ORIGINAL RESEARCH

Perspectives about policy implementation: A learning opportunity from the 2003-2013 Malawi HIV/AIDS Policy

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Abstract

Introduction

Malawi published its first ever HIV and AIDS policy in 2003. The implementation of the policy provided a very necessary and historic step in Malawi's organized response towards HIV and AIDS. Many achievements were registered in the period this policy was implemented. However, some components of the policy were not well-implemented. Our study explored barriers to implementation of provider initiated HIV testing and counseling (PITC) for sexually transmitted infections (STI) within general outpatient settings. Malawi also launched a revised HIV and AIDS Policy in December 2013. Although not part of this policy analysis, future years of implementation may face related issues observed during the implementation of the 2003-2013 policy.

Methods

This is a non-experimental, descriptive study using a case study design. We examined the implementation of provider initiated HIV testing and counseling component of the Malawi HIV and AIDS policy from 2003-2013 focusing on STI and outpatient clinic settings. We sought to understand perspectives of various stakeholders and users of the policy. We conducted in-depth interviews with policy makers, health care worker supervisors, health care workers and health rights activists.

Results

Major problems which affected the implementation of the 2003-2013 HIV policy were: selective prioritization of policies by government, lack of involvement of implementers in the policy making process, non-awareness of health workers about the existence of the policy, lack of healthcare worker training, unsatisfactory supervision of policy implementation, poor harmonization of policies, lack of clarity about guidance to those directly implementing, unclear roles and reporting authority among the main national coordinating units.

Conclusion

Good leadership, effective coordination, involvement of key players in the policy making process, dissemination to primary users and decentralization or empowerment of local supervisors is key to successful policy implementation.

Introduction

Sub-Saharan Africa bears a disproportionate share of the global HIV burden. An estimated 25.8 million people (66% of the global burden) living with HIV resided in sub-Saharan Africa in 2015[1]. Malawi is one of the top ten countries in southern Africa most affected by HIV[1]. The country's adult HIV prevalence is high at 8.8%[2]. HIV and AIDS negatively affects the health and well-being of productive people.

In 2003, Malawi published its first ever HIV/AIDS policy—A Call to Renewed Action. The goal of the policy was to prevent further spread of HIV infection and to mitigate the impact of HIV/AIDS on the socioeconomic status of individuals, families, communities and the nation[3]. This paper reviews the implementation of that policy by assessing provider initiated HIV testing and counseling (PITC) in outpatient settings including routine HIV testing for patients with sexually transmitted infections (STIs). It also looks at how PITC in antenatal care, for prevention of mother to child transmission of HIV (PMTCT), was implemented. This approach was not clarified in the initial design of the Policy but Malawi adopted it soon after World Health Organization (WHO) recommended it in 2007. The 2012 Malawi Global AIDS Response Report indicated an uptake of only 28% in the general outpatient PITC, but 71% among antenatal women (for PMTCT purposes)[4-5]. The universal uptake goal was 75%. The follow up analysis in 2015 showed higher HIV testing uptake of 79% among pregnant women and 49% for STI patients[4-5]. The study's findings explain some of the factors that affected the HIV testing and counseling component of the policy.

There are several known barriers that affect implementation of health-related policies. Fear of stigma and discrimination to implement certain policies, low motivation and commitment, conflicting policies, and challenges in multilevel coordination affected implementation in three United States Agency for International Development (USAID) supported countries[6]. Other barriers are lack of awareness about policies, limited familiarity, and a lack of agreement among related guidelines[7]. Limited time and personnel resources, as well as work pressure have also been noted as contributing

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factors to poor policy implementation[8]. Lack of political will was a barrier to implementation in South Africa, lack of clear government endorsement of these guidelines was another reason[9]. In Uganda, lack of directives on exactly how HIV related policies were to be implemented negatively affected implementation[9]. Top leadership's low regard for HIV/AIDS, at odds with the recommendation of their own renowned technocrats and scientists, is also another barrier to implementation[10]. Issues that enhanced good policy implementation include: health care workers' training and mentorship in HIV-related services as well as their involvement in policy development[11].

Studies that evaluate policies require drawing lessons or concepts from existing policy analysis frameworks. Issues of interest that must be considered include: problem identification, policy formulation, policy implementation, and evaluation[12]. Our work focused on the implementation phase of the policy process and is modeled under the "top down" and "bottom up" perspectives of policy decision making[13]. "Top-down" is defined as hierarchical execution of a centrally-defined or -formulated policy. Such a policy is handed down from the top leadership to those who are supposed to implement it. On the other hand, "bottom-up" is a process of policy formulation that is driven by grassroots' stakeholders and their coalition partners. The latter includes substantial involvement of local users in the process and is very relevant as it stimulates individual motivation, will and internal commitment to influence good implementation[14]. On the other hand, non-involvement of local users in the process brings resistance to acceptance[15].

The leadership of Malawi HIV and AIDS services is well structured in a hierarchical system. The policy keeper and leader for HIV/AIDS in Malawi is the Department of Nutrition and HIV/AIDS (DNHA) in the Office of President and Cabinet (OPC). They work in close cooperation with the National AIDS Commission (NAC), whose role is to provide leadership on the coordination of the national HIV/AIDS response and resource mobilization. There is also the Department of HIV and AIDS (DHA) in the Ministry of Health whose role is to lead implementation of clinical response[16]. We assessed the roles in policy implementation played by these key coordinating entities and other system players such as health care workers, their supervisors and health rights groups to implement the policy. Health leaders exhibited bias by prioritizing PITC for PMTCT operations over the general PITC.

Methods

This is a descriptive case study of the HIV testing and counseling component of the Malawi HIV/AIDS policy from 2003 to 2013. We looked at PITC in STI outpatient settings and PITC in antenatal settings to ensure a balanced understanding of the HIV testing component. Experts, policy makers and health care workers who worked in their respective positions for more than a year were chosen to be part of the interviews. In some cases, former experienced office holders were also interviewed. We conducted twenty in-depth interviews between January and February 2014: 3 senior healthcare workers (high level supervisory), 2 policy makers, 3 healthcare worker supervisors (middle level supervisory), 10 healthcare workers and 2 health rights activists. The healthcare worker interviews were purposefully conducted in 2 of the 5 health zones. We made audio recordings of the interviews and transcribed the records verbatim. The transcripts were later coded. We analyzed data using CDC EZ Text, version 4.06, developed by Info SciSi Co. Inc. We developed a database and entered data from transcripts per corresponding questions. A codebook was developed in Word and re-created in the database. The initial codebook was populated with predetermined themes from the in-depth interview guides which were developed using insights from existing literature and the study's conceptual framework of "top-down and bottom-up perspectives"[13]. Participant data were retrieved through database queries, and emerging themes were noted. We continuously maintained analytical memos of interesting text from the transcripts to supplement database searches and used them during the analysis. Following the initial code determination, intercoder reliability was checked by trained qualitative research scientists. We obtained ethical approval from Malawi National Health Sciences Research Committee and the UNC at Chapel Hill IRB. We also sought written permission from key gatekeepers such as heads of institutions to interview their personnel. We also obtained written or verbal consent from each study participant before conducting interviews.

Results

A descriptive summary of barriers and facilitators to policy implementation across stakeholders (healthcare workers, supervisory/policy and health rights activists) is provided below:

Barriers

- Policy design and selective prioritization by Government[1*]
- Resource constraints
- Problems with policy awareness/dissemination
- Lack of coordination among Government key units of DNHA, NAC and DHA
- Problems with leadership support[1*]
- Health care worker deployment and challenges[1*]

Facilitators

- Availability of policy guidelines
- Adoption of Option B+ plus Policy
- Good political will

Policy Design and Selective Prioritization by the Government

The Government prioritized PITC for PMTCT over the general PITC. For PMTCT, all healthcare workers were trained in HIV testing. There was deliberate deployment of special HIV testing counselors by the government in antenatal clinics but there were none on PITC/STI. Placement of HIV testing counselors was erratic in PITC/STI. A health care worker stated:

"Sometimes you could see that the government had put too much emphasis on one thing and sidelined the other. For example, they put too much attention on PMTCT but they need to know that each service is very important." (PITC/STI 307)

Resource Constraints

Apart from healthcare worker personnel, policy implementation requires some resources and supplies such as HIV test kits, gloves, and other related supplies. The implementation of the 2003 HIV/AIDS policy has been sometimes characterized by shortage of some of these supplies. In times of low supply, priority was given to PITC for PMTCT services at the expense of PITC/STI services.

A senior healthcare worker observed:

"Sometimes it affected services negatively, certain districts would run out of test kits for almost two or three months and we know that if a woman is denied PMTCT services then the baby's health is at risk." (Senior healthcare worker 314)

Process of Policy Making

Healthcare workers' perspectives on policy-making process

Most healthcare workers interviewed were not involved in the policy-making process. This led to poor understanding of the importance of the policy and subsequently affected policy implementation. Only one of the six participants in the STI/PITC category interviewed reported partial involvement in the policy-making process. On the other hand, two of four PMTCT participants interviewed stated having been involved in the policy formulation of the overall HIV/AIDS policy. One of the PMTCT healthcare workers who was involved in the process emphasized the importance of the involvement of healthcare workers in the policy-making process:

"There are a lot of things that even the policy makers are not aware of… My presence in those meetings or in the process of policy development was very important as I was giving them the information on what exactly is happening on the ground." (PMTCT 300)

Health rights activists' perspectives on policy-making process

Health rights activists who were interviewed expressed dissatisfaction with involvement in the policy-making process. They bemoaned their lack of adequate involvement and complained of poor involvement of the healthcare workers on the ground. One of the health rights activists hinted on this challenge:

"As an institution, we were involved but it was not meaningful . . . what I believe is that issues in the policy needed to come from us, people on the ground. That could have been the very first page of the policy process" (Health rights activist 319)

Policy Awareness/Dissemination

Healthcare worker perspectives on policy dissemination

A lot of healthcare workers were not aware of the existence of the actual HIV/AIDS policy. Local healthcare leaders fell short of responsibility to pass on the policy to the implementing healthcare workers. In one instance, a healthcare worker team leader said he had the policy document in his office and library for providers to read but the providers from that facility denied having been informed about where to access the policy. Healthcare workers did not easily find time to read the policy documents. Ironically, the same healthcare worker supervisor observed:

"Training health care workers will be encouraged rather than asking people just to read because people may not necessarily read. You cannot point fingers at them but it may be because they were busy implementing and they don't have the chance to go back and (read)…"(Healthcare worker supervisor 305)

It was interesting to note that the on-the-job training or sensitization about the policy did not go well. Some health care workers were unwilling to be briefed or trained by colleagues who attended formal trainings and they would have preferred to undergo formal training themselves.

Some health care workers, including a senior healthcare worker, indicated that health care workers who are just briefed become jealous and frustrated that their colleagues benefited more in terms of incentives like certification, monetary allowances, and official recognition by various authorities. One healthcare worker said that one does not get recognition or promotion based on knowledge from peer debriefing no matter how well he or she performs on the job unlike those who go for formal training of a particular task. A different health care worker echoed the need for formal training:

"I think formal trainings are very important. When you do formal trainings you just brief your friends only on important aspects but may miss other information." (PITC/STI 307)

Another health care worker thought that on the job orientation was generally acceptable but some did not accept the arrangement:

"Debriefing by colleagues who went for trainings is very acceptable to us and people implement what they learnt from others without problems. However, at a government facility where I am deployed, people resent such an arrangement because they think, someone has been paid and yet want others to do the work for free. I have such a situation where some workers, especially health surveillance assistants would refuse to support some other HIV testing related tasks until they are formally trained." (PMTCT 301)

Health rights activists' perspectives on policy dissemination

Health rights activists indicated that policy dissemination among staff and member organizations was through staff meetings, public awareness, and distribution of copies of policy documents. However, they complained that policy dissemination generally lacked wide community consultation or participation. One health rights activist observed the need for policy holders to make use of existing community structures for effective dissemination of policies:

"… I recommend use of existing structures. The target audience should have a say and decide. This is critical because people will be able to identify what belongs to them." (Health rights activists 319)

Another health rights activist bemoaned lack of clear leadership to enforce the policy process, a view that was supported by two health care workers (PMTCT 300, PITC/STI 305) and a healthcare worker supervisor (312).

"The policy awareness had gaps. Knowledge of what is contained in the policy was not adequate because after the government launched it, they depended on stakeholders to take (the policy) to the community. I did not see any other ways of publicizing it from the Government perspective, the launch was the end". (Health rights activists 318)

Healthcare worker supervisor perspectives on policy dissemination

Healthcare worker supervisors were the least satisfied about the policy-making process. Many felt sidelined by their top-ranking officials in the Ministry of Health in the execution of the HIV/AIDS policy. The major reason for dissatisfaction

was lack of involvement in policy formulation and decision processes about its implementation. One healthcare worker supervisor sounded very concerned about lack of involvement:

"Largely it is because we are not involved or give our contribution to the policy making process. We do not even know what is in the policy. To be honest with you, that there are a lot of things that we are not sure of. We do not know them because we are not involved." (Healthcare worker supervisor 312)

Coordination among Malawi Government units

The HIV testing component of the 2003 HIV/AIDS policy faced coordination problems among the Malawi Government HIV/AIDS leadership units of DNHA, NAC and DHA. This challenge was stated by all the groups of stakeholders. Sometimes healthcare workers received conflicting information from coordinating stakeholders, and they had no way to determine whose guidance should be followed during their implementation. One healthcare worker supervisor spoke strongly about the coordination problem among the stakeholders involved in the implementation of the HIV/AIDS policy:

"I think there should be harmony. Think about the big three; the DHA, NAC, and DNHA in the OPC. I think that they work in isolation. I remember at one point there was information that came from there (DHNA) but then the DHA trashed it. This left healthcare workers confused on the right course of action to take …." (Healthcare worker supervisor 305)

The health rights activists interviewed and a policy maker also decried poor relationship among these three coordinating entities. A policy maker, who was rather hesitant to express the dissatisfaction, said:

"Honestly the coordination through that office (OPC) was sort of political. At the beginning; the role of OPC was very difficult to understand, although there is some improvement now, the reporting relationship and coordination roles between NAC and OPC are still unclear on some issues…." (Policy maker 316)

Although there has been generally poor coordination of policy implementation within the entire health coordination system, a health care worker supervisor (312) who earlier on complained about non-involvement in policy making, commended good coordination at facility level and top leadership at Ministry of Health (MOH) headquarters on some program specific areas such as clinical ART support.

Leadership Support

Lack of good leadership support at various levels of the processes of policy cycle negatively affected implementation. Several participants (healthcare worker supervisor 305, health rights activist 319, and senior healthcare worker 316) expressed a concern that the three coordinating entities—the Office of the President and Cabinet, Ministry of Health, and National AIDS Commission—did not provide a clear coordination among themselves which was a source of confusion to implementers.

Healthcare workers' perspectives about leadership support

Many PITC/STI healthcare worker participants cited problems with current supervision and leadership support. The main complaint was; erratic supervision or no supervision at all. This was more prominent among the PITC/STI participants than PITC for PMTCT. Two participants from PITC/STI lamented:

"Honestly speaking, there is no support but when people are trained in that area, they just do it for the first weeks and then just leave it like that…" PITC/ STI 304)

"I can say supervision is not that good, since I came here I haven't seen anyone coming to supervise services." (PITC/ STI 310)

The top leadership from the Ministry of Health (HIV/AIDS Department) was accused of micro-managing supervision. Local supervisors at district or facility levels were bypassed. One healthcare worker supervisor narrated this:

"Coordination was not that simple, I am supposed to know what changes are taking place in the implementation of services, but sometimes gets surprised during supervision visits, to find somebody doing something "different", and when I ask they tell me, "we were told by somebody from headquarters (Ministry of Health) ..." I feel we were supposed to go together or I was supposed to be informed." (Healthcare worker supervisor 311)

Senior healthcare worker/policy-makers' perspectives about leadership

Senior healthcare worker and policy makers from the main coordinating units of Ministry of Health (MOH), NAC and OPC were responsible for coordinating operations with healthcare workers. There was blame shifting within this level of stakeholders. Those from MOH blamed counterparts from OPC, that their structure did not provide full responsibility and leadership in creating awareness and implementation. Health rights activists, too, expressed concerns about the poor coordination.

Apart from these coordinating units, local leadership of healthcare workers also fell short of their mandate by not effectively enforcing supervision to ensure that the policy is known to healthcare workers and that its implementation was going well. A senior healthcare worker observed:

"…When we do spot check supervision in the field, we get shocked to hear people have not seen the policy document but the good thing is that you will find that they do the right thing regardless of that. This is really an issue of the manager on the site to be responsible and strengthen supervision to ensure that people have the policy document and are adhering to it." (Senior healthcare worker 316)

Health rights activists' perspectives about leadership

There was dissatisfaction among health rights activists about the government's leadership and commitment toward policy implementation. They felt government did not do enough to make necessary mechanisms to ensure policy implementation. There was not much done beyond formulation of the policy and distribution. One health rights activist observed:

"…There has been little commitment of how to get the policy out and use it. The government did not do much apart from distributing as any other IEC materials." (Health rights activist 319)

Another concern of health rights activists was about lack of harmonization of health policies. One activist observed that policies are supposed to be complementary with each other for effective implementation but every related policy seemed to take its own vertical path. He called for the setting up of

a sexual reproductive health (SRH) policy coordination unit with clear coordinating roles so that all related policies "talk to each other" for effective implementation.

Health care worker deployment issues

There was a concern about the need to formally establish a cadre of HIV testing counselors who will help the workers feel recognized and work better to implement services. One health care worker complained:

"Another issue is that although we are doing our job well, we are not a recognized cadre… let the authorities think about us so that we do this work whole heartedly." (PMTCT 301)

Lack of training for the healthcare workers was also highlighted as a source of poor implementation. A policy maker narrated:

"Although the policy has been there, HTC uptake has not been adequate in most outpatient or STI settings. The problem is that many service providers are not trained for HIV testing and this puts implementation at a disadvantage…The best is to train all STI service providers on HIV testing and counseling as well." (Senior healthcare worker 316)

Facilitators of Policy Implementation

Specific facilitators of policy implementation were highlighted and included availability of the policy document. Adoption of Option B+ Policy was another facilitator - a recommendation that all pregnant or breastfeeding women who test HIV-positive be immediately enrolled on ART and remain on treatment for life. This helped further improve the PMTCT component, availability of free HIV test kits. STI drugs availability were also a facilitator for implementation.

"Another facilitator was that all HIV testing services were free and this attracted people." (Policy maker 317)

"Yes, I think at (name of hospital) STI Clinic there is a lot of back up STI drugs and patients were assured that they will be helped. So, the appeal is that the resources should be there so that the government fulfills its mandate of patient care during implementation (of the policy)." (PITC/STI 307)

Many participants highlighted the importance of supervision of healthcare workers as a motivator to implement the policy. Supportive leadership should be demonstrated by ensuring adequate supervision of the HIV policy components. One participant emphasized that supervision is a great motivator for them. Finally, Government commitment and political will is very important in positively affecting implementation.

"*There is highest political will and commitment. Remember, the office of president and cabinet made all it can to move the policy in the right direction. Malawi is a shining example in that regard. This is one of the very few countries that are contributing resources toward HIV, about 2% of each Ministry's funding is dedicated to the (HIV/AIDS) work."* (Policy maker 317)

Discussion

This study was aimed at documenting barriers and facilitators in the implementation of the HIV testing components for the STI/PITC and PITC for PMTCT in the 2003 HIV/AIDS policy in Malawi and to provide lessons on how to move future HIV policies to successful implementation. Policy theoretical frameworks helped build the premise of this study. The key principle applicable to this study is that central policy actors should make good connections with those directly implementing the policy to produce the desired effects[17]. In the case of the Malawi HIV/AIDS policy, healthcare workers are vital and need to be recognized as key contributors of the policy processes. However, their involvement in policy making was not adequate in this case. Measures to include involvement of key players will ensure the smooth implementation of the current ambitious UNAIDS 90-90-90 goal[18]. The Ecological Policy Framework proposes a broad range of important factors that guide effective implementation of policies. Key factors supported by our findings included trainings and technical assistance[19]. To improve policy awareness and dissemination to health care workers, some acceptable options may include orientation sessions by colleagues who receive formal trainings to share with others. This is an easier and cheaper way of knowledge dissemination. The study noted that that some health care workers were reluctant to be given orientation or briefing by their colleagues who went for formal training. This was due to resentment over incentives the former received and a government recognition system that only favors or acknowledges those with formal orientations. This was also observed in another study, where senior people such as doctors refused briefing by junior colleagues who received formal training[20]. Generally, problems of refusal may be mitigated by peer to peer orientation or intensifying the use of trained supervisor to train others. However, in our study, supervision was another challenge in the implementation of the policy. It was acknowledged that some supervisors were trained but failed to orient staff under their jurisdiction. Instances of local supervisors being bypassed or sidelined by national level supervision coordination from headquarters, was reported by some local supervisors. This reduced motivation of these local leaders. There is already an opportunity in Malawi, where the health system supervision is structured per zone and district. However, the decentralized supervisory practice is not strictly followed.

Health care worker deployment was another important challenge. For good implementation of this policy, an adequate number of healthcare workers must be in place. Task shifting to a lay cadre of healthcare workers known as health surveillance assistants (HSAs) has already shown good success in support of HIV testing or ART scale up in Malawi[21,22,23]. However, this cadre had some challenges such as failure to meet some quality clinical competencies and being overwhelmed with several other public health tasks given to them. A specialized and dedicated cadre to be solely responsible for HTC is therefore needed in key health facilities. A cadre known as HIV Diagnostic Assistants has just been adopted in Malawi to support HIV testing services. It is currently supported through non-governmental organizations. However, it is not established as a formal cadre within the government system like the HSAs. One of the healthcare workers proposed that the Malawi Government should formally adopt the special HIV testing cadre (PMTCT 301). In a bid to reach the UNAIDS 90-90-90 targets, there is a need to increase HIV testing strategies. A testing scheme like this could help. There were also problems with leadership support. This is evident from laxity on the part of health care leaders and health rights activists where a health care worker leader acknowledged keeping the policy

document in his office and library without taking proactive steps in coming up with measures to make it available to his staff. On the other hand, there was concern of government's failure to take responsibility of dissemination by rights activists, but these health activists could have as well used their constituency to support the government with policy dissemination process. Collective accountability of moving policies forward at all levels of leadership need to be strongly advocated.

Lack of coordination among key units of the Malawi Government was another major problem. Stakeholders complained about poor coordination and lack of clear roles within the HIV/AIDS policy coordinating stakeholders in the HIV/AIDS Department, MOH and NAC. This may have negatively affected policy implementation. Clear coordination roles are critical to the successful implementation of the policy, would instill confidence in other stakeholders and properly direct healthcare workers.

In Malawi, HIV/AIDS or other health related policies are usually dealt with in more than one ministry. This brings conflicting policy directives and confusion for implementers on the ground[24]. For effective policy implementation, there is need to harmonize some of the policies with similar agenda. A National Policy Harmonization and Supervision Committee for HIV/AIDS and related policies should be created. This entity could be charged with the responsibility of overseeing and coordinating how well the HIV/AIDS and other related health policies are coordinated and implemented. This committee would also be responsible for steering policy formulation, revision, dissemination, and implementation. It should be composed of senior technical officers from various departments or ministries who are policy keepers or collaborators.

Limitations of the study

Stakeholders interviewed included health care workers, governmental leaders and health rights activists. Other important stakeholders would have ideally been included, such as, donor community. These may have had an influence on certain implementation components. Community members were also not included; they could have provided useful insights about the process of implementation. However, in an area that has not been extensively studied, those selected were still important informants who provided useful information that could help improve policy implementation.

Summary of recommendations

The study identified several barriers and facilitators that may help effectively improve policy implementation. We made recommendations to facilitate positive change. These emanate from the study findings and are in concordance with the fact that change does not just happen but is derived from a strong sense of leadership with clear change management attributes[25]. The recommendations are summarized as follows;

- Involve health care workers in the policy making process and dissemination through trainings;
- Improve stakeholder coordination to include formulation of clear terms of reference and clarification of stakeholder roles, linkages of organizational efforts;
- Strengthen policy leadership through decentralization of supervision;
- Enhance human capacity and resource mobilization for HIV/AIDS policy implementation;
- Create a national policy harmonization and supervision committee.

Conclusions and implications for practice

While good strides were made in Malawi's HIV/AIDS response between 2003 and 2013, some aspects of the Malawi HIV/AIDS policy were not well implemented. Given the huge and detrimental effect of HIV and AIDS for peoples' general health and social economic development, it is imperative to effectively implement HIV policies and programs with speed and zeal. Policies and programs that are not well implemented miss a very important step in accounting for the resources and time invested in public health. These results are coming at a time when Malawi is in its early phase of implementing a new HIV/AIDS policy that became operational at the beginning of 2014. The recommendations presented in this study are therefore well timed and should contribute towards implementation of the new policy.

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