A case for a bottom-up approach in the implementation of health policy in Africa

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Introduction

Implementation of healthcare reform remains a challenge for many low- and middle-income countries.[1] The ongoing COVID-19 pandemic has taken a toll on the health systems of even the most resilient countries and exposed inequities in health care access and the barriers presented by inadequate health sector financing[2,3] This has prompted a renewed interest in health policy implementation. Planned improvements in health systems performance need to address the challenges of policy implementation.[4]

There is a paucity of evidence comparing how bottom-up policy implementation approaches have been used for health policy programs in sub-Saharan Africa. In Uganda, while reforms in the systems of governance in the form of decentralisation have been crucial to the success of health service reform, health policy implementation has traditionally taken on a top-down approach.[5] This paper presents an analysis of a bottom-up approach used to implement a user fee policy in Uganda.

Methods

An in-depth qualitative analysis and review of policy implementation literature and case reports on the implementation of user fees in Uganda was conducted. The conceptual framework for this paper was based on a theoretical review of a top-down versus bottom-up approach to policy implementation.

Results

Analysis revealed that the decentralisation of public services was a key precursor to the success of a bottom-up approach. Decentralisation of public service delivery entailed the devolution of power from the central government to local authorities, enabling local district leaders to operate with a distinct amount of discretion to implement and adapt the user fee policy for their districts. Strategies used by district leaders to implement the user fee policy included delegation of roles to local community leaders, direct community engagement and adaptation of the policy to community needs and the local context. Local communities were more receptive to the policy given the opportunity to participate and contribute to its formulation alongside their local leaders.

Conclusion

The uptake and success of health policy in community-based populations in Africa may be reliant on the ability of local leaders to get involved in decision-making and adapt policy to their local needs. Policy practitioners should consider capacity development efforts for local health district teams beyond the traditional focus on administrative skills and focus on learning and leadership skills needed to adapt such polices at local level. ■

References

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