approach (Hill 1984). The top-down approach to implementation sees it as a process which is, essentially, controlled by central government or policy elites and implementers follow instructions more or less without questioning. The bottom-up approach, in contrast, recognizes the influence of the network of actors involved in implementation (Sabatier 1993). This study is located in the bottom-up understanding of implementation. Emphasizing the interactive nature of the process (Hogwood and Gunn 1984), this understanding suggests that implementers influence policy change through their interpretation of policy goals and the decisions that they take in implementation. Walt (1994: 155), thus, states:

'In contrast to the linear view of the policy process and the model of "perfect" implementation, the bottom-up view is that implementers often play an important part in policy implementation, not merely as managers of policy percolated downwards, but as active participants in an extremely complex process that informs policy upwards too.'

The proposals considered here were developed in 2003 as part of the wider body of work of the Cape Town Equity Gauge, a partnership between local and provincial government and the University of the Western Cape. A team consisting of two researchers and approximately 30 mid-level managers (the institutional managers responsible for public primary care in the Cape Metropole region, all district managers and two senior health information managers) engaged in a participatory process. In hindsight a weakness was that frontline nurses who would be most affected by the strategies were not included. A series of interactive workshops explored the feasibility of equitable staff planning, which allowed for debate, consideration of various technical options and consensus building. Several managerial constraints to implementing equity-promoting staff reallocations were identified (such as workload and efficiency parameters) and factored into a staff planning tool which

was conceptualized as a population needs-based formula. The outputs of the tool were a series of strategies on how to reallocate government staff between Cape Town health districts to promote equity in inter-district resource allocations. Ultimately, however, the strategies were not implemented because of resistance from the mid-level managers themselves, as well as from nurse service providers, and equity in inter-district resource allocations was abandoned.

Tackling the inherited inequities of the public health system remains a major challenge for South African health policy makers (Coovadia et al. 2009). While the national and provincial tiers of the South African government are able to initiate action on resource inequities through changes in the budgetary allocations to provinces and regions, respectively, this action only becomes effective if it is reflected in final expenditure patterns. At district level, moreover, significant reallocations of expenditure can only be achieved if district managers reallocate staff posts, as staff form 70% of health district expenditure. As nurses are the main providers of primary care services, they would be most affected by such reallocations.

The paper reports an exploratory study that investigated the responses and views of Cape Town mid-level managers and nurses—the two primary implementation actors in this case—to this set of proposed strategies. It not only demonstrates their opposition to the strategies, despite broad support for health equity policy goals and the managers' involvement in the development of the staff planning tools, but also unpacks the reasons underlying that opposition. It specifically highlights the manager–nurse relationship as an important influence over these responses, as well as how features of the broader context influenced that relationship. We describe the study's methodology, then present the core findings and, finally, consider the implications of these findings for implementation practice.

Methodology

A case study approach, with the policy of focus as the case, was specifically used to allow inquiry into the circumstances, dynamics and complexity of implementing a policy (Bowling 1997). The approach allows for in-depth investigation providing rich descriptions of the factors influencing the actors in the implementation process. Case studies are particularly useful when the surrounding conditions are central in understanding what happens (Yin 1994) and why it happens. The case study approach relies on the use of multi-method data collection for evidence and triangulation (Yin 1994; Stake 1995; Bowling 1997). The study used multi-method data collection approaches involving in-depth interviews and focus group discussions, complemented by secondary data drawn from complementary work conducted by the study team, as outlined in Table 1.

We conducted a thematic analysis to identify factors that contributed to the support and resistance to the proposed strategies and then did a stakeholder analysis. The stakeholder analysis was conducted to understand which actors stood to gain or lose from the specific strategies, how their interests, values and personal experiences, and their power and

influence over one another, shaped their responses to the proposed strategies (Crosby 1997; Brugha and Varvasovszky 2000).

The proposed resource allocation strategies investigated here were selected because, at the time of the study, they were among the few explicit strategies proposed to respond to the broader equity-oriented mandate to address inequity in district and primary health care provision. The views and experiences of two actor groups identified as key at the level of implementation were analysed: mid-level managers, who were involved in the development of the strategies and who are directly responsible for operationalizing new policies and strategies in primary care, and nurses, who are the main and frontline providers of primary care in this setting. Other actors, such as provincial-level managers who also develop policies implemented at district level, were not considered and this limits the range of implementation dynamics that can be considered here.

The researchers conducted in-depth interviews with the institutional managers responsible for public primary care in the Cape Metropole region; eight district managers and two health information managers. The sampling of eight out of a set of 24 district managers was stratified to include four district managers working in districts that stood to gain from the proposed staff reallocations, and four district managers working in districts that stood to lose. All interviewees had participated in the development of the strategies. The interview schedule covered the interviewees' understanding of equity and the proposed resource allocation strategy, the state of equity in Cape Town Metropolitan health services, their views on the importance of the equity strategies in relation to other policy issues on the agenda, how feasible they thought the implementation of the strategies were and what factors would hamper or constrain the implementation.

In addition, six primary care clinics were purposefully selected: three from districts that stood to gain from staff reallocations and three from districts that stood to lose. All the nurses working within each facility were invited to participate in facility-based focus group discussions. On average, 90% of nurses participated (approximately 10 per facility). Facility managers participated in these discussions but no district managers were present. At each focus group discussion a presentation was first made of data demonstrating the extent of staff allocation inequities between districts in Cape Town, and then an outline was given of the proposed staff reallocation strategies intended to promote equity. Nurses where then asked to discuss whether they thought staff allocation equity goals were, in general, important, whether they thought the proposed strategies were feasible and whether there were other ways of achieving the equity goals.

The data from interviews and focus group discussions were initially examined to identify the categories and themes of issues raised within them.

Table 1 Data collection methods and sources

Actor group	Data collection	Description of primary data collection method
Mid-level managers	Primary data collection	In-depth interviews with 12 managers: semi-structured in-depth interviews with managers to explore contextual factors impacting on managers, as well as the effect of their motivational interests, roles and experiences on equity-promoting staff planning.
	Secondary data collection	Notes of a series of interactive workshops: development of a managerial tool for equity-promoting staff planning with exploration of the key managerial constraints in implementation of equity-promoting staff reallocations.
Facility staff	Primary data collection	6 focus group discussions with facility nursing staff (total of 42 nursing staff and 6 facility managers included in the discussion groups): conducted in the form of workshops where a presentation was prepared with extracts of a model on equity-promoting staff planning. The nurses' views and opinions of the feasibility of an equitable reallocation policy were sought.
	Secondary data collection	Report on "A comparative study investigating into nurses' workload in different primary health care settings in the Cape Metropole": description of nurses' perceptions of a high clinical workload in facilities and the contributing factors.

A common coding structure was applied to each interview/discussion, and then the coded data from each interview and discussion were compared with each other to establish common understandings and perceptions, as well as differences in opinions. This was followed by a constant comparison between the two actor groups for emerging themes (Lincoln and Guba 1985 cited in De Vos 1998). For each actor group interviewed, the analysis also specifically identified their responses to the proposed strategies and the underlying concerns shaping those responses, taking account of their formal responsibilities within the health system, and so their power to influence health care provision. Specific quotations have been selected from the interview data to illustrate particular issues, perceptions or views around the key themes.

Findings

Responses to equity goals and the proposed reallocation strategies

Both mid-level managers and frontline nurses expressed a similar understanding of equity (clients should have access to appropriate health care depending on their need) and were broadly supportive of a process to implement equitable service delivery. Importantly this support was equally strong in staff located in both better- and lesser-resourced districts. The technical measures of inequity between health districts incorporated into the staff planning tool were in keeping with managers' and nurses' knowledge and experiences of current inequities in access, quality and staffing in clinics and community health centres. They agreed that this was inherently unfair and inequitable. Mid-level managers were not hopeful of accessing further funding for the health services and so felt that the only feasible way to operationalize equity goals would be through the reallocation of existing resources between health districts (which translates into reallocation of staff):

"I think it [equitable reallocation of staff] is the most important [priority facing us]. I'm saying so because within health, if you look at our budget, I think 67 to 70% of our budget is taken up by labour. And if you can get that right—allocate resources according to need—then I think we will make better impact on the communities that we service."

But the interviews also showed that despite their involvement in the design of the staff planning tools, mid-level managers did not support the actual implementation of a staff reallocation strategy.

Nurses were stronger in their resistance to staff reallocation strategies and some threatened to undermine any reallocation of staff; a common response was: *"I will just leave the service"*. The pathways to this resistance were different between nurses working in better- and lesser-resourced districts (see Figure 1). Nurses in better-resourced districts called for increased funding and resources to be brought into the system to allow staffing improvements in the under-resourced districts:

"There should be more money allocated to (a locally known under-resourced district). We all know they need more staff; they need more money, more resources. But why take (staff) from other areas because everybody is going to suffer then?"

In contrast, nurses in the lesser-resourced districts were less confident that increased funding or reallocation of existing funds would result in sustainable equitable staffing. For them a more immediate priority was to improve the working conditions in the lesser-resourced districts so as to attract staff to work in the lesser-resourced districts:

"(We need) better conditions basically all around."

Resistance was also seen in both mid-level managers' and nurses' attempts to justify their dismissal of equity-promoting strategies through presenting a range of reasons for their non-feasibility (see Box 1). However, as these issues were generally only raised after prompting within the interviews and focus groups, they appeared to be being presented as 'acceptable' justifications that actually belied a deeper source of resistance.

Understanding reasons for resistance

Underlying the legitimate feasibility concerns were differing degrees of resistance that emerged from the different roles, responsibilities and concerns of the managers and nurses (these are summarized in Table 2). The influence of past experience, part of which resulted in change fatigue, and low staff morale also contributed to resistance.

Mid-level managers' concerns and responsibilities

As a group, managers were motivated to promote equity to some extent because of their responsibility for strategic planning in the region as a whole (even district managers were required to participate in decisions affecting the region as a whole). In this role they were required to look beyond the interests of their own district to the effective management of the region. Equity was one of the stated strategic goals for health care delivery in the region and this created support for staff reallocations. However, there was little experience in implementing equity-

promoting resource changes and this created some reluctance. In particular, managers had not previously based staffing decisions on a measure of equity (staff posts were largely historically determined with some modification based on workload), nor had they seen this as a key measurable management performance area.

District managers' support for equitable management practices was, however, in tension with their financial administrative role and their expressed concern for the financial viability of their own districts. Despite having been intimately involved in the development of the staff planning tool, their perceptions of what was fair was still skewed by a sense of loyalty to their own district. They recognized that it was the financial position of their district that was key in determining whether a district manager supported implementation of fair resource reallocation or not:

"It is amazing if you move a manager from a well-resourced area to an under-resourced area, how she changes overnight and all of a sudden sees the need; whilst he or she didn't see the need while she was in a well-resourced area."

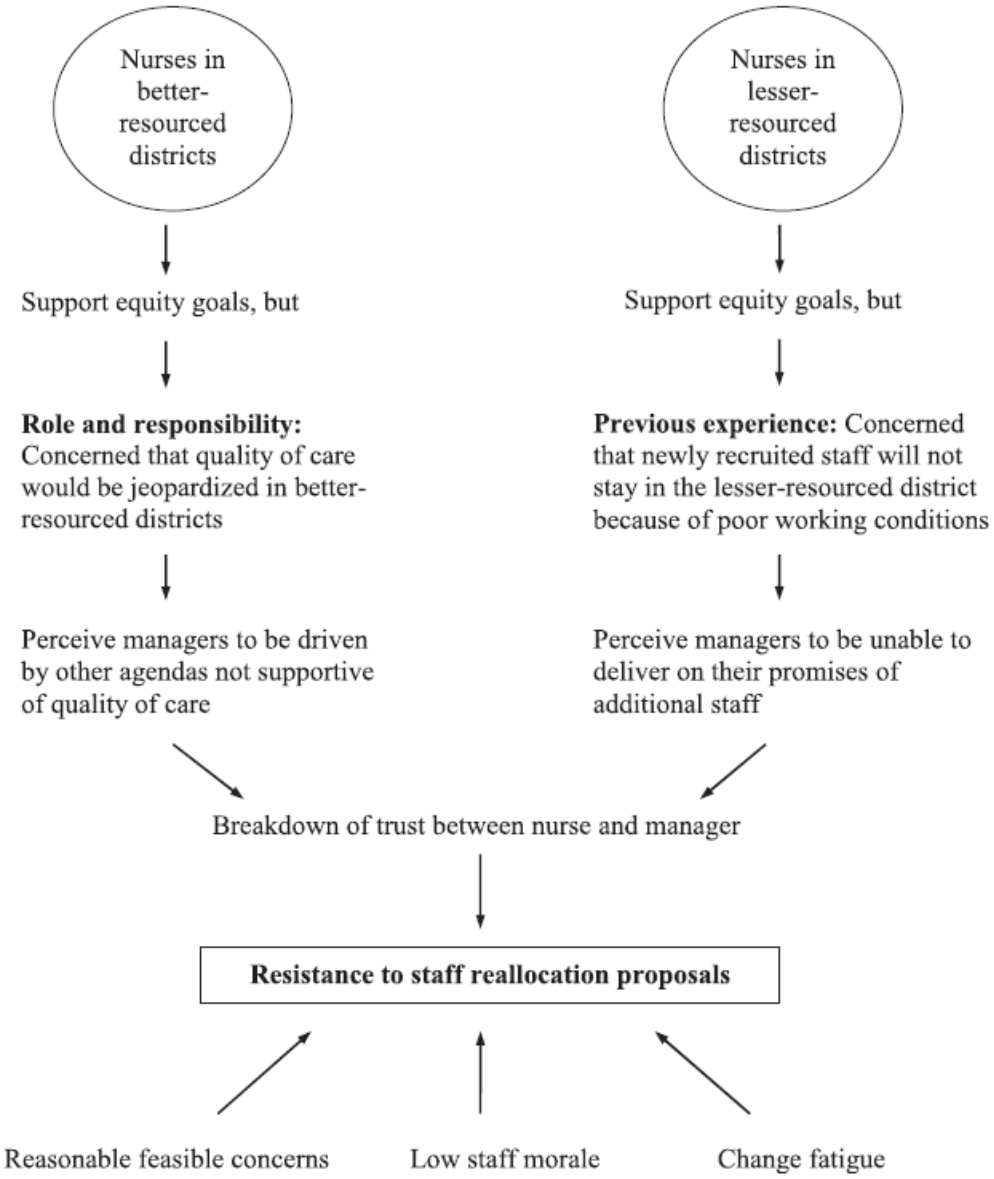

Figure 1 Pathways to resistance in nurses from better- and lesser-resourced districts

A major influence over district managers' views was the wider context. Financial cutbacks had been experienced at provincial and Metropole level since restructuring of the health sector began in 1996. For an extended period there was an embargo on filling vacant staff posts. At the time of the study, while recruitment of staff was again permitted, funding was still limited and there were critical staff shortages given difficulties in attracting and retaining nurses. As part of the broader rationalization of secondary and tertiary hospital services in the city and province, patients had been referred out to the primary care level. Financial cutbacks at primary care level, thus, coincided with a real increase in the scope of practice and client volume. The perception of managers was that *"we are doing much more with less"* and that this resource-scarce environment limited their *"room-to-manoeuvre"* in further cutting back on staff in relatively over-resourced districts, as staff were already perceived to be under pressure.

Managers were also concerned about the well-being of their staff, particularly as they recognized that most of the effects of restructuring had been borne by these staff over the years. Some managers spoke of the difficulty they had on a personal level in dealing with complaints from staff, and many felt inadequate in dealing with what some called *"the emotional reaction of nurses"*. Many had not had basic management training, and some were still in 'acting' positions as the district health system was not fully implemented. In addition, they did not feel supported. This undermined their ability to manage effectively and had implications for the introduction of unpopular new strategies:

"(We are) totally ill-equipped… There has been no Change Management. It never occurred in a conscious way that we have a Change Management Unit with people who are appropriately skilled to advise in how you manage change."

Some district managers found that their strategic regional and district responsibilities got in the way of their supervisory work. They realised that this created tension with staff who were disappointed and angry that managers were not supporting facilities as they ought to:

"I'm very well aware of the fact that I should be (getting round to the clinics). I just can't get there. And then I set up meetings and then I have to cancel it. I'm just glad I'm not there when the message gets carried across that I have cancelled the meeting! .. .And supervision is literally non-existent."

Another factor of increasing concern for health managers was that nurses were leaving the public sector to work outside the country. Managers were concerned that nurses would just leave the service if the conditions of service remain unattractive.

Nurses' concerns and responsibilities

Amongst frontline staff in better-resourced districts, meanwhile, there was a grave concern that implementation of an equity-driven staff reallocation strategy would drive down service quality. In particular, the nurse–client relationship was considered to be at risk, with negative consequences for quality of care, considered the main purpose of their profession:

"We want to render quality but they [managers] don't want that. They want us to see (increased patient numbers) and you are (like a) robot to do this and then go and that is not nursing. I didn't do nursing for this."

As the quote indicates, nurses perceived the managers to be primarily interested in headcount-based workload calculations (a factor considered in the staff planning tool), and considered this to contradict concern for quality of care. Indeed, some of the facility managers argued that reallocating staff to promote equity would be contrary to the mission and vision of the organizations that try to uphold quality. In addition, providing evidence of a possible communication break-down and lack of trust in common goals, some nurses characterized district managers as being distant and having a different agenda to the nurses on the ground:

"They (managers) are sitting up there. They do their own little thing according to this and the other (referring to work on equity) that's working for them. It's not working for us."

Nurses in lesser-resourced areas were also concerned that quality of care would be eroded if the additional staff allocated were unwillingly workers or if they could not cope with the adverse working conditions:

"That those people from those areas may not be able to cope with the conditions that we are coping under. . . they will increase the rate of absenteeism (because) they will be sick very often and do not come on duty, and now the nurse will have to do the extra duty of that nurse who has been (put) off (on sick leave). So you (see) that is a problem."

Effect of past experience and change fatigue

Mid-level managers recognized that the significant restructuring of the health system under the new democratic government had had its greatest impact on the frontline workers. Many changes had been implemented in quick succession. Managers spoke of the need now for stability, rather than further change. Change fatigue was especially felt at district level because the development of district health structures had been the subject of much debate for many years, with inadequate communication down the hierarchy and no clear policy framework established until after the time of this study. Given the prolonged period of uncertainty and associated stress, staff had become sceptical about the benefits of change and resistant to further proposed change:

"And in my opinion that vision is known by a few people but is not explicated very clearly. So change seems to be kind of ongoing. And also, where there is very often no time period given to change. It's a kind of open-endedness of change in terms of the areas that the changes are occurring. It's the time period the changes are occurring. And linked to that, there is no central location for communication strategy."

Box 1 Factors seen as constraining the implementation of equity-promoting staff reallocation

Transport: while it was possible for staff to travel to work in different districts in an urban setting, this affects costs, travel time and can disrupt established routines related to parental responsibilities such as taking children to school.

Language barriers: clients in different districts speak different first languages; some nurses would either require interpreters or need to learn the required language.

Physical working conditions: there are marked differences between facilities in different districts; some are in a state of general bad repair and others are well-equipped, have comfortable tearooms and are situated in a pleasant environment.

Nature of caseload: the disease profile differs between districts, with some experiencing more trauma and emergencies which makes the work more stressful.

Health risk: there are concerns that staff will fall victim to violence which is endemic in some communities within certain districts; there is also a high HIV prevalence in some districts and nurses speak of a higher risk of infection through needle-stick injuries.

Table 2 Formal responsibilities and their effect on support for equity-promoting staff reallocation

	Formal responsibility	Concerns	Effect on support for equity-promoting staff reallocation
Health managers	Strategic management of health service (regional focus)	Improving equity	Creates support
	Strategic management of health service (district focus)	Financial well-being of district	Dependent on financial position of district, whether it stands to gain (support created) or lose (resistance generated)
	Line management functions (staff focus)	Support staff	Diminishes support
Nurses	Work directly with clients in providing health services (individual client focus)	Quality of client care	Creates resistance
Facility manager (as a subset of nurses)	Line management functions (staff focus)	Control workload	Diminishes support

Managers had previous experience of nurse resistance to staff reallocation 2 years prior to this study, when they individually and separately attempted to address workload imbalances within districts. At that time nurses felt they were unfairly the only cadre targeted for redeployment, and they were deeply suspicious of the accuracy and validity of the workload calculations. They actively resisted mandatory redeployment, despite provision for this in their work contracts; only voluntary redeployments were made successfully.

Nurses in districts which stood to gain staff from the proposed strategies described how previous attempts to provide under-resourced facilities with new staff had often ended in failure. Vacant and advertised posts could not be filled and, even when it was possible to recruit new staff, nurses reported that they did not remain in the service—mainly because of high workloads and poor working conditions. It was this experience that caused nurses in lesser-resourced districts to feel that managers were not able to keep their promises and provide additional support, and the quote here demonstrates the lack of trust that becomes a recurrent deeper dynamic:

"Because they haven't replaced nurses (in the existing vacant posts) so where will you get (the additional equity-motivated) nurses. I just don't trust that."

Low morale

One of the key consequences of change fatigue is low nurse morale. Nurses felt victimized: *"Why is it always the nurses who have to move?"* They felt that staff reallocations would not have any benefits for them and would instead lead to an increase in workload, burnout of nurses and an increase in absenteeism and ultimately resignations. A symptom of low morale in both the better- and lesser-resourced districts was the nurses' perception of high workload: they felt overwhelmed by client care and complained that their workload was too high, yet this was not borne out by the workload assessment used in the staff planning tool (Cape Town Equity Gauge 2003). Workloads had become a point of conflict between nurses and managers. Nurses felt that managers just did not take their concerns seriously.

Another symptom of (and possibly contributing factor to) low morale was that nurses felt undervalued in their work. They worked hard to provide a quality service and yet did not feel appreciated by management, nor given credit for their good work:

"We get much more from the patient than from anybody else. We don't get that (appreciation) from managers."

Not being involved in the decision-making process on decisions that affected them contributed to low morale, as it made the nurses feel powerless. Nurses specifically expressed their concern and suspicion regarding the tools used in the equity measurement process, as they had not been asked to provide input by their managers nor even informed about the process. They also claimed that this was a common experience of the way other policies and procedures had come down from management, with changes being forced on them without proper communication and consultation. Nurses saw this as poor management practice, and resented the lack of managerial transparency in decision-making that they felt it reflected.

"Same thing. The same way. No consultation beforehand. Training afterwards. It had to be implemented first and then you go for training. Not the other way around. No feedback how it is impacting on you. You will do it, that's it. No backchat."

Discussion

This study shows that, while the legitimacy of a policy goal (in this case, equity in staff allocations) may be broadly accepted by policy actors, resistance can be generated to specific strategies (in this case, concerning staff reallocations). Where actors stand to lose from proposed strategies, resistance is not surprising. However, in this study some actors who stood to gain from the staff reallocation strategies also expressed opposition to them. The key factors underlying implementors' views and perceptions, therefore, appeared to go beyond whether they would lose or gain from the proposed strategies—a commonly identified issue raised in the analyses of the processes surrounding policies with equity goals (Gilson and Raphaely 2008). The wider set of influencing issues included their formal responsibilities in the health system and contextual factors linked to the time of, and their experience with, South African health system transformation. These factors also helped explain differences in the nature of managers' and nurses' responses to the strategies.

Moreover, at the heart of the influences were a set of relationship problems—both between mid-level managers and health workers, and for managers, in their relationship with their superiors. The range of problems identified included:

1. Nurses felt victimized by managers (*"they are always the ones who are negatively affected by new policies"*);
2. Nurses felt that managers had not kept their promises in the past (for example, in increasing staffing in under-resourced facilities);
3. There was a general unease in communication between managers and nurses (as shown by the example of the manager too ashamed to tell her staff directly that she had to cancel yet another supervisory meeting);
4. Both managers and nurses realised that consultation was poor and that nurses were not involved in decision-making (contributing to nurses' feeling of not being respected);
5. Nurses did not believe managers considered their well-being (for example, in promoting equity over high workloads);
6. Nurses were suspicious that managers might be using researchers to inform them about a new policy rather than dealing directly with them;
7. District managers felt unsupported by their superiors.

Other South African studies have also highlighted the influence of relationships over actors within the health system. Blaauw *et al.* (2004) found that managerial relationships across the health system are often unclear, bedevilled by poor communication and insufficient information sharing. London *et al.* (2007) and Walker and Gilson (2002), meanwhile, also report health workers' concerns that

new policies are imposed on them by managers 'above' without communication or consultation. Both of these last papers also argue that such experiences are indicative of a lack of trust between actors in the South African public health workplace. Trust is understood as 'a judgement/prediction that the other will act in your interest' (Gilson 2003: 1457). The notion of workplace trust combines trust in colleagues, supervisor and employing organization (Gilson *et al.* 2005). Considered against this definition, the views and perspectives outlined in this study seem indicative of a lack of workplace trust for nurses which underpinned their opposition to the staff re-allocation strategies. The literature on trust certainly suggests that trust can provide the basis for the legitimate exercise of authority in a relationship and so, in a hierarchical bureaucracy, for policy implementation (Gilson 2003; Mooney and Houston 2008). By implication, lack of trust would undermine that authority, and so have negative implications for policy implementation.

Overall, this study contributes to the currently small, but vital, body of work in implementation research on the factors influencing equity-oriented policy changes (Gilson and Raphaely 2008). It explicitly focuses on the views and experiences of implementing actors, trying to see implementation through their eyes rather than investigating particular factors that theoretical literature suggests shape implementation practice (Hill and Hupe 2002). Although this focus inevitably restricts the range of conclusions that can be drawn from the study, the paper makes an important contribution in giving voice to the implementers and their perspectives.

Interestingly, the paper also shows how, in this case, implementers' resistance to a new equity-oriented strategy was not simply a response to how it impacted on their interests (as might be emphasized in stakeholder analysis). The strategy of staff reallocation met resistance not just from those who stood to lose resources. Instead, the study points to a set of factors within the workplace, which might be indicative of a lack of trust, as important influences over actor resistance to this particular set of proposed strategies. In other words, resistance was not clearly a response to the equity goals of the proposed strategies, but rather to the broader South African health system context at the time of the study (and the introduction of yet another set of strategies to operationalize a new policy without adequate communication and consultation).

In this regard, resistance seems to reflect an issue of general policy implementation practice, rather than being linked to the equity goal of proposed strategies examined. However, two other possible reasons for resistance are more directly linked to this equity goal. First, as equity is a morally desirable goal to which it is difficult to object, policy resistance may quite often be delayed to the implementation phase. In this study the managers supported and actively participated in the development of a resource allocation strategy and only

expressed reservations when the implementation became imminent. Secondly, as a resource reallocation policy being implemented within a context of limited resources, it inevitably required unpopular staff reallocations. The strategy would make nurses vulnerable and they needed the assurance that managers would engage in decision-making processes in a way that was transparent and fair, and with the nurses' best interests at heart too. Therefore, the relationships between actors were of vital importance in determining how implementing actors responded to the strategy. As a result, trust, or lack of trust, was of central importance to the experience of considering the implementation of this strategy with equity goals.

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