

**HOW AND WHY ARE DIFFERENT FORMS OF
EVIDENCE USED IN POLICY-MAKING IN THE SOUTH
AFRICAN HEALTH SECTOR?**

**A CASE STUDY OF THE NATIONAL CORE
STANDARDS AND THE PREVENTION OF MOTHER-
TO-CHILD TRANSMISSION (PMTCT) OF HIV
POLICIES**

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Thesis presented for the
Degree of Doctor of Philosophy
in the School of Public Health and Family Medicine
University of Cape Town

27 October 2023

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DECLARATION

I declare that this Thesis contains my own unaided work in both concept and execution, and has not been submitted before for any degree or examination to any other university.

Signed by candidate

Thulani Clifford Masilela

27 October 2023

ABSTRACT

PURPOSE

The South African public health sector lacks a formal, documented, and nationally-adopted system through which evidence is infused into policy-making processes. It is, therefore, unclear what evidence informs policy formulation and why and how this evidence is used. The main goal of this study was to examine why and how different types of evidence are used in policy-making in the South African public health sector and what factors determine whether or not these different evidence forms are used.

METHODOLOGY

This study used qualitative research methods. This was an insider-led or embedded research study led by a senior government official. It adopted a broad definition of evidence, embracing not only research but also a wider range of routine evidence. In phase 1 of the study, the overall process of health policy formulation was reviewed, and in phase 2, two specific policy process cases were examined in depth. These were the Prevention of Mother-to-Child Transmission policy and programme (2002) and the National Core Standards policy (2011). A total of 30 in-depth interviews were conducted, with both senior executive managers in the public health sector and local Health Policy and Systems researchers. In addition, a range of documentary evidence and relevant literature was examined.

Phase 1 of this study, which was mainly descriptive, used thematic content analysis to analyse the interview and documentary data collected. **Phase 2** included a more analytic approach, to support explanatory analysis, and so framework analysis was applied – combining inductive analysis with a more deductive approach drawing from relevant theoretical concepts and ideas.

FINDINGS

Findings from **Phase 1** of this study generate an understanding of the key steps in the formal policy-making process in the South African health sector. This is an internal process which is driven by the National Health Council (NHC) and the Technical Advisory Committee of the NHC, and is somewhat closed to stakeholders outside government. This study also shows that policy-makers in South Africa draw on a wide range of sources of evidence, including informal evidence, rather than relying only on research evidence. Findings from **Phase 2** of the study reveal that powerful political actors play a central and influential role in health policy development, and influence the use of evidence. These actors apply issue-framing as a strategy to influence this process, although its influence is transient. In the context of a democratic South Africa, where the Constitution prescribes a separation of powers between organs of state, the study also illustrates the power of stakeholders outside government, such as the judiciary, whose judgements ushered in the PMTCT policy, and civil society. Findings from both Phases of the study show that different sources and forms of evidence were used in the development of the two policy process cases. Finally, this study reveals the contestations that occur between spheres of government, sparked by differences over the use of evidence and national policies perceived by provinces as ‘unfunded mandates’.

CONCLUSIONS

The study concludes that, in South Africa, powerful political actors in government have strong influence over the formal health policy-making processes, which are closed in that external stakeholders cannot observe or influence the use of evidence in policy formulation. This study therefore proposes a transparent, evidence-to-policy framework for future use in the South African health sector, adapted from the work of Liverani, Chheng, and Parkhurst (2018).

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ACKNOWLEDGEMENTS

First and foremost, I wish to express my deepest and sincere gratitude to the Almighty God for carrying me on His shoulders throughout this challenging PhD journey, until its completion.

My most profound and heartfelt gratitude goes to my supervisor, Prof. Lucy Gilson, from the School of Public Health and Family Medicine at the University of Cape Town, for guiding me throughout this long journey. Her patience and wonderful sense of humour during difficult moments kept me inspired. I will always reminisce about Sis' Lucy's words when reviewing my draft chapters of this thesis: "Thulani, this is not one of your government reports!" Thank you very much Sis' Lucy, I am deeply grateful to you for taking me to a better phase of my life. Asante Sana!!!

I wish to thank all the key informants in this study, who gave generously of their time, and comprehensively engaged with me about the policy-making processes in the health sector. These were senior political leaders of the health sector in South Africa, current and former senior executive managers in both the national and provincial spheres of government, senior academics and researchers at various Schools of Public Health, and independent consultants. These are by definition extremely busy people. This makes their gift of time and ideas even more precious to me. My gratitude to them is beyond measure. May this Thesis serve as a contribution, albeit modest, to the existing body of knowledge on the use of various forms of evidence in the development of health policy in South Africa.

I also wish to thank Ms. Megan Moll who painstakingly edited this thesis and assisted in refining it into a higher quality product. I also wish to thank my colleagues in the Department of Planning, Monitoring and Evaluation (DPME) for their moral support.

On one winter evening in 1982, I was watching a small black and white television set with my late grandfather, Bishop Wilson Badi Ndhlovu, at his house, No 2891 Block J, Mamelodi West. The SABC news covered a graduation ceremony that had occurred somewhere in the country. My grandfather suddenly looked at me and said: "Usithwale nawe Mfana lesiya sigqoko, ngelinye ilanga" (*You must wear that academic cap one day, my boy*). My grandfather was kind and generous, but was not the type that discussed issues with children, especially grandchildren. All I could say was, "Yebo Mkhulu". At the age of 12, I thought his instruction was just a distant dream. However, his words stayed with me throughout my life. I trust that with this Thesis, I have finally fulfilled the task my late grandfather assigned to me. I also hope that he is not expecting another PhD from me!

Through God's mercy, my mother Jev. Marriam Maria Masilela, my three sisters, Nomaphakane (Rose), Phumzile (Betty) and Sibongile (Lorraine), and their families, have lived to see the completion of this PhD thesis. The entire Masilela and Ndhlovu Families have always been a source of inspiration to me. My utmost gratitude goes to them for being a united, loving, supportive and tightly knit family.

May this PhD Thesis serve as an inspiration to my three beloved children:

- (a) Pauline Fortunate Dimpho Masilela
- (b) Nsika Masilela
- (c) Mthokozisi Atlegang Masilela

I thank the Almighty God for bringing this trio into my life. May they be inspired to achieve bigger and better things.

My highest level of gratitude also goes to my spiritual leaders, Mother Christina Nku, Archbishop Dr. P.J. Masango and Lady Archbishop Anna Masango, Archbishop Dr. P.T. Matsoso and Lady Archbishop Beatrice Matsoso and Archbishop C. Maphela and Lady Archbishop Maphela, of the Saint Johns Apostolic Faith Mission Church, in all its denominations. Indeed, Prophets never die!!! Ke a le leboha ha holo ba khethwa ba Molimo.

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LIST OF ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Human Immunodeficiency Virus
ANC	African National Congress
ART	Antiretroviral Therapy
AZT	Azidothymidine (Zidovudine)
CQC	Care Quality Commission (United Kingdom)
CEO	Chief Executive Officer
COHSASA	Council for Health Service Accreditation of Southern Africa
CHS	Council on Healthcare Standards (Australia)
Covid-19	Coronavirus Disease
DA	Democratic Alliance
DG	Director-General
DDG	Deputy Director-General
DoH	Department of Health
DPSA	Department of Public Service and Administration
IFP	Inkatha Freedom Party
E2Pi	Evidence-to-Policy Initiative
EBM	Evidence-based Medicine
EBP	Evidence-based Policy
EAS	Evidence Advisory System
HAART	Highly Active Antiretroviral Therapy
HAS	Haute Autorité de Santé (France)
HICs	High Income Countries
HIQA	Health Information and Quality Authority (Ireland)
HIV	Human Immunodeficiency Virus
HIMMER	Health Information Management, Monitoring and Evaluation and Research
HoD	Head of Department
HASA	Hospital Association of South Africa
HPSR	Health Policy and Systems Research
LMICs	Low- and Middle-Income Countries
LSE	London School of Economics
MAC	Ministerial Advisory Committee(s)
MEC	Member of the Executive Council
MinMEC	Minister-MEC Committee
MRC	Medical Research Council
MTSF	Medium Term Strategic Framework

NDP	National Development Plan
NEC	National Executive Committee
NGO	Non-Governmental Organisation
NHA	National Health Act, No. 61 of 2003
NHC	National Health Council
NHI	National Health Insurance
NHRC	National Health Research Committee
NHREC	National Health Research Ethics Committee
NHS	National Health System
NICE	National Institute for Health and Care Excellence
OSC	Office of Standards Compliance
OHSC	Office of Health Standards Compliance
PCR	Polymerase Chain Reaction
PHC	Primary Health Care
PHRC	Provincial Health Restructuring Committee
PHRCs	Provincial Health Research Committees
PMTCT	Prevention of Mother-to-Child Transmission
QIPs	Quality Improvement Plans
RDP	Reconstruction and Development Programme
RCT	Randomised Controlled Trial
TECH-NHC	Technical Advisory Committee of the National Health Council
TAC	Treatment Action Campaign
SALGA	South African Local Government Association
SAMHS	South African Military Health Services
SAPMTCTE	South Africa Prevention of Mother-to-Child Transmission Evaluation
SAZA	South Africa and Zambia Health Financing Reform Project
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization
UCT	University of Cape Town
WITS	University of the Witwatersrand

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CHAPTER 1: INTRODUCTION

1.1. Purpose and rationale

Health policy is an important enabler of any nation's efforts to improve its health status. As Mondal et al. (2022) state, "health policies play a central role in ensuring access, reducing inequities and improving health and well-being" (p. 2). It is therefore imperative that health policies are informed by the best available evidence. In its 2021 *Guide for evidence-Informed decision-making*, the World Health Organization (WHO) embraces the concept of evidence-informed decision-making, and defines it as an approach that "emphasizes that decisions should be informed by the best available evidence from research, as well as other factors such as context, public opinion, equity, feasibility of implementation, affordability, sustainability, and acceptability to stakeholders" (p. 6). This research study therefore sought to generate insight into how different types of evidence are used in policy-making in the South African public health sector, how this evidence reaches health policy-makers, and why these types of evidence are used.

The study adopted a broad definition of evidence, crafted by Bowen and Zwi (2005), which transcends the narrow concept of research evidence and extends to other forms. These authors state that "...evidence is information that affects existing beliefs of important people about significant features of the problem under study and how it might be solved or mitigated" (p. 0601). WHO (2021) also defines evidence broadly and posits that "Evidence is defined as factual knowledge gained through observation or experimentation in support of a conclusion" (p. 6). This study therefore characterised evidence as more extensive than just *research evidence*, which Verboom and Baumann (2020) describe as "research produced by academic researchers and/or published in academic journals" (p. 4).

This was an insider-led research study, which Costley, Elliot and Gibbs (2010) define as a study conducted within the researchers' own work practice. I am an Outcomes Facilitator for Health in the Department of Planning, Monitoring and Evaluation (DPME), in the Presidency of the Republic of South Africa. My job description is to monitor progress with the implementation of the Health Chapter of the country's National Development Plan (NDP) 2030, adopted by Cabinet in 2012 as a blueprint for overcoming the triple challenges of unemployment, poverty, and inequality. The NDP stipulates that by 2030, South Africa should have: raised the life expectancy of South Africans to at least 70 years; produced a generation of under-20s that is largely free of HIV; reduced the burden of disease; achieved an infant mortality rate of less than 20 deaths per thousand live births, including an under-5 Mortality rate of less than 30 per thousand; achieved universal coverage; and significantly reduced the social determinants of disease.

By virtue of my Outcomes Facilitator role, I always participate in meetings of the Technical Advisory Committee of National Health Council (TECH-NHC), and the fully-fledged National Health Council (NHC). The NHC was established in terms of the National Health Act, No. 61 of 2003 (NHA), and consists of the Minister of Health, Deputy Minister of Health, Provincial MECs for Health, South African Local Government Association (SALGA), the Director-General and the Deputy Directors-

General of the national department, and the head of the South African Military Health Services (SAMHS).

Both the SAMHS and organised local government were again formally included in the TECH-NHC and NHC in accordance with the National Health Act.

Table 1.1: Composition of structures of the National Health Council

Structure	Function	Membership
National Health Council (NHC)	• The National Health Act stipulates that the NHC must advise the Minister on policy concerning any matter that will protect, promote, improve and maintain the health of the population • NHC must “strive to reach its decisions by consensus but where a decision cannot be reached by consensus, the decision of the majority of the members of the National Health Council is the decision the National Health Council” [section 23(3)]. This is because one of the aims of the study was to examine what happens when there is contestation of proposed health policies about the use of evidence in health policy development and how consensus is achieved.	• Minister of Health (Chairperson) • Deputy Minister of Health • Provincial Members of the Executive Council (MECs) for Health in the 9 Provinces • South African Military Health Services • South African Local Government Association (SALGA) • Director-General of Health\ • Deputy Directors General (DDGs) of Health
Technical Advisory Committee of National Health Council (TECH-NHC),	• TECH-NHC provides technical advice and support to the NHC • TECH-NHC replaced the old Provincial Health Restructuring Committee (PHRC)	• DG of the National DoH (Chairperson) • DDGs in the National DoH • Heads of Health in the 9 provinces • SAMHS • SALGA

I have also participated (and still participate) in all meetings of both the NHC and TECH-NHC, by virtue of the monitoring and evaluation role of the DPME. This includes tracking progress with the implementation of Chapter 10 of the country's macroplan, the National Development Plan (NDP) 2030.

Prior to joining the DPME in April 2013, I worked in the National Department of Health (DoH) in various capacities, first as Director for Strategic Planning (2004-2008), then as Chief Director for Strategic Planning (2008-2011), and then as Chief Director for Health Information Management, Monitoring and Evaluation and Research (HIMMER) (2011-2013). I worked in the National DoH for a consecutive period of 9 years and 2 months.

The inspiration for this study occurred while I worked as the Chief Director for Strategic Planning. In May 2010, I was part of a Ministerial Study Visit to Brazil, funded by the Kaiser Family Foundation, to enable the health sector leadership to learn about progress towards Universal Health Coverage in four Latin American countries: Brazil, Colombia, Mexico, and Chile. The key takeaway messages from this study tour were that:

- (a) Politics matters. Health financing reform and national health reform generally take place in a highly political and politicised environment, and in themselves, they prompt contestations.
- (b) To be effective champions for health reform, political leaders must have a shared vision of the objectives of the reforms and the expected benefits of the reform process. This vision must be shared across government and between government and communities.

These takeaway messages inspired this study. The first message corroborated my personal experience of policy-making in the health sector as essentially a political process. The second message resonated with the processes through which the two tracer policies in this study were developed, as they highlighted the *lack of shared vision* and the existence of opposed perspectives between key actors in the policy-making processes, particularly in the formulation of the first policy process case, the Prevention of Mother-to-Child Transmission (PMTCT) policy. However, I wished to undertake a formal research study to generate deeper insights into the policy processes of the PMTCT policy, as well as a comparator policy, the National Core Standards for Health Establishments.

During this visit to Brazil, the South African delegation visited the *Oswaldo Cruz Foundation* in Rio de Janeiro, which is a scientific institution for research and development. My observation was that the relationship between this foundation and the government of Brazil was well defined, and there were clear processes through which the results of the empirical work of the foundation, both biomedical and public health, were infused into government policy development. The Oswaldo Cruz Foundation stated that its work was driven by the need to promote health and social development, generate and disseminate scientific and technological knowledge, and to be an agent of citizenship. This mantra is also reflected in their public profile (Fiocruz, n.d.). The South African delegation was extensively inspired by the work of the Oswaldo Cruz Foundation and proposed that when *the formal Agreement on Cooperation* between South Africa and Brazil was signed, collaboration around research would be a key component. This priority area was indeed included in the agreement signed by the Presidents of South Africa and Brazil on 10 July 2010.

I harboured an aspiration to learn from the Brazilian experience around the research-to-policy interface, with the aim of enhancing South Africa's health policy formulation processes.

A final motivation for this study arose from the proceedings of the National Health Research Summit convened by the National DoH and the National Health Research Committee in 2011, in which over 300 researchers participated. I was still the Chief Director for HIMMER in the National DoH, and a key player in planning the summit. One of the weaknesses identified by the research community was the "absence of an

organised pathway to translate new evidence into policy, programmes, and practice” (Abdool Karim, 2011, in Mayosi et al., 2011, p. 3). This observation struck a chord with me, particularly in light of the lessons learnt during the Brazil study tour. This is an area that this study has sought to consider, by generating ideas about a formal pathway to promote stronger relations between evidence in its various forms and government policy-making processes.

1.2. Problem Statement

In South Africa, there is a lack of a clear, established, and documented system outlining how evidence enters the policy-making space, and how it is factored into policy processes. South Africa is not alone in this challenge. This problem has also been identified across different African countries, where there are many settings without published evidence of local knowledge translation strategies (Edwards, Zweigenthal & Olivier, 2019). In such contexts, commonly reported knowledge translation strategies include policy briefs, capacity building workshops, and policy dialogues (Edwards, Zweigenthal & Olivier, 2019).

The yearning for evidence-informed decision-making in South Africa has grown over the last two decades (2000-2020), evidenced among others by the establishment of the Africa Centre for Evidence at the University of Johannesburg (Tannous, 2019). The centre now includes a network of over 3,000 individuals with an interest in the production and use of evidence for poverty reduction in Africa (Tannous, 2019).

The field of Health Policy and Systems Research (HPSR) in South Africa also reflects an upward trajectory, with numerous academic and research institutions involved in advancing this body of work, which entails examining the evidence-to-policy interphase (Orgill et al., 2013). South Africa has also seen growth in research institutions housing platforms for Knowledge Translation, which is a field of endeavour focusing on how research-based knowledge can inform health policy formulation (Edwards, Zweigenthal & Olivier, 2019). Such institutions include the Centre for Evidence-based Healthcare at Stellenbosch University, the Knowledge Translation Unit at the University of Cape Town’s Lung Institute, and the Cochrane African Network at the South African Medical Research Council (Edwards, Zweigenthal & Olivier, 2019).

While the growth of HPSR and Knowledge Translation platforms in South Africa is noteworthy, there is still a paucity of studies published by local scholars which describe mechanisms through which research and other types of evidence succeed (or fail) in influencing health policy-making processes. Further work is required to understand and strengthen such mechanisms (Orgill et al., 2013).

Twenty years ago, a widespread recognition occurred that despite the growing interest in the use of evidence for policy development and practice, devising effective strategies to ensure that evidence is integrated into policy and used in practice was difficult (Nutley, Walter & Davies, 2003). Globally, and in South Africa, both policy-makers and researchers realised that linear mechanisms for pushing research evidence into the policy space were not useful and sought to understand the complex

ways in which research, evidence, and ideas may influence policy-makers and policy thinking (Nutley, Walter & Davies, 2003; Gilson & McIntyre, 2008).

More recent literature contends that, in the past, greater emphasis was placed on researchers' own views of research use, and less focus was placed on policy-makers' perspectives (Oliver, Lorenc & Innvaer, 2014; Cairney & Oliver, 2017). Based on their systematic reviews of studies relevant to evidence-based policy-making in high-income countries (HICs), Cairney and Oliver (2017) concluded that some evidence-based policy studies had erroneously identified a key barrier to evidence use as a limited supply of evidence to policy-makers, and subsequently developed strategies to improve dissemination. According to Cairney and Oliver (2017), too many studies assumed that "better dissemination will prompt policy-makers to think, like scientists, that the scientific evidence alone is persuasive or self-evident" (p. 2). Furthermore, as the two scholars state, too few studies recognised the role of values in politics, and instead believed erroneously that policy-making should be as 'evidence-based' as medicine. Cairney and Oliver (2017) assert that greater effort must be channelled towards gathering the perspectives of policy-makers as well, to supplement the views of the research community.

1.3. Knowledge base and starting points of the study

This study was informed by the wider work of scholars in the field of Health Policy and Systems Research (HPSR), as well as in the Evidence-to-Policy initiative (E2Pi). According to the Alliance for Health Policy and Systems Research (2007), HPSR is defined as "the production of new knowledge to improve how societies organize themselves to achieve health goals". The Alliance therefore works to support the generation and use of evidence that strengthens health systems.

International health policy scholars have specifically identified a need for improved understanding of evidence use in health policy-making, and that this requires both additional empirical studies of evidence use and an engagement with theories and approaches beyond the current remit of public health and knowledge utilisation studies (e.g. Liverani, Hawkins & Parkhurst, 2013). It has also been asserted that despite a massive growth in global health research expenditure, health policy and practice are not adequately informed by the best available evidence (Liverani, Hawkins & Parkhurst, 2013).

This study therefore focused on the formal health policy formulation processes in the public health sector but did not extend to policy implementation. The scope of this study was confined to the phase of policy development located between *agenda setting* and *policy implementation*, which Berlan et al. (2014) refer to as the "bit in the middle". According to Mhazo and Maponga (2021), *agenda setting* is defined as "how a particular issue gains the attention of policy-makers amongst other issues competing for priority" (p. 1). This study focuses on the stages of policy development occurring after agenda setting but before policy implementation.

Berlan et al.'s (2014) "bit in the middle" consists of seven steps, namely: the generation of policy alternatives, deliberation and/or consultation, advocacy for

specific alternatives, lobbying for specific alternatives, negotiation on policy alternatives, drafting or enactment of policy, and guidance/influence on implementation. These authors posit that these seven steps constitute “a foundation for advancing research on this stage of the policy process” (p. iii23). This study examines the use of evidence in these steps.

The study drew particular inspiration from the conceptual policy analysis work of scholars such as Weiss (1979), Lavis et al. (2003), Lavis et al. (2008), Abeyasinghe and Parkhurst (2013), Oliver et al. (2015), Oliver & de Vocht (2017), Parkhurst (2017), Liverani, Chheng and Parkhurst (2018), and Kuchenmueller et al. (2022). The scholarly work of these authors has evolved global thinking from the original paradigm of evidence-based medicine, to evidence-based policy, to evidence-informed policy and to the good governance of evidence. Parkhurst (2017) and his co-workers have contributed substantially to a body of work de-bunking the myth of objective, value-free, sacrosanct scientific evidence, which exists in pristine condition, evidence that constitutes absolute truth. Parkhurst (2017) contend that evidence is not apolitical, but in fact, it can be decidedly political by promoting a *de facto* choice among competing values.

1.4. Brief overview of Evidence-based Medicine and Evidence-based Policy

From outside the field of health, pioneers such as Weiss (1979) grappled with the subject of the interface between research evidence and policy. Weiss (1979) postulated six models for enabling the translation of evidence into policy: *the knowledge driven model, the problem solving model, the interactive model, the political model, the tactical model, and the enlightenment model*. As reflected in Chapter 3 of this study, the scholarly work of Weiss (1979) subsequently inspired scholarly thought beyond general policy development, and this also permeated into the health sector. However, in the 1980s, a strong health movement emerged known as evidence-based medicine (EBM). According to Donald (2002), the term EBM was coined by clinicians and epidemiologists at McMaster University in Canada in 1988, and it became known worldwide during the 1990s. This was followed by the emergence of a field of endeavour known as evidence-based policy (EBP), inspired by the premise that policy decisions should be better informed by available evidence (Sutcliffe & Court, 2005). Policy based on systematic evidence was seen to produce better outcomes (Sutcliffe & Court, 2005).

As is also reflected in Chapter 3, in the health sector the concept of EBP was readily embraced, in part because of the easy analogy with the EBM movement (Abeyasinghe & Parkhurst, 2013). The flow of evidence between global health researchers and policy-makers was emphasised as an important tool for improving health outcomes (Yamey & Feachem, 2011). In the 1990s, the United Kingdom (UK) government under Prime Minister Tony Blair also popularised the concept of EBP. The objective of the Blair Administration was to replace ideologically-driven politics with rational decision-making based on evidence (Sutcliffe & Court, 2005).

Beyond the health sector, the much broader concept of *evidence-informed policy* subsequently emerged, which took into account the complexity of policy development and the context in which policy processes occurred. Scholars such as Bowen and Zwi (2005) also advanced a cogent discourse that the term EBP actually relates to only one type of evidence, namely *research*. They argued that the terms “evidence-influenced” or “evidence-informed” reflected the need to be context-sensitive and consider use of the best available evidence when dealing with everyday circumstances (Bowen & Zwi, 2005). Other critics of the notion of EBP suggested that it reflected a naïve rationality, which incorrectly assumed that policy-making is merely an exercise in ‘decision science’ rather than acknowledging that the policy process is, instead, a “struggle over ideas and values” (Russell et al., 2008, cited in Parkhurst, 2017, p. 5).

South Africa has, however, lagged behind other countries in terms of institutionalising within government systems for supporting long-term evidence use. Authors such as Ettelt, Hawkins and Parkhurst (2018) perceive such systems as good practice. South Africa has national health legislation (National Health Act, No. 61 of 2003) which makes provision for the establishment of a National Health Research Committee to advise government on health priorities, but lacks a formally adopted and documented process through which evidence is considered in health policy development in the country. The country has legislation and committees, but lacks the levers through which evidence is pulled into health policy-making. This study, therefore, aimed to contribute towards addressing this by proposing a framework in which evidence might be leveraged in policy-making in South Africa.

1.5. Research Questions and Objectives

The overall question addressed in this study was: “*How and why are different forms of evidence used in policy-making in the South African health sector?*”

The specific **objectives** of the study were:

- (a) To describe the routine avenues of national health policy-making in the South African public health sector
- (b) To explore the nature of evidence that is viewed as important and used for policy-making processes in the public health sector in South Africa
- (c) To explain factors that facilitate and those that inhibit the use of different types of evidence in policy-making from the perspectives of both policy-makers and researchers
- (d) To explore mechanisms of fortifying the research-to-policy interface in South Africa

1.6. Overview and structure of the thesis

The thesis is organised in terms of eight **subsequent chapters**, as outlined below.

Chapter 2 is a review of the literature. This chapter reflects the approach to the selection and categorisation of literature, an exposition of the key debates in the published literature, and gaps in the literature, which this study sought to contribute

towards addressing. This chapter outlines the **conceptual literature** on policy analysis, which was examined in this study. This includes the characterisation of policy-making processes, critical considerations and factors that influence policy formulation, and theoretical literature exploring ways in which evidence might be brought to bear in policy processes. The literature reviewed is drawn from both HICs and low- and middle-income countries (LMICs) and from South Africa. **Chapter 2** also presents **empirical literature** from HICs and LMICs, including South Africa, which reflects lessons from various efforts across continents to enhance an understanding of how various forms of evidence might influence policy development processes. Gaps in the literature are identified and the potential contributions of this study are presented.

Chapter 3 outlines the methodology used in the study. The chapter presents the study design, focusing on data collection methods followed in the two phases of the study, Phase 1 and Phase 2. This chapter also outlines the data analysis processes. This includes the techniques used in the analysis of interviews and documents, the principles of rigour, and methods of triangulation and validation. This section also outlines limitations of the study and how these were addressed.

Chapter 4 presents a background to the South African political governance system and the organisation of the health system.

Chapter 5 presents the findings from **Phase 1** of the study and outlines the formal health policy formulation processes in the South African public health sector. It graphically outlines the formal policy formulation processes led by the Technical Advisory Committee of the NHC and the fully-fledged NHC itself. Chapter 5 also reflects the institutional arrangements for policy-making in South Africa, the extent to which evidence is used, and sources of such evidence, at each step of the policy process.

Chapter 6 presents the results from **Phase 2** of the study. The focus of this chapter is on the use of evidence in the development of PMTCT policy, the first of two policy process cases.

Chapter 7 also presents findings from **Phase 2** of the study, but focuses on the use of evidence in the development of National Core Standards policy, the second of the two policy process cases.

Chapter 8 presents a discussion of the findings of the study and covers results from both Phase 1 and Phase 2 of the study. The chapter also reflects on how these findings are affirmed or contradicted by the wider empirical and conceptual literature. Finally, Chapter 8 presents a framework for enhancing the evidence-to-policy interphase in the South African health sector, in accordance with the fourth objective of this study.

Chapter 9 presents a set of reflections on the PhD experience and journey, and reflects on what the research study set out to achieve and what it actually attained, and vital milestones generated by the study. Most importantly, it reflects on the value-additions and new insights from this study to the existing body of knowledge in South Africa, as well as the limitations to the judgements that can be drawn from this study.

CHAPTER 2: LITERATURE REVIEW

2.1. Introduction

This study is located within the field of Policy Analysis and Evidence-Informed Policy (EIP), which Kuchenmueller et al. (2022) define as the “systematic and transparent use of the best available data, research and other forms of evidence depending on the nature of the decision-making process...supporting governments in improving the effectiveness, efficiency and perceived legitimacy of decision making” (p. 2). The study is specifically located within the paradigm of *health policy analysis*, which Ile (2021) defines as “a multidisciplinary approach to public policy that aims to explain the interactions between institutions, interests, and ideas in policy in the policy process” (p. 7).

As indicated in the previous chapter, this study focused on the phase of policy development known as policy formulation, which lies between agenda setting and policy implementation and which Berlan et al. (2014) describe as the ‘the bit in the middle’. These authors suggest that seven steps constitute ‘the bit in the middle’, namely: generation of policy alternatives, deliberation and/or consultation, advocacy for specific alternatives, lobbying for specific alternatives, negotiation on policy alternatives, drafting or enactment of policy, and guidance/influence on implementation. Similarly, Okeyo, Lehman and Schneider (2020) refer to this phase as the *policy adoption or formulation* and define it as “the stage of public policy-making where policy alternatives are considered, including the allocation of responsibilities and resources” (p. 2).

This chapter presents an overview of the conceptual and empirical literature on the use of evidence in health policy development processes. Both categories of literature are essential to review. This is because the conceptual literature exposes global and local (South African) theories and theoretical frameworks illuminating the dynamics of policy-making and evidence use in policy-making, whereas the empirical literature provides lessons from various primary research studies in different geographical settings.

A common theme in the literature on policy formulation and the use of various forms of evidence in policy development is that there is a paucity of empirical literature in these areas. For instance, Verboom and Baumann (2020) argue that the literature on evidence-informed policy-making lacks “in-depth, rich case studies on policy decisions and processes, and few attempts to study evidence use as it occurs in real-world practice through the use of observational methods” (p.13). However, in their systematic review of 379 studies from HICs and LMICs, these authors also noted a gradual shift towards studies examining how and why evidence was used, or not used, in specific instances of policy development or change (p.13). This study endeavoured to contribute to this emerging body of knowledge.

The chapter is structured according to four subsections, namely:

- (a) Approach to the literature review and search
- (b) Conceptual literature on policy and policy formulation

- (c) Empirical literature on evidence and policy-making
- (d) Efforts to promote the use of evidence in health policy-making in South Africa

The chapter adopts a *narrative review* approach, which is defined as a “scholarly summary along with interpretation and critique” (MacLure, 2005, cited in Greenhalgh, Thorne & Malterud, 2018, p. 2). Greenhalgh, Thorne and Malterud (2018) elucidate the value of narrative reviews, noting that conventional systematic reviews and narrative reviews are two complementary approaches which serve different purposes. They argue that conventional systematic reviews “address narrowly focused questions and their key contribution is summarising data. Narrative reviews provide interpretation and critique; their key contribution is deepening understanding” (Greenhalgh, Thorne & Malterud, 2018, p. 2). These scholars also note that different types of reviews provide different kinds of truth. They contend that whereas “conventional systematic reviews with meta-analysis deal with probabilistic (typically, Bayesian) truth, and is concerned with producing generalizable facts to aid prediction...the narrative review in contrast deals in plausible truth...Its goal is an authoritative argument based on informed wisdom that is convincing to an audience of fellow experts” (Greenhalgh, Thorne & Malterud, 2018, p. 3). Most importantly, Greenhalgh, Thorne and Malterud (2018) assert that the narrative review is “**not** a poor cousin of the systematic review, but a different and potentially complementary form of scholarship” (p. 4).

This study sought to deepen understanding of the use of evidence in policy-making in South Africa, rather than to produce generalisable facts to aid prediction. A narrative literature review is therefore a method of choice.

2.2. Approach to the literature review and search

2.2.1. Selection of Conceptual Literature

The conceptual literature cited in this chapter was sourced from various search engines, namely Google Scholar, ISI Web of Knowledge, and PubMed. This was complemented by consultation with experts in the field, who referred me to other pertinent and recent articles.

Conceptually, this study is anchored in the theoretical work of Dr. Justin Parkhurst, an Associate Professor of Global Health Policy in the London School of Economics and Political Science (LSE), as well as the chair of the LSE Global Health Initiative in the United Kingdom (LSE, n.d.). Parkhurst’s research interests lie in global health politics and policy, as well as the political nature of evidence used to inform policy decisions. Parkhurst has published extensively in these fields, which lie at the crux of this study and his authority in the field is demonstrated by citation indices^{1,2}. Among

¹ <https://scholar.google.co.uk/citations?user=AKor1-wAAAAJ&hl=en>, accessed 23 July 2023

² According to Google Scholar, Parkhurst has an overall h-index of 32, an i10-index of **55**, as well as 5,985 citations. Since 2018 to date, his h-index, a widely-used measure of scholarly performance, has moved from 21 to 32, and his i10-index has shifted from 40 to 55. (<https://scholar.google.co.uk/citations?user=AKor1-wAAAAJ&hl=en>, accessed 23 July 2023)

his over 100 publications, Parkhurst has published two seminal books: *The Politics of Evidence: From Evidence Based Policy to the Good Governance of Evidence* (Routledge, 2017) and *Evidence Use in Health Policy Making: An International Public Policy Perspective* (Palgrave Macmillan, 2018). Although based in the UK, Parkhurst has also published widely about policy processes in various African and other LMIC settings.

A snowball approach was also used to identify related conceptual literature, including published articles from co-workers of Parkhurst, such as Abeysinghe, Ettelt, Hawkins, and Liverani. The literature reviewed in this chapter also draws from the seminal work of Carol Weiss in the late 1970s and 1980s, which contributed knowledge on the different ways in which evidence can be used in the policy space.

2.2.2. Search for Empirical Literature

The empirical literature reviewed in this study was identified using three search engines: Google Scholar, ISI Web of Knowledge, and PubMed. These engines were searched using key words such as *policy analysis*, *policy development*; *health policy*, *evidence*; *evidence and policy*, *evidence to policy*, and *sources of information used by policy-makers*. I used these words individually and in combination to search for relevant literature. I also purposefully reviewed the references at the end of each authoritative article to identify additional relevant articles. The geographic search of these articles was both high income countries (HICs) and low- and middle-income countries (LMICs). Finally, if not otherwise identified, I specifically included relevant papers from two eminent scholars in the field of evidence use for policy: Justin Parkhurst (discussed earlier) and Kathryn Oliver (discussed below). In synthesising the findings from the reviewed papers (in section 2.4), I purposefully drew, first, on existing systematic reviews of relevant literature, complemented, second, by specific additional studies that added insight.

Oliver is an eminent scholar currently based at the London School of Hygiene and Tropical Medicine. Although she, like Parkhurst, is based in the UK, she has also done scholarly work both in the UK and to a lesser extent in West Africa³. As is the case with various other authors (e.g. Edwards, Zweigenthal & Olivier, 2019), Oliver has also published systematic reviews of *barriers to* and *facilitators of* the use of evidence by policy-makers, as well as systemic reviews of advice to academics on the do's and don'ts of influencing policy. Oliver has also produced empirical literature on themes such as misconceptions about the impact of research on policy, co-production of knowledge by researchers and policy-makers, EBP, and EBM, and has also proposed new directions in EBP research. Oliver's empirical work in the UK as well as in West Africa (Ghana) has exposed the diverse forms of evidence and a variety of sources of evidence used by policy-makers.

³ According to Google Scholar, Oliver has an overall h-index of 35 and an i10-index of 50. Since 2018, her h-index has shifted from 27 to 35, and her i10-index has improved from 46 to 50 (<https://scholar.google.com/citations?user=oWJTDC0AAAAJ&hl=en>, accessed 23 July 2023). The literature search started with Oliver's work, and snowballed to tracing other related articles.

Findings from the work of Oliver and her co-workers (e.g. Oliver, Lorenc & Innvaer, 2014; Oliver et al., 2014; Oliver et al., 2015) show that evidence must be defined much more broadly to incorporate other types and sources of evidence, including routine information systems and expert knowledge. This resonates strongly with the use of evidence in health policy-making in South Africa, where policy-makers use a variety of sources of evidence, including data from routine information systems.

2.3. Conceptual literature on policy and policy formulation

2.3.1. Policy-making processes

Most of the broad theoretical literature on policy analysis, which does **not** focus exclusively on the health sector, but on how governments develop policies generally, originated from HICs, particularly in the early 1970s and 1980s (e.g. Weiss, 1979). Across countries, the context of policy-making differs. Thus, although ideas and concepts from general policy analysis derived from studies on HICs have resonance for developing countries, transferring such concepts to LMIC contexts needs to be undertaken with caution (Walt et al., 2008). At the same time, the policy environment in the health sector is increasingly populated by complex cross-border, inter-organisational and network relationships, in which policies are influenced by both global decisions and domestic actions (Walt et al., 2008). More recently, Balane et al. (2020) concurred with this view and asserted that “Policy is shaped by a diverse set of stakeholders at the global, national and local levels” (p. 1)

In both HICs and LMICs, then, policy-making is characterised as a dynamic, iterative, and non-static process. The policy environment is portrayed as continuously shifting and transforming relations between groups and between organisations (Walt & Gilson, 1994). The process of policy-making is characterised as neither rational nor linear. On the contrary, it is described in the literature as an *inherently political process* (Sutcliffe & Court, 2005; Oliver et al., 2015; Oliver & de Vocht, 2017; Oliver & Pearce, 2017; Thow et al., 2018; Oliver & Boaz, 2019; Bertscher, London & Orgill, 2018; Mhazo & Maponga, 2021; Tendengu, 2021; Oliver et al., 2022; Kuchenmueller et al., 2022), a *lengthy* process that includes “back and forth consultations with many diverse stakeholder groups” (Naude et al., 2015, p. 1), a *fluid* process (Burris et al., 2011), a *complex* process (Votruba et al., 2018; Young et al., 2018), and a *complex, multifaceted, and inherently political* process (Kuchenmueller et al., 2022). In the same vein, Onono et al. (2019) contend that regardless of the setting where it takes place, “priority setting is often value-laden and political” (p. 2). However, with specific reference to LMICs, Onono et al. (2019) assert that “in developing countries, the priority setting process is often “messy”, “ad hoc,” and happens by chance” (p. 1). Oliver et al. (2022) allude to the “perceived failure of decision-makers to use evidence” (p. 692), which has “led researchers to investigate barriers and facilitators of evidence” (p. 692). Oliver et al. (2022) cogently refer to this as a *perception*, because it depends on how evidence and the use of evidence are defined. Another common theme in the policy analysis literature is that various factors influence the policy-making process, not only evidence.

Conceptual literature emphasises that health policy analysis should **not** focus excessively on policy content to the neglect of the processes of developing and

implementing the required change and the context within which policy is developed (Walt & Gilson, 1994). The content, context, and process of policy development are therefore critical for understanding policy. Most importantly, across the conceptual literature, actors and networks of actors are portrayed as occupying the centre stage, as individuals and members of groups in every instance of policy-making (Walt & Gilson, 1994; Burris et al., 2011). They play a decisive role in influencing public policy outcomes (Burris et al., 2011). It is therefore imperative that actors are managed judiciously during policy processes, as they will influence and be influenced by the content, context, and process of new policy (Walt & Gilson, 1994; Burris et al., 2011; Onoka et al., 2015; Oliver et al., 2015; Oliver & de Vocht, 2017; Oliver & Pearce, 2017; Thow et al., 2018; Oliver & Boaz, 2019; Bertscher, London & Orgill, 2018; Onono et al., 2019; Mhazo & Maponga, 2021; Tendengu, 2021; Oliver et al., 2022; Kuchenmueller et al., 2022).

With specific reference to policy elites, Grindle and Thomas (1989) postulate three important aspects of the policy-making process. According to these authors, the first feature is the decisive role of policy elites, both political leaders and technical/bureaucratic officials (Grindle & Thomas, 1989). The two scholars contend that “policy elites play important roles in shaping policy and institutional outcomes but also demonstrate the concrete ways in which the options available to them are constrained by contextual factors” (p. 215). The second aspect is that the dynamics and process of policy-making are affected by “circumstances unique to a particular policy initiative” (p. 215). Lastly, Grindle and Thomas (1989) assert that “the characteristics of particular reforms determine the type of conflict and opposition that surround their implementation...characteristics of a policy have a powerful influence on whether it will be implemented as intended or whether the outcome will be significantly different” (p. 216).

Grindle and Thomas (1989) also postulate four factors influencing decision-making, namely: technical analysis, bureaucratic motivation, political stability and support, and international leverage. On the issue of technical analysis, influential actors are “technocrats, ministers, and other high level bureaucrats; technical advisors, as well as foreign advisors” (Grindle & Thomas, 1989, p. 223). With respect to bureaucratic motivation, the influential actors are “ministers and other high level bureaucrats; middle level bureaucrats; international bureaucrats; and advisors” (p. 223). On the dimension of political stability and support, the influential actors are “political leadership; dominant economic elites; leaders of class, ethnic, interest associations; and the military” (p. 223). Finally, on the dimension on international leverage, the influential actors are “IMF; USAID, World Bank; governments of former colonial powers; USA, and international banks” (p. 223).

It has also been recognised that political decisions take place within contextually specific institutional structures that direct, shape, or constrain the range of possible policy choices and outcomes (Parkhurst, 2017). This field of policy studies, known as institutionalism, recognises that political institutional arrangements determine policy processes and outcomes, including by dictating issues to be considered by decision-makers whose interests are represented, or the steps and processes through which decisions can or cannot be made (Parkhurst, 2017). These types of institutional arrangements also shape evidence-informed policy decisions (Parkhurst, 2017). In tandem with Parkhurst (2017), Ettelt, Hawkins and Parkhurst (2018) assert that a

public policy perspective requires consideration of the structures, rules, processes, and norms (i.e. the political institutions) existing in different country settings, to generate an understanding of when, why, and how pieces of evidence may be used to inform health decisions. This is the crux of this study.

Consistent with the work of Walt and Gilson (1994) and Walt et al. (2008), a more recent systematic review of conceptual studies of policy environments by Cairney and Oliver (2018) identified five components of the policy-making environment: (a) a recognition of the existence of many actors influencing choices at many levels of government, including researchers competing with many actors to present evidence and secure a policy-maker audience; (b) a proliferation of ‘institutions’, or the rules and norms maintained by many policy-making organisations, which include rules of evidence gathering, from who takes the lead to the sources and types of evidence they favour; (c) the relationships between policy-makers and influencers, many of which develop in ‘subsystems’ and contain relatively small groups of specialists; (d) a tendency for well-established ‘ideas’ – as the ‘core beliefs’ of policy-makers or ‘paradigms’ in which they operate; and (e) policy conditions and events that can reinforce stability or prompt policy-makers’ attention to shift (Cairney & Oliver, 2018).

These five conditions suggest that policy-makers do not necessarily function in an environment where they can simply exercise their will and judgement, and implement policy choices of their preference. Rather, they operate in an environment with constraints. This insight points to the relevance of the notion of ‘*bounded rationality*’ in considering the factors influencing how policy-makers use evidence. The construct was developed by Herbert Simon, 1946 (cited in Hoffrage & Reimer, 2004, p. 5). Hoffrage and Reimer assert that “in a complex and uncertain world, humans draw inferences and make decisions under the constraints of limited knowledge, resources, and time” (p. 5). In terms of evidence use, it could be argued that policy-makers’ rationality is bounded both by limited knowledge but also by the reality of political factors, including political constraints, which influence if, how, and why evidence is drawn into decision-making.

In summary, the conceptual policy analysis literature converges to highlight the dynamic and iterative nature of the policy formulation process, the central role of powerful political actors, and the importance of political institutional arrangements that determine policy processes and outcomes, which also creates ‘bounded rationality’ (Simon, 1946, cited in Hoffrage & Reimer, 2004) for policy elites, both the political leadership and the technocrats. Finally, conceptual literature also points to the importance of analysing the *interests, position, and power* of policy-makers and other stakeholders, beyond the narrow notion of bounded rationality.

2.3.2. Evidence and policy-making

The use of evidence in policy-making processes has featured prominently in the conceptual literature from both HICs and LMICs. The origins of published theoretical paradigms about the interface between evidence and policy can be traced to HICs in the 1970s and 1980s. It is embodied in the conceptual work of scholars such as Weiss (1979), who reviewed different approaches to the research-to-policy interface, which were advocated by social science researchers at the time. Weiss postulated six models, namely *the knowledge driven model, the problem solving model, the*

interactive model, the political model, the tactical model, and the enlightenment model.

In this seminal work, Weiss observed that the *knowledge driven model* assumed that basic (operational) research provides some public policy-relevant results, that applied research is then conducted to test the findings of basic research, and that if this is successful, appropriate technologies are developed to implement the findings, and application then happens. Her critique was that this is highly unlikely to unfold in the implementation of government decisions. The *problem solving model*, meanwhile, involves the direct application of research results to a pending policy decision and assumes that policy-makers have a clear idea of their goals and possible alternatives, and only need research to clarify their choice. Again, Weiss judged that this expectation is wildly optimistic. Weiss understood, then, that research was not the only cornerstone of policy decisions, nor the decisive factor in policy-making, but one of the factors to be considered. This is evident from the other models that she presented (Weiss, 1979), as outlined below.

The *interactive model* assumes that policy-makers seek information not only from social scientists but from other sources including planners, administrators, politicians, and interest groups. According to Weiss (1979), this is not a linear model, but a credible model that accepts that research is only part of a complicated process of policy-making, which also uses experience, political insight, and judgement. The *political model* suggests that policy-makers could legitimately use research results to support predetermined positions, as long as the results were neither distorted nor misinterpreted (Weiss, 1979). The *tactical model* occurs when policy-makers use research for purposes that have little relation to the substance of the research. In this context, it is not the content of the research that is used but the fact that research is being done, which is used to deflect criticism.

Lastly, in Weiss' *enlightenment model*, it is not the findings of a single study or a body of research that was considered important, but the concepts and theoretical perspectives of social science that come to permeate the policy-making process. Policy-makers accept that social science research has refocused their thinking and has had important consequences (Weiss, 1979). To be useful, research results do not necessarily have to be compatible with decision-makers' values and goals. Research that challenges policy-makers' views and beliefs can overturn traditional patterns of thought (Weiss, 1979). In summary, Weiss viewed the political, tactical and enlightenment models of research use as most relevant because they acknowledged the complex nature of policy-making, in which research was only one ingredient, and accepted the fact that not all research would influence policy.

The work of Weiss (1979) is widely acknowledged as having pioneered the identification and description of models to illustrate how research is used in policy formulation (e.g. Almeida & Bascolo, 2006). More recently, scholars such as Oliver and Boaz (2019) have expanded on the concept of evidence use in policy formulation, although focusing specifically on the use of research evidence. In line with Weiss' arguments, Oliver and Boaz (2019) assert that "use is not a straightforward concept. Using research well implies the existence of a diverse and robust evidence base; a range of pathways for evidence to reach decision-makers; both users and producers

of knowledge having the capacity and willingness to engage in relationship-building and deliberations about policy and practice issues..." (p. 5).

With the passage of time, other scholars have also postulated ways of understanding the evidence-to-policy interface. Within the health sector, the term "evidence-based medicine" (EBM) was coined by clinicians and epidemiologists at McMaster University in Canada in 1988, and became known worldwide during the 1990s (Donald, 2002). The field of evidence-based policy (EBP) also emerged, based on the premise that policy decisions should be better informed by available evidence and should include rational analysis (Sutcliffe & Court, 2005). Such evidence included formal research and formal systematic reviews, with formalised reviews deemed important because policy based on systematic evidence was seen to produce better outcomes (Sutcliffe & Court, 2005). A decade later, institutions such as the Coalition for Evidence-Based Policy (2015) and the UK Government 2013 (cited in Parkhurst, 2017) argued that an *evidence-informed approach to policy-making and implementation* would achieve better decisions and outcomes for a better future, and ensuring effective use of scarce resources.

The concept of *evidence-informed policy* was postulated in recognition of the complexity of policy development and the context in which policy processes occur. It arose from debate around the limitations of EBP ideas. One argument was that the term *evidence-based policy* actually relates to only one type of evidence, namely *research* (Bowen & Zwi, 2005). These authors further argued, quite cogently, that the term "evidence-influenced" or "evidence-informed" reflects the need to be context sensitive and consider use of the best available evidence when dealing with everyday circumstances (Bowen & Zwi, 2005). Moreover, they noted that policy is actually informed by different pieces of evidence and sources of knowledge such as histories and experience, beliefs, values, competency/skills, legislation, politics and politicians, protocols, and research results. As Verboom and Baumann (2020) note that "proponents of evidence-informed policy-making in health assert that studies of various kinds can be used to address a range of questions of relevance to health policy-making" (p. 1).

EBP was also specifically perceived as implying a linear and narrow approach of infusing evidence into policy-making (Nutley, Walter & Davies, 2003; Bowen & Zwi, 2005). Other scholars argued that evidence alone cannot determine the right choices in the arrangements of benefits, nor can it dictate social outcomes that should be pursued over others (Parkhurst, 2017). The latter are seen rather as decisions that must be made on the basis of some formal consideration of social values, which modern democratic principles would suggest needs to be done in transparent and accountable ways that serve to represent the public (Parkhurst, 2017). Indeed, a critical point of contestation about EBP focused on what its advocates and critics regard as the core problem in relation to evidence use in policy-making: EBP advocates argue that the problem is the politicisation of science, which manifests in the ways in which political interests drive the misuse, manipulation, or cherry-picking of evidence to promote political interests (Pielke, 2002, cited in Parkhurst, 2017; Wise, 2006, cited in Parkhurst, 2017). In contrast, EBP critics assert that the real problem is the depoliticisation of politics, which is reflected in the ways in which social values can be "obscured or marginalised through the promotion of certain forms of evidence use" (Parkhurst, 2017, p. 7).

Parkhurst (2017) further argues that the complexity of using evidence in policy-making arises from the intricacies of policy-making itself (see Box 2.1). This process is influenced by a multiplicity of factors apart from empirical evidence, including experience, expertise and judgement of policy-makers, resources, values, lobbyists, pressure groups and consultants, as well as pragmatics and contingencies of political life, such as timetables and parliamentary terms (Abeyasinghe & Parkhurst, 2013).

Recent literature also specifically considers how political institutional arrangements enable or inhibit the use of evidence in policy decisions (Parkhurst, 2017; Ettelt, Hawkins & Parkhurst, 2018; Kuchenmueller et al., 2022). The concept of political institutions does not refer to concrete structures such as Parliament, but rather to how political power is acquired and exercised. Political institutional arrangements enable powerful political actors to influence and shape the use of evidence in health policy-making. The *public policy perspective* of political institutions also outlines how these country-level institutions (i.e. the structures, rules, processes, and norms) influence when, why, and how pieces of evidence may be used to inform health policy decisions (Ettelt, Hawkins & Parkhurst, 2018).

Box 2.1: Parkhurst's (2017) tenets on the complexity of the policy-making process

- Parkhurst (2017) asserts that it is imperative to retain the goal of improving social policy outcomes through using evidence, but that it is equally important to recognise the complexity of the policy process.
- Parkhurst (2017) disagrees with the notion that **more evidence** should be provided to policy-makers to increase the opportunities of its utilisation. His contrasting view is that more evidence does **not** necessarily improve the opportunities for its use in policy-making. Policy decisions are distinct from technical exercises which weigh up data on a single agreed outcome (Parkhurst, 2017).
- In policy-making, disagreements about which social outcomes are important in society or how to value different arrangements of social outcomes are common, and indeed the norm (Parkhurst, 2017). This does not imply that evidence is irrelevant, but rather that it is **only one of the factors considered**.
- It is imperative for countries to build evidence-advisory institutions that embed key principles of both scientific good practice and democratic representation. Parkhurst (2017) defines '**good governance**' of evidence as "a concept that represents the use of rigorous, systematic and technically valid pieces of evidence within decision-making processes that are representative of, and accountable to, populations served". In this context, accountability is key.
- **Evidence is political.** Parkhurst (2017) contends that evidence is **not** apolitical, but can in fact be decidedly political by promoting a *de facto* choice amongst competing values. Much as policy-making is political, so is the use of evidence in this process. Parkhurst (2017) asserts that policy-makers normally have difficult choices to make, and cites the work of Lin (2003) who described these choices as "competing rationalities" (Parkhurst, 2017, p. 58). This assertion is consistent with the notion of bounded rationalities, described in the

2.3.3. Strengthening researcher-policy-maker engagement to support evidence informed policy

Conceptual literature around the interface between researchers and policy-makers can be traced back over two decades. In 2006, three scholars from the Institute for Work and Health in Toronto, Canada, namely Reardon, Lavis and Gibson (2006), produced a guide for Knowledge Transfer and Exchange practitioners. Knowledge Translation and Exchange is defined as an “interactive process involving the interchange of knowledge between research users and researcher producers (Mitton et al., 2007, p. 729). Reardon, Lavis and Gibson (2006) postulated three models for conveying research evidence to policy-makers, namely producer push, user pull, and exchange. *Producer push* occurs when the producers of research knowledge explicitly plan and implement strategies to push knowledge towards audiences they identify as needing to know. *User pull* refers to situations whereby users of research knowledge explicitly plan and implement strategies to pull knowledge from sources they identify as producing research useful to their own decision-making. *Exchange* is when relationships are built and nurtured between those who produce research and those who might use research knowledge to enable an exchange of information, ideas, and experience. According to Reardon, Lavis and Gibson (2006), the exchange model is ideal and entails a mutually beneficial relationship in which researchers assist audiences to build capacity to use research knowledge, with audiences helping researchers to make their work more relevant. This suggests that building relationships of trust between researchers and policy-makers is of vital importance to evidence use in policy-making.

Some scholars have also highlighted key issues for researchers to consider as they engage policy-makers, and that link to trust-building, and the use of evidence by policy-makers. Lavis et al. (2003), for example, raise three relevant points. First, researchers should refrain from an excessive focus on *identifying problems*, generating hypotheses or developing new methodologies, and focus more on *informing decision-makers about solutions*. Even then, solution-oriented take-home messages should be seen as only a starting point for a discussion with decision-makers, given that research will not always be able to predict the incentives and constraints that different decision-makers might face. Second, not all research will have a *take home* message, either because the research on some issues has no relevance to decision-makers or the findings are inconclusive. Oxman et al. (2009b) contend, moreover, that when there is insufficient research evidence, it is risky not to acknowledge uncertainty for the sake of political expediency. Third, the credibility of the researcher delivering the message – whether the researcher is an individual, group or organisation – is important for knowledge transfer.

Abeyasinghe and Parkhurst (2013), meanwhile, suggest that it is imperative to examine evidence through the specific lens of ‘appropriateness’. In this context, appropriateness refers to the relevance of the evidence to the policy issues at hand. This view is consistent with the emphasis that Gilson and McIntyre (2008) place on the relevance of research to policy-makers. Waddell et al. (2007) also argue that “both university and policy researchers must balance academic rigour and policy relevance to make meaningful contributions to policy” (p. 181). There is convergence that the use of evidence in policy-making is likely to be enhanced if the evidence is of a

relevant nature to the policy issues that policy-makers are dealing with. The emphasis on the relevance of evidence presents a counter argument to the school of thought that emphasises the need to increase the volume of evidence that is provided to policy-makers.

Finally, there is a growing focus on developing new approaches to bringing researchers and policy-makers together in generating and interpreting research, such as the co-creation and co-production of knowledge (Oliver, Lorenc & Innvaer, 2014; Oliver et al., 2014). Drawing on the systematic review they conducted, Koon et al. (2020) found that in LMICs, HPSR researchers were “increasingly aware of the need to design effective institutions for supporting knowledge utilization in LMICs” (p. 1). A case in point was Burkina Faso, where scholarly effort was devoted to the formation of institutionalised structures to support knowledge-informed policy-making (Koon et al., 2020).

In Burkina Faso, diverse knowledge translation platforms were implemented to strengthen evidence-informed decision-making, which included the rapid response service for health, a platform to “provide quick access for policy-makers in Burkina Faso to high quality research evidence about health systems” (Zida et al., 2018, p. 15). Project leaders won the trust of policy-makers at national and subnational levels and convinced them of the importance of the rapid response service and its importance in providing timely evidence required for policy-making. The authors concluded that the rapid response service had “reached the consolidation stage, but now required additional efforts to reach maturity” (Zida et al., 2018, p. 15). This case study illustrates one of the efforts of LMICs to bring together researchers as producers of evidence and policy-makers as potential users of evidence.

2.4. Empirical literature on evidence and policy-making

2.4.1. The evidence-to-policy interface

This section addresses empirical literature that examines the evidence-to-policy interface across country settings. A total of seven common strands emerge from the country studies and related literature reviews, and these are discussed below – also clarifying links to relevant conceptual literature.

First, as with conceptual literature (Walt & Gilson, 1994; Burris et al., 2011), empirical literature accentuates the need to locate evidence use within the broader political context of policy-making (Oliver, Lorenc & Innvaer, 2014; Oliver et al., 2022). On this starting premise, the empirical literature dovetails with the conceptual literature, for instance, the work of Parkhurst (2017) who has argued that the belief that the solution to the evidence-policy gap is to provide policy-makers with more evidence is misguided. Oliver et al. (2022) concur with Parkhurst, and assert that “there has been huge expansion in research-policy engagement initiatives, probably a natural result of the longstanding (academic) focus on the perceived failure of policymakers to use evidence well” (p. 11). Oliver et al. (2022) continue to state that “most activity, and probably most money is still spent on disseminating and communicating research, which, as a sole strategy, has long been known to be ineffective at producing policy and practice change, or societal impact” (p. 11). In summary, Parkhurst (2017) and

Oliver et al. (2022) concur with each other that the belief that providing policy-makers with more evidence will improve its use for the policy-making process is misplaced.

From a review of empirical literature, Oliver, Lorenc and Innvaer (2014) conclude that the use of research within policy formulation has become “divorced from a broader perspective on policy-making” (p. 2). Many research studies aimed at promoting the use of evidence in policy-making have exclusively focused on the use of evidence in policy-making, while avoiding other influences over the policy-making process, including the context within which policy is made and the reality that the use of evidence is only one aspect of a complex policy-making process (Oliver, Lorenc & Innvaer, 2014). This approach is flawed, as evidence use has to be understood as part of the entire policy-making process.

The **second** strand of the empirical literature is the imperative to understand different ways in which evidence might influence policy development, or be used by policy-makers. The ways in which evidence might be used in policy-making spaces are **not** only always explicit (i.e. direct or instrumental), but can also include enhancing the tacit knowledge of policy-makers or their policy positions when they are informed by research and are influential in the policy-making process (Lavis, Ross & Hurley, 2002). Lavis, Ross and Hurley (2002) arrived at this conclusion based on their exploratory study on the use of health services research by Canadian provincial policy-makers. Their seminal work inspired similar empirical work in South Africa, which is discussed later in this chapter.

These different uses of research evidence are also referred to as indirect and tactical use of research evidence (Lavis, Ross & Hurley, 2002). *Indirect use* of research (also known as conceptual use or enlightenment) is defined as changes in knowledge, awareness, or attitude, for example, when research has informed political debate, or audiences have adopted the ideas, concepts or language of the research to inform decision-making and assist problem-solving (Lavis, Ross & Hurley, 2002). *Direct use* of research (also known as instrumental, structural, or problem-solving use) refers to changes in behaviour, such as observed or self-reported changes in policies, procedures, and programmes, changes in clinical practice, and improved patient care and outcomes (Lavis, Ross & Hurley, 2002). *Tactical use* of research (also known as political, structural, strategic or symbolic use) occurs when research is used to validate or legitimise or defend a position already taken (or taken for other reasons), for instance, when political leaders select a study that validates policy direction as opposed to reviewing all the evidence to inform policy direction (Lavis, Ross & Hurley, 2002).

Although developed on the basis of empirical studies, these three forms of evidence use are consistent with the first three typologies of the use of evidence by policy-makers proposed by Weiss (1979). More recently, Verboom and Baumann (2020) assert that “uses of research evidence can therefore be understood to serve not just instrumental (e.g. problem-solving) functions, but also conceptual (e.g. enlightenment) and symbolic (e.g. political) functions in policy-making processes” (p. 2).

The **third thread** in the empirical literature is that certain conditions may promote the use of research in policy-making, including sustained interactions between

researchers and policy-makers (Lavis, Ross & Hurley, 2002; Gilson & McIntyre, 2008). A 2014 systematic review of 145 studies, half of which were published between 2010 and 2012, and 13 systematic reviews from both HICs and LMICs, also identified factors influencing the use of evidence in policy-making. They included collaboration between researchers and policy-makers, improved relationships and skills, timely access to good quality and relevant research evidence, and skills-building with policy-makers (Oliver et al., 2014). Finally, based on their systematic reviews of 86 academic and non-academic documents (published papers and grey literature) on the evidence-to-policy interphase, Oliver and Cairney (2019) synthesised a set of eight recommendations for researchers, ranging from doing quality research to being entrepreneurial and to continuously reflecting (see Box 2.2). The **fourth thread** in the empirical literature is the conclusion that it is imperative for the research community to understand the evidence-needs of policy-makers, the types of evidence used by policy-makers, and the sources of this evidence (Oliver et al., 2015; Oliver & de Vocht, 2017). This is a growing area of focus, particularly in LMICs over the last two decades. However, there is still a paucity of empirical studies that illustrate the types of evidence used by policy-makers, and the sources of this evidence.

Box 2.2: Recommendations for researchers to promote the use of research in policy-making

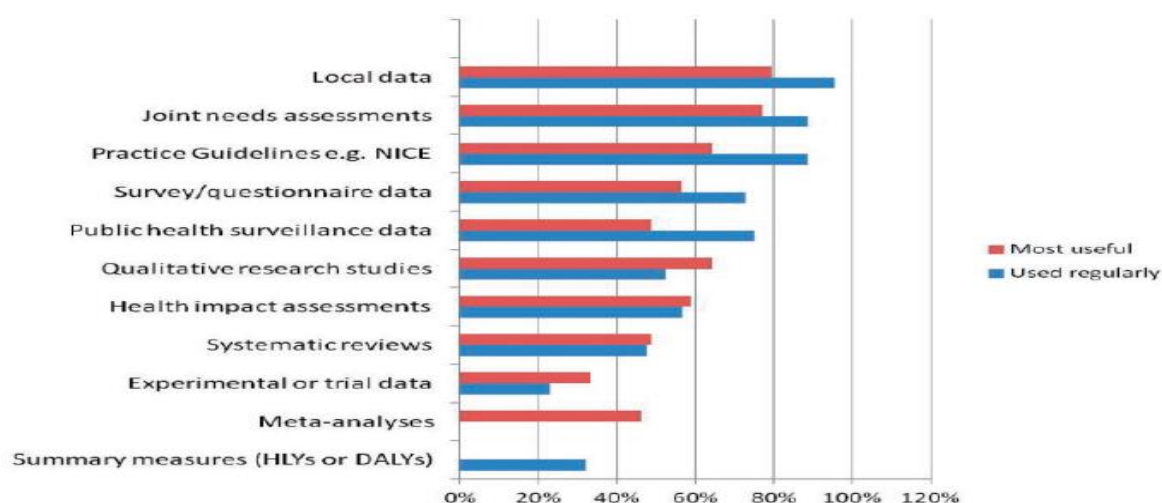
- (1) Do high quality research
- (2) Make your research relevant and readable
- (3) Understand policy processes
- (4) Be accessible to policy-makers: engage routinely, flexibly, and humbly
- (5) Decide if you want to be an issue advocate or honest broker
- (6) Build relationships (and ground rules) with policy-makers
- (7) Be 'entrepreneurial' or find someone who is
- (8) Reflect continuously: should you engage, do you want to, and is it working?

Sources: Cairney & Oliver (2018); Oliver & Cairney (2019)

Among the evidence-to-policy studies in HICs, Oliver and de Vocht (2017) found that in Manchester City, United Kingdom (UK), policy-makers actually use 11 different types of evidence in the policy formulation process. The types of evidence most regularly used included local data, joint needs assessments, practice guidelines (e.g. NICE), survey/questionnaire data, public health surveillance data, qualitative research studies, health impact assessments, systematic reviews, experimental or trial data, meta-analyses, and summary measures such as Disability Adjusted Life Years (DALYs) (Oliver & de Vocht, 2017).

Figure 2.1 below, extracted from Oliver and de Vocht (2017), reflects graphically the different types of types of evidence that policy-makers in Manchester, UK, reported to be using in the policy-making process.

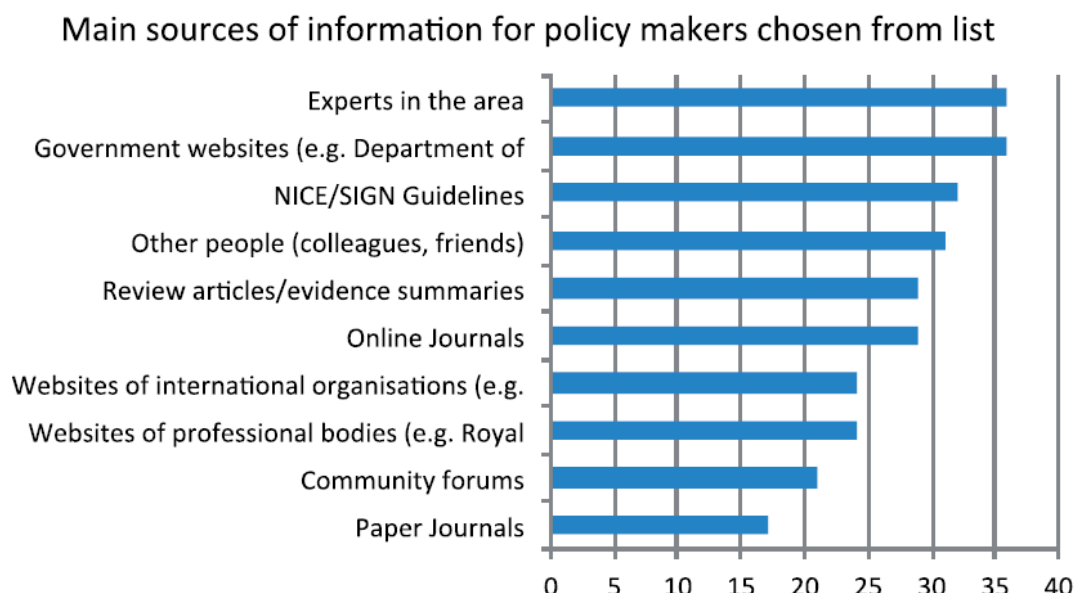
Figure 2.1: Types of information or evidence regularly used/considered most useful by policy actors (percentage of respondents)



Source: Oliver and de Vocht (2017, p. 114)

Several more empirical studies arrived at findings consistent with those of Oliver and de Vocht (2017). In a separate study also conducted in Manchester (UK), Oliver et al. (2015) reviewed 68 public health policy-makers' main sources of information, which examined the policy-makers' main *sources of information and evidence* (not the types of evidence used or preferred by policy-makers, which were examined in the aforementioned study). As reflected in Figure 2.2. below, Oliver et al. (2015) found that the most frequently chosen sources of information from the list provided were 'experts in the area' (n=36/68) and government websites (n= 36/68), NICE guidelines, review articles, online journals, websites of international organisations, and websites of professional journals. A small proportion of respondents (26% of all responses) indicated that they used a range of 'resources', including online and/or paper journals, and the British Medical Journal websites. This accentuates the fact that a broader definition of evidence and sources of evidence is required, which extends beyond the current traditional and narrow definitions of evidence as being research results produced from empirical research studies.

Figure 2.2: Main sources of information for policy-makers chosen by key respondents from list



Source: Oliver et al. (2015)

In keeping with the theme of examining the types of evidence considered useful for policy-making, Burchett et al. (2015) explored the perceived value of public health research and the types of research considered useful in Ghana, West Africa. This study entailed interviews with 69 decision-makers, researchers, and stakeholders. Burchett et al. (2015) found that a broad range of research was highly valued, but **not** research defined in the narrow academic sense. Two traits that were common across the valued research were (a) the relevance of the research topics and (b) the quick production of research results. Burchett et al. (2015) found that the respondents valued research which explored implementation issues or enhanced their understanding of immediate health problems confronting the country. Research that examined the effectiveness of interventions or programmes was **not** generally considered as important because it was implicitly assumed that as long as interventions were based on a good understanding of the situation and were implemented well, they would be effective.

Another important theme from the empirical studies is that good quality evidence is often not enough to influence policy (D'Souza & Parkhurst, 2018). These two scholars examined evidence use in global malaria policy development at the WHO, through interviews with 29 key informants, as well as documentary reviews. Findings of this study pointed to the fact that "good evidence" from a technical perspective, or as perceived by the producers of the evidence, was important but not sufficient to ensure universal agreement and uptake of recommendations. Two additional important characteristics were identified, the first being the relevance of evidence to the policy question being asked, and the second that expert actors in the policy-making space remained concerned about the legitimacy of processes by which technical evidence

is brought to bear in the policy development process (D'Souza & Parkhurst, 2018). The significance of this work is that it corroborates the conceptual literature elucidating factors that promote or inhibit the use of various forms of evidence in policy-making processes.

The **fifth thread** considers the barriers to the successful uptake of evidence in policy-making. A recently published systematic overview of 62 studies on knowledge translation strategies employed by health system researchers and policy-makers in African countries has unearthed three sets of barriers facing policy-makers, researchers, and both groups (Edwards, Zweigenthal & Olivier, 2019).

Box 2.3 presents the **mutual barriers**. Among these are the lack of standardised processes, lack of institutional support, and specific **political factors**, which seem to be pertinent for South Africa, as discussed further in Chapter 4 of this study.

Box 2.3: Mutual Barriers

- (a) Insufficient skills
- (b) Time constraints
- (c) Insufficient resources
- (d) Funding constraints
- (e) Political factors
- (f) Lack of skilled staff
- (g) Lack of infrastructure
- (h) Internet access
- (i) Lack of standardised processes
- (j) Institutional support
- (k) Need for engagement with diverse stakeholder groups
- (l) Sustainability of knowledge translation initiatives (mainly due to funding limitations)

Source: Edwards, Zweigenthal & Olivier, 2019

Barriers to the use of evidence in policy, pertaining to **policy-makers** are reflected in **Box 2.4** (Edwards, Zweigenthal & Olivier, 2019). These include the lack of access to relevant, reliable research and the lack of locally applicable quality research.

Box 2.4: Policy-maker Barriers

- (a) Lack of access to relevant, reliable research
- (b) Lack of locally applicable quality research
- (c) Use of technical language/jargon
- (d) Mismatch in timelines between policy-maker needs and research
- (e) Lack of specific guidelines/recommendations for implementation
- (f) Contextual threats (e.g. political instability)
- (g) Competition for policy attention
- (h) Clarity of research results
- (i) Language constraints
- (j) Hierarchical power dynamics between actors within the health system prevents local policy decisions

Source: Edwards, Zweigenthal & Olivier, 2019

Finally, barriers to the use of evidence associated with researchers are reflected in **Box 2.5** (Edwards, Zweigenthal & Olivier, 2019). The major limitation of these barriers is that they still focus on the weaknesses among policy-makers and government institutions, instead of identifying limitations on the part of researchers, which militate against the use in policy-making of the evidence they generate.

Box 2.5: Researcher Barriers

- (a) Power communication with decision-makers
- (b) Policy-maker attitudes and willingness to use research (including their motivation, personal interests, values, and ideas)
- (c) Limited awareness of need for knowledge translation
- (d) High turnover of government staff
- (e) Donor influences (e.g. on priorities through funding)
- (f) Context specificity
- (g) Negative/conflicting research results
- (h) Resistance to change
- (i) Weak institutional and personal links with stakeholders
- (j) Lack of support from public authorities

Source: *Edwards, Zweigenthal & Olivier, 2019*

The **sixth** and most important thread from the empirical literature is the importance of actors in the policy-making space, as was also identified in the conceptual literature. Most recently, the published experiences of the Western Cape HPSR Journal Club Team (2020) in South Africa, which is described later in this chapter, accentuates the importance of deepening of relationships and mutual learning between HPSR researchers and provincial and local health managers.

Another important set of actors in the policy-making process introduced in the empirical literature are technocrats, or bureaucrats, who are not political office bearers, but career civil servants. This is consistent with the definition of technical policy elites or bureaucrats by Grindle and Thomas (1989). Writing from the National Collaborating Centre for Healthy Public Policy (NCCHPP) in Canada, Morestin (2017) also reminds us of another important category of actors in the policy-making space, the advisors of policy-makers. This view is informed by a systematic review of literature published between 2000 and 2014, which identified 105 documents, which explored the role played by policy advisors with regards to scientific knowledge (Morestin, 2017). The systematic review identified three major categories of advisors of policy-makers, namely: (a) non-managerial public servants, who contribute to public policy development – which makes them policy advisors even if they do not interact directly with policy-makers; (b) managerial public servants, who include a broad range of ranks, from middle management up to the most senior positions; and (c) political policy advisors in ministerial offices. Morestin (2017) cautions against the first instinct of trying to share scientific knowledge directly with policy-makers (i.e. political leaders) and overlooking the advisors who play a central role in policy circles. These three categories of policy-makers are pivotal both in how knowledge circulates in the political sphere and on public policy development (Morestin, 2017).

The **seventh** theme from the empirical literature is that studies on the research-to-policy interface are published predominantly by researchers, who also have the capacity to publish and disseminate their work. A systematic review conducted by Oliver et al. (2014) found that of the 145 studies reviewed, which included 13 systematic reviews, a total of 137 study reports (94%) were written by researchers or people with academic affiliations. Clinical researchers were co-authors in 57 of these studies, and policy-makers were credited as authors in only three studies.

2.4.2. The institutionalisation of evidence in government policy-making

Several scholarly articles highlight the importance of institutionalising evidence in government, and others provide actual case studies of efforts to achieve this by governments in different countries. These are important to consider for this study, considering its fourth objective of exploring mechanisms of fortifying the research-to-policy interface in South Africa.

In the 1990s, the UK government under Prime Minister Tony Blair popularised the concept of the evidence-based policy (EBP), with a particular focus on the public sector. The objective of the Blair Administration was to replace ideologically-driven politics with rational decision-making, based on evidence (Sutcliffe & Court, 2005). As previously stated, however, evidence is not the only factor considered in policy-making. In his presentation to the World Bank Middle East and North Africa Region Regional Impact Evaluation Workshop entitled '*Making Policy Evidence-Based: The UK Experience*', Davies (2008), who studied the use of evidence during the Blair Administration, identified eight other factors that influence policy-making processes, namely experience and expertise, pragmatics and contingencies, judgement, lobbyists and pressure groups, research evidence, resources, habits and tradition, and values and decision-making context.

In addition, there was leadership from the Prime Minister himself in promoting EBP. The use of EBP during the Blair Administration was certainly useful and pioneering, in that it expanded beyond the linear conceptualisation that policy should always be based on evidence, which overemphasised the direct or instrumental use of evidence. This was achieved through the large growth in government research personnel from 250 people in 1997 to 1000 during the period 1999-2006, the large increase in government research spending from £40m in 1997 to £175m in 2006, the proliferation of guidance on research and analysis, and the development of websites such as www.policyhub.gov.uk, as well as training in research use for Ministers and senior civil servants (Davies, 2008).

On the African continent, one country that has defined and documented entry points for research evidence in the health sector is Ethiopia. As Vecchione and Parkhurst (2016) cogently assert, "for research evidence to inform policy, it must have a conduit through which it can reach decision makers who might be usefully informed by it" (p. 8). Ethiopia has a documented Evidence Advisory System (EAS) that encompasses the key entry points through which research evidence can make its way into relevant health policy decisions, including both formal systems (government mandated) and

informal pathways. Key decision-making structures are outlined at federal government level, regional/state level, and local bodies (Vecchione & Parkhurst, 2016). Primary decision-making points for health include *Public Health and Health Promotion*, which entails high level decisions affecting large segments of the population; *Health Service Priority Setting and Management*, which includes decisions concerned with the allocation of resources across the health system, or the structure of service provision and funding, including priorities within the system; *Programme Planning*, which includes decisions within the remit of specialised agencies, such as programmes dedicated to individual conditions; and *Service Provider Decision Making*, which is the most specific and tailored to individual cases, and which can be health centre or hospital policies, or individual clinician decisions about patient care evidence (Vecchione & Parkhurst, 2016).

At a formal level, the Federal Ministry of Health (FMOH) identifies priorities based on official statistics produced by the Central Statistical Agency, and subsequently carries out or commissions research institutes or consultants (e.g. academic research units) to undertake research on health priorities. At the informal level, Ethiopia also has an NGO known as Ethiopian Academy of Sciences (EAS), which is independent from the Government, and mandated by an act of the Parliament to advise the Government on science-related matters. The responsibilities of the Academy are to assess data generated, to review and commission research (including to university institutes and professional associations), and to disseminate evidence (Vecchione & Parkhurst, 2016).

The empirical literature on LMICs cogently raises the need for formal institutions or structures that promote evidence-informed policy-making. Based on their work in Cambodia examining factors influencing the production and use of health evidence within the country, Liverani, Chheng and Parkhurst (2018) arrived at two major findings. On the positive side, these scholars found that the increasing availability of health data and research products in Cambodia, combined with recent reforms of the health system, could serve an evidence advisory role in the health sector. On the negative side, the lack of clear guidelines and weak domestic research capacities were found to be a risk factor making the use of evidence in line with best practices less likely (Liverani, Chheng & Parkhurst, 2018).

2.5. Efforts to promote the use of evidence in health policy-making in South Africa

In the South African context, some work has emerged over the last 25 years of democracy which examines the evidence-to-policy transition, particularly in the health sector, and the processes through which this might be achieved. This includes work informed by Health Policy and Systems Research (HPSR), a growing field in South Africa (Orgill et al., 2013).

Drawing inspiration from the work of Lavis, Ross and Hurley (2002), South African scholars from two Health Policy and Research (HPSR) entities located at the universities of the Witwatersrand and Cape Town, the Centre for Health Policy and the Health Economics Unit respectively, examined the development and implementation of three areas of health care financing policy change and debate in

South Africa between 1994 and 1999, focusing on three policies, namely the removal of fees for government primary care, the implementation of formulae for re-allocating budgetary resources between geographical areas, and debates over whether to introduce some form of social health insurance (Gilson & McIntyre, 2008). The findings of this study confirmed the paradigm of three possible uses of evidence for policy: conceptual use, instrumental use, and symbolic use (Gilson & McIntyre, 2008). Conceptual use occurs when evidence changes the existing ideas of policy-makers, instrumental use is when evidence changes practice and some specific recommendations are implemented, and symbolic use occurs when evidence is used to justify or legitimise policy positions, as long as the research results are neither distorted nor misinterpreted (Weiss, 1979).

The work of Gilson and McIntyre (2008) provides the important insight that the instrumental use of evidence is not always the 'acid test of policy impact', although it is sometimes an important research goal (Gilson & McIntyre, 2008). The two scholars further assert that on some policy issues, the conceptual use of research is critical in encouraging the policy debate that stimulates change (Gilson & McIntyre, 2008). This approach is the lifeblood of HPSR researchers. As the Western Cape HPSR Journal Club Team (2020) assert, HPSR researchers are encouraged to engage in learning and action by working with health policy-makers, managers, community, and civil society groups (p. 1).

Several empirical studies were published which traced the methods, successes, and limitations of efforts to facilitate evidence-informed policy in the health sector, particularly during the first decade of democracy (Doherty, Gilson & McIntyre, 2002; Gilson & Macintyre, 2008; Rispel & Doherty, 2011). Two papers reporting relevant experience consider the SAZA (South Africa and Zambia) Project (Doherty, Gilson & McIntyre, 2002) and the wider work of the Centre for Health Policy (CHP) (Rispel & Doherty, 2011). The South African component of the SAZA Project evaluated the development of three high-profile policies during the first term of the democratic government (1994-1999), namely: (a) removal of fees for certain health care services (including primary health care), (b) social health insurance, and (c) the geographic re-allocation of budgets according to a population-based formula. The project was implemented by two health systems and policy research institutions in South Africa, the Centre for Health Policy (CHP) attached to the University of the Witwatersrand and the Health Economics Unit (HEU) located at the University of Cape Town, with funding from the European Union. The second case study outlined the wider work of the CHP, including several projects which impacted positively on health policy in South Africa. These included analyses of the level and distribution of health care expenditure, which contributed to the impetus to shift resources between provinces and from hospitals to primary care, and to the creation of an understanding of the stark imbalances between public and private health sectors. This work also contributed to the development of models, norms, and costing of comprehensive Primary Health Care (PHC), which helped to develop practical models for the delivery of comprehensive PHC and the development of PHC service packages, and HIV and AIDS policy work, which contributed to the development of the national HIV and AIDS policy and plans, and supported civil society movements for expanded antiretroviral treatment access (Rispel & Doherty, 2011).

Lessons that emerged from the experience of CHP and HEU include six key issues that may influence whether research is taken up in policy (Gilson & McIntyre, 2008). First, the importance of the *nature of the policy issue*, as the influence of research differs between policy issues (Gilson & McIntyre, 2008). Second, the *political context* is always an important influence over the research/policy interface, providing or constraining opportunities for engagement. Third, *research credibility* in the eyes of research users is imperative. The perceived validity, openness, and relevance of research to policy-makers may contribute to its acceptance and partial use. Fourth, strategies adopted in *disseminating research findings* are critical for influencing the potential of research to impact on policy issues (Gilson & McIntyre, 2008). Fifth, *researcher credibility or policy-makers' trust* in the researchers involved in any study may contribute more towards encouraging the use of research findings than valid research activities or effective dissemination strategies. Finally, a researcher's credibility is also rooted in how entrepreneurial she and her organisation are with respect both to specific projects and their broader programme (Gilson & McIntyre, 2008).

Further lessons emerging from the case studies pertain to key factors essential for influencing policy, which include research quality and trustworthiness, strategic alliances and networking, as well as capacity building, specifically the training of future policy-makers (Rispel & Doherty, 2011). These factors are consistent with Innvaer et al.'s (2002) findings a decade earlier, which accentuated that the following are critical elements: personal contact between researchers and policy-makers, timeliness and relevance of the research, research that includes a summary with clear recommendations, good quality research, research that confirms current policy or endorses self-interest, community pressure or client demand for research, and research that includes effectiveness data.

Outside the health sector, there has also been considerable growth in support for evidence translation. The establishment of the Africa Centre for Evidence (ACE) at the University of Johannesburg attests to this phenomenon (Tannous, 2019). The centre now includes over 3,000 individuals with an interest in the production and use of evidence for poverty reduction in Africa (Tannous, 2019). ACE has also established the Africa Evidence Network, which is regarded as "the world's first and largest cross-sector regional evidence network" (The Conversation, n.d.). Although not referring to the health sector specifically, Stewart et al. (2019) assert that the local evidence ecosystem in South Africa is increasingly resilient despite some limitations. These authors contend that this overall ecosystem "has strong structural foundations, includes many diverse organisations, is supported by not inconsiderable investment, is enabled by growing and significant capacity, contains iterations and innovations, and last but not least, incorporates complexity that gives the ecosystem resilience" (p. 1). It is boldly asserted that the global movement has much to learn from the South (Stewart et al., 2019).

One innovative platform for the exchange of important ideas between HPSR researchers and policy-makers in South Africa, which emerged and grew strongly between 2012 and 2020, is a Journal Club established by the Universities of Cape Town (UCT) and the Western Cape (UWC), in collaboration with the Provincial Health Department of the WC (WC PDoH) and the City of Cape Town Health Services (The

Western Cape HPSR Journal Club Team, 2020). Over the period 2012-2020, the Journal Club has succeeded in bringing together an average of over 40 people attending at least three meetings a year, to discuss complex systems' and social science perspectives on health system development. The Journal Club has enabled the deepening of relationships and emergence of shared ideas, and most importantly facilitated mutual learning between HPSR researchers and provincial and local health managers. In this process, ideas and concepts generated have provided managers with the language and frames to make sense of their own experience. Simultaneously, the Journal Club has provided researchers with the language to deepen their thinking, and to also test their concepts and ideas against real world realities through engagement with the health sector managers.

The emerging practices in the Western Cape province of South Africa are steps in the right direction. However, the existing work is still a small body of literature, and there still limited ideas about how to strengthen Evidence-Informed Policy-making (EIP) in the country. As reflected in Chapters 8 and 9, the present research study offers some proposals about strengthening EIP.

2.6. Conclusion

This chapter has presented an overview of the theoretical literature from both HICs and LMICs on policy analysis and the use of evidence in policy-making. It has also outlined the empirical literature on the evidence-to-policy interface, also from both HICs and LMICs, including South Africa. Overall, the literature highlights a number of key issues for this study.

First, the literature reviewed highlights several critical factors influencing policy-making processes and the use of evidence within them. These are: a) the importance of actors in these processes, b) the political and institutional influences over policy-making and the recognition that evidence is not value-free (Parkhurst, 2017), (c) the use of an array of sources of information, not only formal research evidence, by policy-makers (Bowen & Zwi, 2005; Oliver & Cairney, 2019), and d) the varying levels of confidence by policy-makers in the different types of evidence available to inform policy.

Second, the review has identified several gaps in the literature, which this study seeks to contribute towards addressing. Despite the existence of a strong body of literature on the use of evidence within policy development, it remains an unclear process (Abeyasinghe & Parkhurst, 2013). Oliver et al. (2014) judged that there are very few studies providing empirical data about policy processes and this limits the ability to describe the role of evidence and other factors influencing policy. This study sought to contribute towards addressing this gap by clarifying the formal policy-making processes in the South African public health sector. There is still limited (although growing) literature that elucidates the pathways through which evidence might be brought to the attention of policy-makers and used in the policy process in South Africa.

A further gap in both the global and South African literature concerns the types and sources of evidence used by policy-makers in the health sector, as well as reasons

for their preferences. Various forms of evidence exist which are considered by policy-makers in the process of policy development (Oliver, Lorenc & Innvaer, 2014; Oliver et al., 2015; Oliver & de Vocht, 2017). This study aimed to deepen an understanding of the diverse sources of evidence used by policy-makers, including expert committees, beyond the traditional “scientific” sources. In addition, the reviewed literature converges around the point that evidence cannot be used alone to make decisions, and judgements are always required for decision-making or policy-making. In addition, more evidence is not necessarily better for policy-makers, unless the researchers comprehend the complexity of the policy-making process. This study, therefore, aimed to expose other factors that are considered in the policy-making process in the South African health sector.

CHAPTER 3: METHODOLOGY

3.1. Introduction

This chapter presents a detailed review of the research methodology used in this study.

3.2. Aims of the study

The main aims of the study were to understand the routine avenues of national health policy-making in the South African public health sector and to assess and explain the nature of evidence that is viewed as important and used for policy-making processes in these avenues.

3.3. Research Question

Drawing from the literature review, the major question addressed in this study was:

How and why are different forms of evidence used in health policy formulation in the South African Health Sector?

The WHO defines health policy as “the decisions, plans, and actions that are undertaken to achieve specific health care goals within a society” (WHO, 2018). The focus of this study was on policy in the sense of larger-scale decisions and plans affecting the whole of society. The focus was on policy formulation only, excluding policy implementation. As discussed further below, the study considered two policy process cases, the National Core Standards in South Africa, which is a health systems policy, and the Prevention-of-Mother-to-Child Transmission (PMTCT) of HIV policy for South Africa, which is a clinical policy.

3.4. Specific objectives

The **specific objectives** of the study were as follows:

- (a) To describe the routine avenues of national health policy-making in the South African public health sector
- (b) To explore the nature of evidence that is viewed as important and used for policy-making processes in the public health sector in South Africa
- (c) To explain factors that facilitate and those that inhibit the use of different types of evidence in policy-making from the perspectives of both policy-makers and researchers
- (d) To explore mechanisms of fortifying the research-to-policy interface in South Africa

3.5. Insider-led/Embedded Research

The philosophy of the present research study was that of “*insider-led research*” or “work-based research”. This approach is defined by Costley, Elliot and Gibbs (2010) as a study conducted within the researchers’ own work practice, and the researcher who conducts such a study is an insider-researcher. As indicated in Chapter 1, I am an Outcomes Facilitator for Health in the Department of Planning, Monitoring and Evaluation (DPME), which is located in The Presidency, and the mandate of which is to monitor and evaluate the performance of other government departments. My job entails monitoring progress towards the targets set in the Health Chapter of the National Development Plan (NDP) 2030, which is South Africa’s national macroplan for socio-economic development, adopted by Cabinet in 2012. I attend all meetings of the National Health Council (NHC) and the Technical Advisory Committee of the NHC (TECH-NHC). Prior to joining the DPME in April 2013, I worked as Director and then Chief Director in the National Department of Health (DoH) for a period of 9 years and 2 months.

Costley, Elliot and Gibbs (2010) accentuate the need for the researcher (i.e. me) to understand the concept of situatedness, which is the interplay between the agent (i.e. the researcher), the situation (i.e. the particular set of circumstances and the researcher’s position within it), and the context (i.e. where, when, and background). There are both benefits and risks associated with being a work-based researcher. As Costley, Elliot and Gibbs (2010) state, “when researchers are insiders, they draw upon the shared understandings and trust of their immediate and more removed colleagues with whom normal social interactions of working communities have been developed” (p. 1). These scholars elucidate further advantages of work-based research, led by the insider-researcher. They are that the insider-researcher:

- (a) Is in a **unique position** to study a particular issue in depth and with special knowledge about that issue. In addition to their own insider knowledge, the researcher has easy access to people and information that can further enhance that knowledge;
- (b) Is in a **prime position** to investigate and make changes to a practice situation, and can challenge the status quo from an informed perspective;
- (c) Has an advantage when dealing with the **complexity of work situations**, because the insider-researcher has in-depth knowledge of many of the complex issues. This knowledge becomes vital when exploring complex problems;
- (d) Can understand what the **tensions** are between the specific and the general when dealing with complex issues;
- (e) Is in a better position to unravel **paradoxes and ambiguity** in the work situation.

(Costley, Elliot & Gibbs, 2010, p. 2)

The relevance of each of these factors to this study is discussed below.

My previous and current work positions and network of relationships placed me in a **unique position** to carry out this present study successfully. This was by virtue of my attendance and participation in the key national structures of policy-making in the

public health sector in South Africa, namely the NHC and TECH-NHC. My 19 years of service in government has placed me in a **prime position** to observe how policies are developed in the health sector. This unique position also enabled me to easily access the Senior Executive Managers in the National and Provincial spheres of the public health sector. Several key informants expressed their pleasure with the fact that one of their colleagues was pursuing a PhD with an eminent institution such as UCT, as this would contribute towards informing policy practices in the public health sector, as suggested by Costley, Elliot and Gibbs (2010).

The **complexity of the health sector** arises from the fact that constitutionally, health is an area of concurrent responsibility between the national and provincial spheres of government. My deep-seated understanding of this complexity enabled me to craft specific questions about how this concurrency is managed when health policies are developed, as well as questions about the use of evidence in these policy processes.

The insider-researcher position enabled trust between me as a researcher and the study participants. This position also enabled me to **explore tensions** arising in health policy formulation in general and around the specific tracer policies: for example, those that arose from the argument that national policies are developed in the national department of health, but are implemented by the provincial sphere and its health districts. I was also able to unravel paradoxes and ambiguities, for instance, when the provincial sphere of the health system argued that health policies were developed by the national sphere, when in fact provinces form part of the TECH-NHC and the NHC, and constitute a core component of the national policy-making formulation process.

3.6. Overall Research Strategy and Design

This study did **not** seek to establish *whether* evidence is used in health policy-making in South Africa. This was taken as recognised. Rather, the study sought to establish how evidence is used, what different forms of evidence are used, and why these forms are selected for use.

It was an exploratory and explanatory study using a **flexible research design** (Gilson, 2012) which evolved across the study. The findings from Phase 1 specifically contributed towards the design of Phase 2 of the study.

3.6.1. Phase 1: Understanding health policy development in South Africa

An important concern advanced in the literature is that any effort to understand the use of research evidence in policy formulation must commence with an understanding of broader policy-making processes, including the particular 'policy stage' of focus or the entire policy cycle, the context within which the process occurs, the actors influencing the process (or potentially doing so), and power relations among them in the policy space. The policy framework (or policy triangle) designed by Walt and Gilson (1994) provides a useful framework for understanding the dynamic interactions between these factors. The simplicity of this framework and its broad

applicability across contexts was valuable in guiding my initial thinking and original study design.

Against this background, **Phase 1** of this study considered the policy formulation processes in the South African health sector, borrowing from the policy framework developed by Walt and Gilson (1994) and expanded on by scholars such as Burris et al. (2011). The focus was on the phase of policy development which lies between agenda setting and policy implementation and for which Berlan et al. (2014) coined the term '*the bit in the middle*'. This phase is referred to as policy formulation, policy adoption, policy-making or diffusion.

Phase 1 was, in essence, **exploratory** in nature. As Gilson (2012) states, exploratory research aims to “find out what is happening, especially in little-understood situations; generate new insights and ask questions; assess phenomena in new light; and generate ideas and hypotheses and for future research” (p. 49). Although as an insider-researcher, I had a fairly strong understanding of the practice within policy formulation processes, I sought to both deepen and test this understanding through open-ended interviews.

Phase 1 was also important in generating questions to be asked of key informants during the second phase of research, to ensure that the latter phase was focused and oriented towards the needs of the study.

3.6.2. Phase 2: Understanding the use of evidence in health policy development in South Africa

Phase 2 of the study was **explanatory** and sought to generate a deeper understanding of the use of evidence in health policy formulation in South Africa. According to Gilson (2012), **explanatory** research aims to “explain a situation or problem, traditionally, but not necessarily, in the form of causal relationship (evaluative research); to explain patterns relating to the phenomenon being researched; and to identify and explain relationships between aspects of phenomenon/phenomena” (p. 49).

Phase 2 examined the use of research evidence in health policy formulation in South Africa, using two policy process cases, the Prevention of Mother-to-Child Transmission (PMTCT) of HIV and the National Core Standards.

Rationale for the selection of the two policy processes

The most important rationale for the selection of the two policies was that where the PMTCT policy is a programmatic and clinical policy, and the National Core Standards policy is a health systems policy. A health programme-related policy strives to enhance the delivery of a specific and particular programme, in this case the Prevention of Mother-to-Child Transmission of HIV programme. Such a policy is accompanied by a set of specific guidelines. In contrast, a health systems policy is characterised in this study as a policy aimed at strengthening the entire system, rather than a specific health programme. The National Core Standards aims to improve the

whole system through regulatory mechanisms. These are two broad categories of policies traditionally developed in the health system.

In addition, the two policy process cases were selected to provide contrasting experiences around which to explore critical factors likely to influence evidence use in policy change. These include: (a) different actor networks, (b) different processes of policy development, (c) different types of evidence drawn upon and how these are drawn upon, and (d) different levels of confidence by policy-makers in the types of evidence available to inform policy.

Rationale for case study design

I considered the use of the case study design as the most appropriate lens through which to examine the evidence-to-policy interface in phase 2. In terms of the definition of case study, Thomas, Chataway and Wuyts (1998) adopt the description first advanced by Curry (1992), which posits that a case study is “an account and an analysis of particular events and decisions” (Curry, 1992, p. 1, cited in Thomas Chataway & Wuyts, 1998, p. 307). Thomas, Chataway and Wuyts (1998) also concur with Schramm (1971, cited in Yin, 1994, p. 12) that a case study can be “used to illuminate a decision or set of decisions, why they were taken, how they were implemented, and with what result” (p. 307). This definition was pertinent to the questions that this study strove to answer, through considering the development of the National Core Standards in South Africa and the PMTCT of HIV policies, and how evidence was used in these policy formulation processes.

According to Thomas, Chataway and Wuyts (1998) the case study approach is most suited to dealing with research questions about “why” and “how” certain phenomena occur (p. 311). These are the main questions that this study aimed to address with regard to the use of evidence in health policy development in South Africa, focusing on the two aforementioned tracer policies. Thomas, Chataway and Wuyts (1998) assert that each particular policy or policy process is a case.

Drawing from the work of Yin (1994), Thomas, Chataway and Wuyts (1998) assert that case study research design should be theory-led (p. 313). According to these scholars, at the outset the researcher has his/her own ideas about what to expect from a policy situation or process being investigated. However, a case study investigation would then elicit “the evidence that would challenge (or validate) the researcher’s ideas” (Thomas, Chataway & Wuyts, 1998, p. 313). The theoretical underpinnings of this study are rooted in the policy analysis literature, particularly the body of work of HPSR scholars. This work converges to demonstrate that policy development is essentially a political process, the outcome of which is determined by many diverse factors, evidence being only one of these factors (Buse, Mays & Walt, 2012; Buse et al., 2007; Gilson & McIntyre, 2008; Bennett et al., 2011; Hawkins & Parkhurst, 2016; Parkhurst, 2017).

This study is also founded on the understanding that the concept of evidence does not refer only to research evidence, but includes diverse forms of evidence that may be used by policy-makers. Commencing with this theoretical background, this study sought to unearth the specific factors that influenced the use of evidence in the development of the two policy process cases. In terms of empirical frameworks, I

again used the lens of the policy triangle, with the aim of examining the context, content, and process of developing the two tracer policies, as well as the actors who were centrally involved in policy processes (Walt & Gilson, 1994).

In terms of analysis, Thomas, Chataway and Wuyts (1998) state that a case study is a “unit of analysis whose characteristics and interrelationships can be analysed within a universe of a particular sector” (p. 311). In this study, the National Core Standards in South Africa and PMTCT of HIV policies are the *units of analysis*, whose characteristics and interrelationships can be analysed within the larger universe of the health policy development in South Africa. Thomas, Chataway and Wuyts (1998) caution that once the principle is accepted that case studies focus on units of analysis within a population or universe, it is inappropriate to expect a representative sample of case studies (p. 314). Consistent with this view, this study drew qualitative inferences from the generic health policy development processes in Phase 1, and the use of evidence in the development of each of two tracer policies in Phase 2. The focus was not on quantitative comparisons of the two policy cases. The aim of this study is not to generalise the findings from the two case studies to the rest of the health policy processes in the country with statistical power, as would be done in a quantitative study. Instead, case studies lend themselves to **theoretical generalisation**. According to Thomas, Chataway and Wuyts (1998), “if the case studies are based on theoretical ideas, and if these ideas succeed in explaining the case studies, then the researcher can make general explanatory statements that apply to all cases where the interrelationships are similar” (p. 323).

Thomas, Chataway and Wuyts (1998) assert that case study selection should challenge the ideas of the researcher. In selecting the two tracer policies for this study, my aim was to identify one health systems policy and one programmatic, clinical policy, to compare and contrast the use of evidence in the development of two policies of contrasting focus. The underlying assumption was that the different foci of the policy would be reflected in different policy process experiences, including in the use of evidence. The approach used in the selection of case studies in this study is what Thomas, Chataway and Wuyts (1998) refer to as the critical case approach, which compares two sets of ideas. According to these scholars, this approach entails “framing a case so that two competing sets of ideas or theories can challenge each other”. This is also referred to as the “contrastive approach” (Thomas, Chataway & Wuyts, 1998, p. 323). Thomas, Chataway and Wuyts (1998) assert that the critical case approach of comparing two sets of ideas looks for evidence to provide answers to the questions as to “how” and “why” particular phenomena take place. This approach is a method of choice for this study, given its objectives. One proposition that emerged from interviews conducted in Phase 1 of this study was that in the South African health sector, evidence is used only in the development of clinical policies, and not during health systems policy development. Another school of thought from subnational levels of the health system was that evidence is not used at all in the development of new health policies, otherwise the national sphere of the health sector would fully comprehend their resource implications and provide the necessary, thereby avoiding unfunded mandates in the health sector. These ideas were examined in **Phase 2** of this study. What emerged in **Phase 2** was that the use of evidence for health policy development is primarily determined by powerful political actors.

3.7. Background to policy process cases

The **Prevention of Mother-to-Child Transmission (PMTCT) of HIV policy** was first developed in 2002. This study focuses on the national contestations about the adequacy of the existing evidence which informed the PMTCT policy development, as well as the policy processes that took place in 2002, after a breakthrough was achieved. This study examines the use of evidence in the further iterations of the PMTCT after changes in the political leadership of the country occurred in 2008.

The Medical Research Council (MRC) has conducted systematic studies of mother and baby pairs to periodically monitor the effectiveness of the PMTCT programme in reducing perinatal transmission of HIV from mothers to infants, measured at 4-8 weeks after infant birth. The MRC's findings reveal that the implementation of the 2008 PMTCT policy in South Africa has yielded desirable results.

In 2008, the MRC found the mother to child transmission (MTCT) rate to be on average 8,5% nationally. As reflected in **Table 3.1 below**, subsequent MRC studies conducted in 2010 and 2011 found that the MTCT rate had decreased to 3,5% and 2,7% respectively. This is reflected in **Table 3.1 below**. The 2013 MRC study concluded that since 2010, a total of 107 000 babies were saved from HIV, assuming that the perinatal MTCT without the South African national PMTCT programme was 30% (Goga et al., 2013). In 2011, an additional 3100 babies were saved from infection compared with the 2010 results (Goga et al., 2013).

Table 3.1: Weighted Infant HIV exposure and 4–8-week (early) MTCT of HIV by Province for 2010 and 2011

Province	Infant HIV exposure 2010 (%)	MTCT (%) 95% CI 2010	Infant HIV exposure 2011 (%)	MTCT (%) 95% CI 2011
Eastern Cape*	30.5 (26.9-34.2)	4.7 (2.4-7.0)	32.0 (29.6-35.5)	3.82 (2.1-5.5)
Free State	31.3 (29.1-33.5)	5.9 (3.8-8.0)	30.9 (28.6-33.3)	3.80 (2.3-5.3)
Gauteng	30.4 (27.9-33.0)	2.5 (1.5-3.6)	33.1 (29.8-36.4)	2.13 (0.2-3.4)
KwaZulu-Natal	44.3 (40.2-48.4)	2.9 (1.7-4.0)	44.4 (39.8-48.9)	2.10 (0.9-3.3)
Limpopo	23.9 (21.8-25.9)	3.6 (1.4-5.8)	23.0 (19.9-26.2)	3.06 (1.2-4.9)
Mpumalanga	37.0 (34.3-39.7)	5.7 (4.1-7.3)	35.6 (33.3-37.8)	3.32 (2.2-4.5)
Northern Cape*	16.0 (13.7-18.3)	1.4 (0.1-3.4)	15.1(12.7-17.5)	6.1 (2.5-9.6)
Northwest	31.3 (29.0-33.5)	4.4 (2.9-5.9)	30.8 (28.5-33.1)	2.6 (1.1-4.0)
Western Cape	21.0 (17.0-25.0)	3.9 (1.9-5.8)	17.8 (14.8-20.8)	1.98 (0.65-3.31)
South Africa	32.0 (30.7-33.3)	3.5 (2.9-4.1)	32.2 (30.7-33.6)	2.7 (2.1-3.2)

Source: Goga et al. (2013)

The second policy process examined is the **National Core Standards policy**, which was adopted by the health sector in 2011. This policy had three clearly defined objectives, namely: (a) to develop a common definition of quality care which should be found in all health establishments in South Africa, as a guide to the public and to managers and staff at all levels; (b) to establish a benchmark against which health establishments can be assessed, gaps identified, and strengths appraised; and (c) to provide for the national certification of compliance of health establishments with mandatory standards (Department of Health, 2011).

The National DoH stated in 2011 that these National Core Standards were a statement of what is expected, and required, to deliver decent, safe, quality care in the public and private sectors. Also, through a national process of certification, an external body would formally assess each health establishment for compliance against these standards (Department of Health, 2011, p. 6). The major value-add of the policy was that it prescribed very clear norms and standards, which could not have been specified in national legislation.

The National Core Standards were further buttressed by the signing into law of the National Health Amendment Act, No. 12 of 2013, by the President of South Africa, which enabled the health sector to establish an independent Office of Health Standards Compliance (OHSC).

3.8. Data collection methods and procedures (Phase 1 and Phase 2)

3.8.1. Characteristics of the key informant sample

The total study sample of **30** key informants were categorised into two broad groups of *policy-makers in the public health sector* and *health policy and systems researchers*. In both phases of the study, respondents were purposefully selected by virtue of their involvement in health sector policy processes. In **Phase 1**, key informants from the public sector were senior technical bureaucrats, who, like myself, also participate in the NHC and TECH-NHC. Senior researchers across research organisations were selected based on their expertise and scholarly contributions to health policy development in the country. In **Phase 2**, key informants were identified on the basis of their previous involvement in the development of either of the two tracer policies, the National Core Standards and the PMTCT Policy. No respondent was a key informant on both tracer policies.

The total of **30** key informants consisted of 15 policy-makers and 15 researchers, as reflected in **Table 3.2.** below. Given that this was a qualitative study, emphasis was not on the representativeness of the sample, but rather on the respondents' unique insights about South African health policy formulation and the richness and strength of the interview data.

Table 3.2: Study Sample

	Public Sector Policy-makers	(n = 15)
	National Sphere of Government	
1	Political Leadership	2
2	Administrative and Technical Leadership	7
	Provincial Sphere of Government	
3	Administrative and Technical Leadership	6
	Total	15
	Research Community	(n = 15)
1	Independent Researchers	6
2	Research Institutions and Public Entities	5
3	University Research Groups	4
	Total	15
	Grand Total	30

Across phases, my insider-researcher status enabled me to access the highest elite of policy-makers in the South African health system, including the political leadership. Purposive sampling was used, and key respondents were identified by virtue of their role in the health policy structures and processes in the South African health sector. I obtained approval to conduct the study in the health sector from the Office of the Director-General of Health in August 2016. Approval from the National DoH for the study was subject to three conditions: (a) that the Research Ethics Committee Approval or Research Clearance Certificate was submitted to the National DoH; (b)

that permission to present or publish the findings of the study was sought from the National DoH; and (c) that the final report should be submitted and presented to the National DoH.

I also engaged personally with the identified study participants during meetings of the NHC and Technical Advisory Committee of the NHC. The identified respondents were requested to participate in the study by granting me an interview. Given their positions in government, this group of respondents had unique insights into the policy formulation processes investigated in this study and were drawn from both the national level and six of the nine provinces.

A total of 15 respondents from the research community participated in the interviews. These were independent researchers, and scholars from research institutions and public entities, as well as from university research groups. All had engaged with health policy formulation processes and had insights of relevance to the study. I contacted them via email, requesting an opportunity to interview them, and sent them consent forms. All the respondents from the research community who were contacted agreed to be interviewed.

The purpose of these interviews was to generate insight into the perspectives of researchers about the nature of evidence used in policy-making in the South African health sector, and factors that contribute to or inhibit the use of such evidence (and other forms of evidence). This was imperative, as researchers are the producers of empirical evidence, which is one of the different types of evidence used by policy-makers.

3.8.2. Key informant interview approach

This being a qualitative research study, open-ended face-to-face interviews with key informants were conducted, aided by self-designed semi-structured interview guides. This was prior to the advent of the Coronavirus Disease (Covid-19), which resulted in lockdown restrictions limiting human and social contact. An interview is defined as a conversation that is directed more or less towards the researcher's particular needs for data (Green & Thorogood, 2004). An in-depth interview is one that allows respondents enough time to develop their own accounts of the issues important to them (Green & Thorogood, 2004).

Written informed consent was obtained from all the participants. Invariably, interviews were conducted in the offices of the participants, and at the home of one retired key informant, to minimise inconvenience to their busy work schedules. The open-ended interview guide contained different questions for Phase 1 and Phase 2.

Given the seniority of the respondents in Phase 1 and Phase 2, the nature of the interviews was conversational as well as in-depth. The interviews sought to elicit the knowledge, experience, and expertise of the respondents in health policy-making processes in South Africa, as well as the use of evidence in these processes. Policy-makers interviewed consisted of two subcategories, namely the *political leadership* and the *senior most administrators* of the health sector.

In Phase 1 of the study, questions asked were open-ended, aimed at eliciting the experience and perspectives of interviewees. My position of trust made it more likely that the respondents would answer openly and frankly. This assisted in generating a fuller sense of the experiences and perspectives of the key informants. **Box 3.1** below reflects the questions posed to the study participants in Phase 1 of the study. The questions included in the Interview Guide for Phase 2 were open-ended, aimed at eliciting the experiences and perspectives of interviewees. These questions sought to identify key actors in the development of national policy and the roles they have played across policy processes, as well as to elicit data about contestations in priority setting in the health sector. They also sought to identify the role of different types of evidence in the development of national health policy, the sources of evidence used by policy-makers, and the ways in which the use of evidence in health policy-making can be strengthened in South Africa.

Box 3.1: Questions posed to the study participants in Phase 1 of the study

1	Who are the key actors in the development of national health policy in South Africa?
2	Can you give me some examples of how these actors have played a role in particular policy processes, or the types of roles they have played across these processes?
3	What roles do external stakeholders such as researchers, NGOs, or CBOs play in the policy development process?
4	Are there contestations about policy priorities that occur between the national and provincial spheres of government – given that health is a concurrent function constitutionally? How are these handled? Can you give me some examples?
5	Once an issue has been identified as a policy priority for the public health sector, how is consensus reached about the content of the policy ?
6	Can you identify the critical steps in the development of any health policy in SA? Which steps do you think are most important, and why? Please give concrete examples.
7	In your view, does evidence play a major part in the development of national health policy?
8	To what extent is research evidence or other forms of evidence used in the policy-making process? Can you give me some examples?
9	In your view, which sources of evidence are mostly used by government? What are the characteristics or quality of these sources?
10	How can the use of evidence in policy-making be strengthened in South Africa?
11	Are there any additional comments you would like to make?

3.8.3. Records of discussions in the health sector

The key informant interviews were enriched by my own almost 10-year experience and insider knowledge of the health sector, and knowledge of publicly available policy documents, grey literature, and published literature. However, I did not rely solely on my personal institutional memory of the health sector, but also reviewed the records (minutes) of discussions in the sector, which took place over the period of almost a decade in which I was a member of Senior Management Services (SMS), first as a Director, and then as the Chief Director for Strategic Planning (later including Health Information Management and Research). These were minutes of meetings of the National Health Council (NHC), which is chaired by the Minister of Health, and the Technical Advisory Committee of the NHC, which is chaired by the Director-General

of Health. These minutes are classified as confidential in terms of government's Minimum Information Security Standards (MISS) policy, which is managed by the Department of Public Service and Administration (DPSA). I could not, therefore, cite these minutes in the thesis, but they provided background information of relevance to it – that buttressed my memory, and supported interpretation of wider experience. I did, moreover, provide extracts from these minutes to my Supervisor to validate the written accounts based on memory I developed, as a step of validation.

3.8.4. Specific South African documentation

I reviewed a range of South African documentation to determine the legislative bases of health policy formulation processes, understand the role of evidence within these processes and consider factors influencing them. This documentary analysis further complemented the interviews and supplemented my personal institutional memory. As noted, some documents cannot be cited in the text, as they are not publicly available. The documents reviewed are described in **Table 3.3** below.

Table 3.3: South African documents reviewed in this study

Document type	Rationale for inclusion in the review
Constitution of South Africa	✚ Section 27 (1) (a) which states that “everyone has the right to have access to health care services, including reproductive health care”. This Constitutional provision was pertinent to the case study on the PMTCT policy, in which the principle of the right of access to the PMTCT programme was contested. Schedule 4 of the Constitution (Part A), which reflects the Functional Areas of Concurrent National and Provincial Legislative Competence and includes health services in this list, was important for this study. This was because it provides the relevant context for the contestations between the national and provincial spheres of government during the formulation of both the PMTCT and National Core Standards policies. ✚ This matter is explored in detail in Chapters 6 and 7 of this study
National Health Act, 61 of 2003.	✚ This legislation provides for the specific distribution of powers, roles, and functions of the national and provincial spheres of government, and health districts. I also read the National Health Amendment Act, 12 of 2013, which provided
National Health Amendment Act, No 12 of 2013	✚ The Act provides for the establishment of the Office of Health Standards Compliance (OHSC) as an independent, juristic entity, tasked with setting norms and standards for health establishments in the country. This was essential for understanding the evolution of the National Core Standards, from their origin in the National DoH to their administration by the independent OHSC.

Document type	Rationale for inclusion in the review
Documents of the ruling African National Congress (ANC)	 Policy documents of the ruling ANC were relevant to this study,, particularly documents on the deployment of ANC leaders in the government of South Africa. These were important for elucidating the expectations of the ruling party of its members who are deployed to positions of responsibility in government. Theirs are positions of responsibility but the authority rests in and is vested with the ruling party. These documents were important in generating an understanding of the 'bounded rationality' in which ANC deployees in government find themselves, as explained in detail in Chapter 6.
South African Government Policy Documents	• Policy documents that anchored this study included the White Paper for the Transformation of the Health System in South Africa, released by the Department of Health in 1997. This policy paper was important to this studyas it outlined the envisaged relationship between government and the research community. • Other key policy documents were: (a) policy documents on the first tracer policy, entitled: "Towards Quality Care for Patients": National Core Standards for Health Establishments in South Africa, Pretoria, and (b) the Procedural Regulations Pertaining to the Functioning of the Office of Health Standards Compliance and its Board, released by the Department in 2015. These documents reflect the policy process and content of the National Core Standards policy, as well as the role of the OHSC. I also studied national documents pertinent to the PMTCT policy, including the work of the Medical Research Council (Goga et al., 2012, 2013) and Simelela and Venter (2014). 
South African Grey Literature	• I also reviewed various pieces of relevant grey literature, which included the following unpublished reports of the National DoH: (a) Kaiser Family Foundation (2010), Political Leadership in Health Roundtable Meeting on National Health Insurance: The Foundation for Universal Access, Affordability and Quality, Summary Report, Rio de Janeiro, May 28-30, 2010, and (b) DoH (2010c), Report on the Ministerial Traveling Seminar to Brazil, 26 May to 03 June 2010, 21 June 2010.

3.8.5. Data Safety and Management

Established methods for ensuring data safety and monitoring were used in this study. The first approach involved ensuring the physical safety of the recorded interview. In cases where participants granted me permission to use a tape recorder, the tapes were transcribed into a narrative (word) format by an external service provider who was sworn to confidentiality, within one month of the interview. The tapes were protected by an encrypted password to prevent any possible leakage or unauthorised use. All audio-files were destroyed once transcripts were verified as true reflections of them. All transcripts, electronic field notes, and electronic documents will be disposed of through secure data wiping or erasure 10 years after the completion of the study. Where respondents requested that transcripts of the interviews be sent back to them to confirm, validate, or amend the content, this was done. This was in rare cases, however. Most respondents indicated that they preferred to see the draft research report, instead of interview transcripts which would simply reflect back to them their own viewpoints.

The second approach for ensuring safety entailed the protection of the transcripts. They were placed on a password-protected laptop computer belonging to me. Only my supervisor (Principal Investigator) and I had access to these transcripts. The third approach entailed encryption and anonymisation of data. The transcripts and interview files were saved with anonymous codes which did not reflect the name or position or any form of identification of the respondents. Only my supervisor and I had access to the list of names and codes.

3.9. Data Analysis

Phase 1 of this study, which was mainly descriptive, used thematic content analysis to analyse the interview and documentary data collected. Consistent with the definition advanced by Green and Thorogood (2004), I studied the data from Phase 1 to identify common themes and assigned them labels (or codes). While it is common practice in qualitative work to develop coding schemes from the empirical data, elements of coding can be predetermined from the interview questions (Green & Thorogood, 2004). This was the case in Phase 1 of this study. Major themes that emerged from the interview data were closely related to the questions posed to respondents. Findings from Phase 1 were tested further during interviews in Phase 2.

Phase 2 was more analytical. The interview data analysis approach for Phase 2 therefore transitioned from Thematic Content Analysis to Framework Analysis, described by Ritchie and Spencer (1994). This framework consists of 5 phases, namely: (a) familiarisation, (b) identifying a thematic framework, (c) indexing, (d) charting and mapping, and (e) interpretation (Ritchie & Spencer, 1994; Green & Thorogood, 2004).

Familiarisation involves listening to tapes and re-reading field notes or transcripts until the researcher is closely familiar with them in their entirety (Green & Thorogood, 2014). In this study, I familiarised myself with the data from both Phase 1 and Phase 2 of this study by replaying the tapes of the interviews and reading the narrative

transcripts of my interviews with key informants at least twice. The transcripts of interviews from both phases of the study were on average 25-28 pages long. I then produced three- to four-page summaries of each interview, which were reviewed by my supervisor, who provided further guidance. The three- to four-page summaries were the foundation of my thematic framework and data-based codes, which are discussed in detail below.

Identifying a thematic framework entails conducting thematic analysis to develop a coding scheme (Ritchie & Spencer, 1994; Green & Thorogood, 2014). In this study, I identified the common and constantly recurring issues emerging from the interviews I conducted with key informants, and grouped these into common themes. Using the Walt and Gilson (1994) policy framework (triangle), I classified these themes into categories such as: the role of powerful political actors in influencing policy, policy context, policy content, and policy processes. The results of both phases of the study were grouped into themes based on the policy triangle. This theoretical framework also enabled a comparison of the two policy process cases examined in this study.

Indexing entails applying codes to the whole data set in a systematic way (Ritchie & Spencer, 1994; Green & Thorogood, 2014). I conducted my indexing numerically, by assigning numbers to each of the themes I had distilled from my interview data and also to sub-themes that emerged from each theme (e.g. 1.1, 1.2, and 2.1, 2.2, and 3.1, 3.2)

According to Ritchie and Spencer (1994) and Green and Thorogood (2014), charting and mapping entail rearranging the data according to the thematic content, either case by case, or by theme. Charts only contain summaries of data to enable the researcher to see the range of data across themes (Green & Thorogood, 2014). I applied the methods proposed by Ritchie and Spencer (1994) and Green and Thorogood (2014) in a stepwise manner. From the three- to four-page summaries of my interview data, and the indices that I had developed by assigning numerical values to each theme, I was able to create charts and map the data. Using this approach, I was able to identify common and contrasting themes expressed by policy-makers from both the national and provincial spheres of the health system, as well as those articulated by the HPSR researchers.

The fifth step postulated by Ritchie and Spencer (1994) and Green and Thorogood (2014) is **interpretation**, which refers to giving meaning to the coded data, and reflecting the relationships between concepts and typologies. Once the charts and maps were produced, it was much more feasible for me to interpret the data and produce a coherent storyline, and reflect on where the findings from the literature and interviews were consistent, and where there were divergent views on common issues. It was striking how in certain instances, specific issues from the same thematic content area could be diametrically opposed. The PMTCT policy is a case in point. One of the pervasive themes and sub-themes that emerged in this study, articulated by key informants, was that the political context (or climate) in which the PMTCT policy emerged was hostile, and that the political leaders of the country and of the health sector in 2001 and early 2002 were autocratic, domineering, and bullying to other stakeholders in the policy-making process. However, other key informants described the same leaders as intellectually gifted and highly talented, but as working in an environment where their counterparts could not understand their policy

priorities, because they were not equally talented, or too slow to comprehend the policy direction.

Two additional analytic frameworks were used to assist data analysis and interpretation around: the key actors and networks of actors who were involved in the evolution of the policy process cases; the relative power and influence that they commanded in these cases and their sources of power; how this power and influence were used during this process; and the interests that shaped the behaviour of the actors and the dynamic interplay between them. The first framework is a force field analysis borrowed from Gilson et al. (2003), which enabled me to depict the stakeholders involved in the development of both the PMTCT and National Core Standards policies, considering both the stakeholders' support or opposition to each of the two policies, and their power relative to each other in these processes. For this analysis, I also drew definitions from the work of Balane et al. (2020): "*Interest* refers to their concerns (i.e. stakeholders' concerns) about how a particular policy will affect them; *position* reflects their level of support for or opposition to the policy; and *power* is their ability to affect policy, reflecting their resources and ability to mobilise them" (p. 2).

The second framework I used is derived from Shiffman and Smith (2007). The two authors examine why certain global health initiatives receive priority from political leaders and others receive little attention, and propose a framework that consists of four interacting elements. These are: "the strength of the actors involved in the initiative; the power of the ideas they use to portray the issue; the nature of the political contexts in which they operate; and the characteristics of the issue itself" (Shiffman & Smith, 2007, p. 1370). Walt and Gilson (2014) tested this framework's relevance to national policy processes, including policy formulation, through the synthesis of relevant literature, and judged it valuable at this level. It is particularly useful for my analysis because it pays attention to the interactions between evidence, ideas, and power. Definitions of the four elements, drawn from Shiffman and Smith (2007), are presented below.

<i>Element</i>	<i>Definition</i>
Political context	The environment within which actors operate
Actors and actor power	The strength of the individuals and networks concerned with the issue
Ideas	Ways in which those involved with the issue understand and portray it
Issue characteristics	Features of the problem (and of the solution)

3.10. Ensuring Rigour

I reviewed my interview transcripts with my supervisor for quality assurance, to assess relevance to the aims of the study, and to ensure the absence of bias in the line of questioning. I also applied the five methods suggested by Gilson (2012) in the Methodology Reader of the Alliance for Health Policy and Systems Research to ensure rigour in this study. These are: (a) triangulation, (b) negative case analysis,

(c) peer debriefing and support, (d) respondent validation (member checking), and (e) clear report of methods of data collection and analysis (audit trail).

Gilson (2012) defines **triangulation** as “looking for patterns of convergence by comparing results cross multiple sources of evidence (e.g. across interviewees, and between interview and other data), between researchers, across methodological approaches, with theory” (p. 57). The findings of both **Phase 1 and Phase 2** of this study were compared across interviewees, as well as with relevant documentary evidence and with my own insider-knowledge of the health sector. Theoretical frameworks were used to give meaning to the amassed data.

With specific reference to case studies and cross-cases in particular, Gilson (2012) states that triangulation involves “comparing initial case reports with each other to look for common and different experiences across cases, and also compared with theory to look for convergence or divergence” (p. 57). In **Phase 2** of this study, the two tracer policies, the PMTCT Policy and the National Core Standards Policy, were compared and contrasted with each other, to examine both the similarities and differences in their context, process, content, and key actors involved in their development.

According to Gilson (2012), **negative case analysis** entails “looking for evidence that contradicts your explanations and theory, and refining them in response to this evidence” (p. 57). In this study, I examined the data to identify any patterns that might be diametrically opposed to the assumptions and views that I originally espoused prior to the study, as well as the published literature that I reviewed, which encompassed both international and local studies. Findings from Phase 1 of the study about the generic health sector policy formulation processes were tested in Phase 2 with a specific focus on the two tracer policies. These findings from Phase 1 were useful in the analysis of the different policy experiences of the PMTCT and National Core Standards, despite being subjected to the same policy-making processes in the TECH-NHC and fully-fledged NHC.

Peer debriefing and support is defined as a “review of findings and reports by other researchers” or “members of the research team” (Gilson, 2012, p. 57). In this study, I was the only researcher. However, my supervisor effectively played the role of debriefing and support by reviewing my preliminary case study reports and providing me with constant feedback and support. This assisted greatly in continuously ensuring rigour in the study.

Respondent validation, also known as member checking, is defined as a “review of findings and reports by respondents” (Gilson, 2012, p. 57). This was done in this study. The interview transcripts were sent to the key respondents who requested them. The schematic representation of the health policy-making process was validated with the national sphere of the health sector, and refined based on feedback received.

Finally, Gilson (2012) asserts that a “clear report of methods of data collection and analysis (audit trail) should be kept” (p. 57). Consistent with this view, in this study, I also kept a full record of activities, methods, and analysis that can be made available to other researchers.

3.11. Addressing potential sources of bias

Given that I was an insider-researcher, it was essential that I did not view this study as another monitoring and evaluation activity of the DPME in the Presidency – and so did not conduct myself like an “inspector” instead of an “investigator”. This was important to reduce the risk of the study participants perceiving me as ‘an inspector’, which would have introduced bias into the interview.

During the data analysis phase, I endeavoured to avoid the risk of personal bias in the interpretation of the viewpoints articulated by the respondents. Where possible, I triangulated interview data with publicly available documents and literature, and with ‘institutional memory’ (the combination of my personal memory and its validation by reference to confidential health sector records). This institutional memory also provided rich context of the interpretation of interview data. Finally, my thesis supervisor played a crucial role in reading transcripts as well as my three- to four-page summaries of interviews, testing my analytic judgements, and providing me with invaluable feedback, which was itself incorporated into the study.

With regards to the case study approach, Thomas, Chataway and Wuyts (1998) assert that this approach can be criticised for “simply finding evidence to fit with your preconceived ideas” (p. 329). This is because in using this approach, the researcher starts with a theoretical explanation in mind, and then finds evidence to fit within the pre-prepared story, which may appear to be a “self-fulfilling prophecy” (p. 329). However, the authors note that this is unavoidable but acceptable when using the case study approach. To address this potential limitation, Thomas, Chataway and Wuyts (1998) concur with Woodhouse (cited in Thomas, Chataway & Wuyts, 1998) that two approaches, namely triangulation and documentation, are very useful in achieving rigour in both case study research and semi-structured interviews. Triangulation is defined as “getting evidence on the same point from different points of view” (Thomas, Chataway & Wuyts, 1998, p. 329). This was achieved in this study by triangulating the views and perspectives of policy-makers with those of the research community, and by reviewing extensive literature.

3.12. Ethical issues

On 3 November 2016, the Human Research Ethics Committee at the Faculty of Health Sciences at the University of Cape Town (UCT) granted approval for this study to proceed. Data collection subsequently commenced in 2017, and was conducted over the two-year period 2017-2019.

I designed an *Informed Consent Form* and distributed it to the participants together with the request for their participation. The Informed Consent Form indicated the purpose of the study and its potential benefits to the health policy development in South Africa. It explicitly asked the respondents to participate in the study, and also stated that the participants could withdraw from the interviews at any stage if they did not feel comfortable. I also included a section in the *Informed Consent Form* requesting consent to use a tape recorder during the interviews. The respondents were also informed that they could decline both requests. Only in 2 out of 30

interviews was a request for a face-to-face interview declined. Due to their tight work schedules, which changed at the eleventh hour, the two respondents completed a written questionnaire with which I provided them.

I protected the privacy and confidentiality of the views expressed by the participants in various ways. The Informed Consent Form described above included a section on non-disclosure of information provided by the participants. The findings were anonymised and protected from being traceable to any individual respondent. The quotes reported in later chapters are presented only in terms of the sphere of government that expressed the views, rather than the names of the individuals who expressed those opinions.

3.13. Conclusion

This chapter has presented in detail the research methodology used in this study. The first section of the chapter presented the aims and objectives of the study, the research question, and the specific objectives of the study. The chapter also outlined the uniqueness of this study as an insider-led or embedded research or work-based research study. The major advantages of such a study have been outlined, drawn from Costley, Elliot and Gibbs (2010). The potential bias that might arise from an insider-led study were also covered. The chapter has also outlined the two phases of the study and the goals of each phase. The chapter also outlined the two policy process cases, the PMTCT and the National Core Standards policies, as well as the criteria used to select them. Other important components of the methodological approach explained in the chapter include the methodological literature, the research strategy, the study design, the key informant sample, the data collection methods and research procedures, data analysis techniques, ethical considerations, and the limitations and risks associated with this study.

CHAPTER 4: BACKGROUND TO SOUTH AFRICA'S POLITICAL AND GOVERNANCE SYSTEM AND ORGANISATION OF HEALTH SERVICES

4.1. Introduction

South Africa became a democratic country following the national elections in April 1994. The 1993 Interim Constitution adopted at the multiparty negotiations enabled the 1994 national elections, with a final constitution subsequently adopted in 1996. The country has three spheres of government, namely national, provincial, and local government. The focus of this chapter is on the public health sector, which provides leadership for overall health policy-making in this country, with policies and legislation being applicable to both the public and private sectors.

4.2. The Political and Public Governance System

South Africa is a multiparty democracy, based on the Constitution, and it is a unitary state, albeit with a quasi-federal governance structure (with devolved authorities held by nine provincial governments). The ruling party is the African National Congress (ANC), which has won six consecutive national elections (in 1994, 1999, 2004, 2009, 2014, and 2019). During this period, the ANC won the majority of seats in the National Assembly and was consistently dominant in seven of the nine Provinces. KwaZulu-Natal (KZN) was governed by the Inkatha Freedom Party (IFP) in the first five years of democracy, and the Western Cape by the New National Party (NNP) and subsequently the Democratic Alliance (DA), which runs this province to date (2023). The ANC has governed KZN since 2004.

The two policy process cases examined in this study took place in 2002 (PMTCT) and 2011 (National Core Standards). The time frames within which the two tracer policies were developed coincide with the Presidency of Mr. Thabo Mbeki. In December 1997, Mbeki was elected President of the ANC at the 50th National Conference of the ANC held in Mafikeng, North West Province. Two years later, on 2 June 1999, South Africa's second democratic elections took place, and the ANC emerged victorious. Mbeki became incumbent President of South Africa, after the founding father of the democratic South Africa, Nelson Mandela, had declined a nomination to serve a second term, as is allowed in terms of the 1996 Constitution of the country. President Mbeki subsequently announced his Cabinet on 17 June 1999, and appointed Dr. Manto Tshabalala-Msimang, his close ally from the ANC days in exile, as the Minister of Health.

The first phase of the development of the PMTCT policy and programme occurred in 2002, during the Mbeki administration, with the Ministry of Health under the leadership of Dr. Tshabalala-Msimang. During this period, which was the first decade of democracy, many South Africans harboured hope that the democratic government would usher in both a better life for all South Africans, as its 1994 elections manifesto had declared, and an effective response to the challenge of HIV/AIDS. After all, the ANC had declared in its 1994 manifesto that "to build a better life for all requires clear

goals and a workable plan. Any solution to the crisis of apartheid needs an approach which rises above narrow interests and harnesses all our country's resources" (ANC, 2012). Ahead of the development of the original PMTCT policy (2002), the ANC's 1999 national election manifesto had also declared that "we must act together, in conditions of social discipline, further to give birth to a South Africa of freedom, prosperity and security for all, committed to act together to solve the national problems that confront all of us, including the advancement of national unity and reconciliation" (ANC, 1999). South Africans might therefore have assumed that communicable diseases such as HIV/AIDS, tuberculosis (TB) and other diseases of poverty were part of the national problems that ought to be solved.

To ensure seamless governance of the health sector in a unitary state with a quasi-federal governance structure, the national government adopted the concept of MinMECs in 1994. These political decision-making structures consisted of National Ministers and the political leaders in the 9 provincial governments responsible for the corresponding portfolio, who are known as the Members of Executive Councils (MECs) of Health in the provinces. In 1999, the Health MinMEC consisted of Minister Tshabalala-Msimang and 9 MECs of Health, of whom 7 were from the provinces under the political leadership of the ruling ANC, and 2 were from provinces governed by the IFP and the NNP. When the National Health Act 61 of 2003 was promulgated in 2004, the Health MinMEC transitioned into the National Health Council, which is provided for in the new legislation, with the same membership as the previous Health MinMEC.

The second phase of the evolution of the PMTCT policy commenced in 2008, the last year of the Mbeki Administration, which saw the President being recalled by the ruling party in September 2008. The National Core Standards policy process occurred in 2011, during the Presidency of Mr. Jacob Zuma, with Dr. Aaron Motsoaledi being the Minister of Health. However, preliminary work on the National Core Standards policy, including the piloting of standards, had commenced during the term of office of Minister Tshabalala-Msimang. This is reflected in detail in Chapter 6 of this study.

The National Core Standards policy was produced in 2011, when the South African health system was under the leadership of Dr. Aaron Motsoaledi as Minister and Dr. Molefi Paul Sefularo as Deputy Minister, both of whom were members of the ANC, which had emerged victorious in both the 1994 and 1999 national elections. Motsoaledi, a medical doctor by profession, had previously held various portfolios in Limpopo Province, including Education and Agriculture. Minister Motsoaledi had been deployed by the ANC to lead the national health system which was in a crisis, resulting both from a decade and half (1994-2008) of AIDS denialism under Mbeki, as outlined later in Chapter 6, and because of widespread concerns about poor quality of care in the public sector. When he assumed office in 2009, Motsoaledi committed himself to the implementation of a 10-Point Plan for strengthening the health system, which had been adopted by the ruling party and government as a roadmap, after extensive research work done by the Development Bank of South Africa (DBSA) in 2008. In the foreword to the three-year Strategic Plan of the National Department of Health (DoH) for the three-year period 2010/11-2012/13, Motsoaledi stated that the 10-Point Plan was aimed at "creating a well-functioning health system capable of producing improved health outcomes" (DoH, 2010b, p. 3).

The priorities in the 10-Point Plan 1999-2004 were as follows: (a) Provision of strategic leadership and creation of a social compact for better health outcomes, (b) Implementation of National Health Insurance (NHI), (c) Improving the quality of health services, (d) Overhauling the health care system and improving its management, (e) Improving Human Resources Management, Planning and Development, (f) Revitalisation of infrastructure, (g) Accelerated implementation of HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increasing focus on TB and other communicable diseases, (h) Mass mobilisation for better health for the population, (i) Review of the Drug Policy, and (j) Strengthening research and development. The political mandate for the development of the National Core Standards Policy was buttressed by the 10-Point Plan.

4.3. Decision-making within the ruling ANC

The documentation of the ruling party in South Africa, the ANC, indicates that the organisation has a Deployment Committee, which is a subcommittee of the National Executive Committee (NEC), and which is chaired by the Deputy President of the organisation, David Mabuza (ANC, n.d. a). The Deployment Committee consists of 8 senior members of the organisation, as well as all secretary-generals of leagues (Women's League, Youth League, and Veterans' League), as well as the Alliance Representatives (ANC, n.d. b). A former President of the ANC explained in 2019 that there was a deployment committee in the ANC because it was the ruling party, and that Ministers used this committee for recommendations for deployments (Ntsabo, 2019). The former President also stated that this Committee helped the government to make candidates available, to look at specific people, and finally that the deployment committee did not necessarily appoint, but only made recommendations (Ntsabo, 2019). This implies that policy-makers have to be loyal to the party that deployed them in government. The process of "reshuffling" occurs frequently in South Africa when there is a disregard of the resolution and decisions of the ruling party.

A construct that has emerged from the literature on the constraints facing policy-makers is that they work in a context of 'bounded rationality' (as noted in Chapter 2). In South Africa, the first aspect of bounded rationality that impacts on policy-making processes is that policy-makers are political deployees who are guided by and loyal to the prescripts of the party that runs government.

4.4. The Judiciary

Constitutionally, South Africa has had an independent judiciary since 1994, serving as a third arm of the state, with the executive (Cabinet) and the legislature (Parliament) being the other two arms. As the Department of Justice (DoJ) states, the Constitutional Court is the "highest in South Africa on constitutional matters, and was born out of the country's first democratic Constitution in 1994. The Constitutional Court only makes decisions about issues that have to do with the Constitution. It is also the highest court in the land since its decisions cannot be changed by any other court" (DoJ, 2022). Below the Constitutional Court lies the Supreme Court of Appeal, based in Bloemfontein in the Free State. This is the second highest court in South Africa, which only deals with cases sent to it from the High Court. South Africa also has High Courts, previously known as Supreme Courts, which listen to cases that are

“too serious for the Magistrate’s Court or when a person or organisation goes to the court to change a decision of a Magistrate’s Court, which means appealing a case” (DoJ, 2022).

It is imperative to emphasise that South Africa’s constitution prescribes the separation of powers between the three arms of the state, namely cabinet, parliament, and the judiciary. As will be shown in Chapter 6, the judiciary played a critical role in ensuring that government implemented a national PMTCT programme, beyond the original 18 pilot sites.

4.5. Organisation of health care services

In 1994, the new democratic government of South Africa inherited a fragmented, inequitable, racially segregated, predominantly curative, and hospital-centric health system with a quadruple burden of disease. The public health sector consisted of 14 previous Departments of Health, 10 of which belonged to homeland administrations and 4 of which were previous provincial administrations that were part of White South Africa.

In 2023, the South African health system is dichotomous, consisting of the public and the private health sectors. The public sector comprises 9 Provincial Departments of Health (DoHs), 52 health districts, and 3880 health facilities. As at the midpoint of 2022, Statistics South Africa (StatsSA) estimated the country’s population at 60,6 million (Maluleke, 2022). For the year 2021, StatsSA estimated that the public sector served 83,9% of the population, and the private health sector served only 16,1% of the population, who, with their families, are members of Medical Aid Schemes (StatsSA, 2022). Health is a concurrent function between the National DoH and the 9 Provincial DoHs. ‘Municipal Health Services’ are the responsibility of Local Government. These include environmental health services and non-personal personal Primary Health Care (PHC) (i.e. prevention and promotion).

4.6. Critical health policy developments since 1994

The Reconstruction and Development Programme (RDP) of 1994 (ANC, 1994), which was the cornerstone for the transformation of South Africa into a non-racial and equitable society, envisioned a unified National Health System, working towards better-quality health for all in South Africa. Consistent with the RDP of 1994, the democratic government developed a plethora of pro-poor policies and legislation, inclusive of free healthcare for children under the age of six and pregnant and lactating women, later expanded to free PHC for all citizens, and an extensive clinic building and upgrading programme in rural areas and informal settlements.

Other key policies that are pertinent to this study include the White Paper on the Transformation of the Health System of 1997, the National Health Act 61 of 2003 and the Green Paper and White Paper on National Health Insurance (NHI) in 2011 and 2017, respectively. The NHI provides for a policy framework to ensure universal access to healthcare for all South Africans irrespective of their ability to pay.

This study explored why and how certain forms of evidence are used in health policy development in South Africa, and recognised that the use of evidence requires an interface between the producers (researchers, sector experts, and routine monitoring experts) and the users of the evidence (policy-makers). In the 1997 White Paper, the National DoH made an explicit commitment to an inclusive process of developing a new research agenda for the country, in collaboration with all key role players. The White Paper for the Transformation of the Health System (1997) stated that “the research agenda should be developed to address the country's major health problems and initiate a process involving scientist decision-makers and population representatives as equal, inclusive partners... the process of setting priorities should be all-inclusive and allow all role-players jointly to determine the agenda... The major role-players are community researchers and health service providers. The process should identify the research agenda that will address the country's health problems” (DoH, 1997, pp. 53-54). The 1997 White Paper therefore bound the health sector to three important goals: (a) including the research community in setting the research agenda, as equal partners, (b) using evidence for information-based decision-making, and by extension evidence-based policy-making, and (c) transforming the national sphere of the health system into a learning organisation. this study used the two tracer policies to examine the extent to which these noble objectives were achieved and whether this has strengthened the use of evidence in policy development in the health sector.

Seven years after the White Paper, the National Health Act 61 of 2003 was promulgated. This legislation buttressed the goals of the White Paper of 1997 and made provision for the creation of a National Health Research Committee (NHRC) to advise the Minister on health research priorities. Section 70(1) of the National Health Act 61 of 2003 states that “the National Health Research Committee must identify and advise the Minister on health research priorities”. The NHA of 2003 further indicated that the NHRC must (among others) ensure that health research agendas and research resources focus on priority health problems. The NHA of 2003 also made provision for the creation of a National Health Research Ethics Council (NHREC). The objectives of the NHREC are, among others, to: determine guidelines for the functioning of health research ethics committees; set norms and standards for conducting research on humans and animals, including norms and standards for conducting clinical trials; and advise the national department and provincial departments on any ethical issues concerning research. However, despite the existence of policies, legislation, and structures, the processes by which research findings inform policy-making processes remain undocumented and unclear.

4.7. Role of civil society in the health system

Civil society organisations in South Africa have also played a pivotal role in the struggle for better quality health services for all. In the first decade of democracy, civil society joined the South African government in the legal battles against the pharmaceutical industry, aimed at making essential medicines affordable and accessible. Also in the first decade of democracy, during the period of AIDS denialism in the country, civil society advocated for a rational and scientific response to the AIDS pandemic, based on a simple treatise that HIV causes AIDS, and that the provision of antiretroviral therapy (ART), including a nevirapine-based PMTCT

programme, was an essential component of the country's response. In advocating for the national scale-up of the PMTCT policy and programme in 2001 and 2002, civil society formations worked in alliance with academic and research institutions, as well as independent scientists and acclaimed HIV researchers. This is discussed in detail in Chapter 6.

4.8. Commitments towards collaboration between health policy-makers and researchers in the democratic South Africa: An historical perspective

In 2006, the national sphere of the health system convened a national conference on priority setting for health research, which identified key research priorities to be pursued by the leading research institutions in the country, including: the Medical Research Council (MRC), the Human Sciences Research Council (HSRC), the Council for Scientific & Industrial Research (CSIR), academic institutions, and research organisations. During that period, I was a Director for Strategic Planning in the national sphere of the health system and followed the outcomes of the conference closely. Although there were no contractual obligations that were entered into, the conference agreed on a set of key priorities to be pursued by each research institution. A defined process of translating research findings into government policy was not adopted at the conference.

In July 2011, five years after the first conference, the national sphere of the health system and the National Health Research Committee (NHRC) convened a National Health Research Summit, which attracted over 300 researchers from Clinical, Biomedical, Epidemiological and, although fewer, HPSR backgrounds, drawn from academic institutions, research institutions, and NGOs. The aims were to conduct a SWOT analysis of research for health in South Africa and identify health research priorities for South Africa.

During this period, I was a Chief Director for Health Information Management, Monitoring and Evaluation and Research (HIMMER) in the national sphere of the health system. The HIMMER Cluster worked with the NHRC chaired by the late Prof. Bongani Mayosi, an academic and researcher at UCT, in the planning of the research summit, and also funded it. The 2011 National Health Research Summit identified several challenges, including the following:

- (a) Shortage of human resources for health research in South Africa, especially black South Africans and women, with a far lower associated research production than the world average for a middle-income country (Mayosi et al., 2011).
- (b) Virtual absence of national planning, coordination, and translation of research into health innovations, policy, programmes, and practice, and inadequate alignment of the funding programme of the MRC to achieve the health outcomes of the country (Mayosi et al., 2011).
- (c) Several recommendations were made for addressing the identified challenges, which included progressively increasing levels of funding by government, doubling the number of researchers over the next 10 years, and creating a National Priority Health Research Fund (Mayosi et al., 2011).

One of the concrete outcomes of this conference was the development of a PhD scholarship programme focusing on health research, funded by the national sphere of the health system, and managed by the MRC, on behalf of the department. In June 2020, the department reported to DPME that since the onset of the PhD programme in 2013, a total of 120 postgraduate students had been funded, of which 44 had graduated with PhD degrees, 7 with MSc degrees, and 27 were still being funded.

4.9. Conclusion

This chapter has sketched a brief background of the South African political and governance system, the organisation of the health system, and the context in which the policy process cases examined in this study, the PMTCT policy and programme and the National Core Standards policy, were developed. The chapter has also reflected the commitments made by the democratic government to ensure collaboration between health policy-makers and researchers.

CHAPTER 5: POLICY-DEVELOPMENT PROCESSES IN THE SOUTH AFRICAN PUBLIC HEALTH SECTOR

5.1. Introduction

This chapter presents the findings from Phase 1 of the study, which examined policy formulation processes in the South African public health sector and sought to depict the stages of formal policy-making processes. Phase 1 also sought to identify the types and sources of evidence that inform these processes.

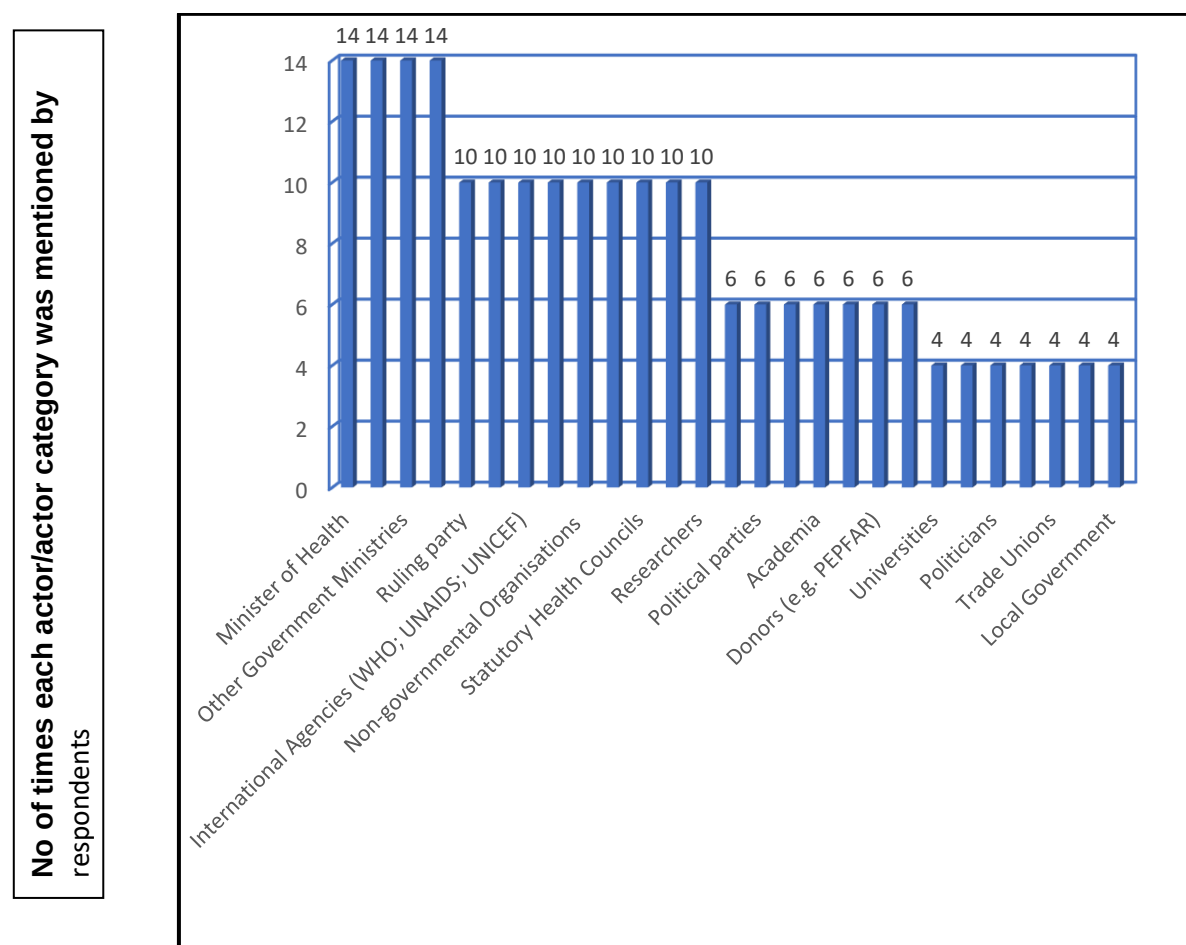
Drawing on my own tacit knowledge, validated through initial interviews, the chapter firstly identifies the key actors involved in the South African national health policy formulation processes as part of understanding their complexity. Secondly, it presents the steps in the national health policy formulation process, and then, thirdly, it considers how various non-state actors influence these processes, although not formally involved within them.

In this presentation, the perspectives of the different groups of respondents are purposefully contrasted to reflect different experiences and insights. I also clarify when I present my own perspectives, noting similarities and differences of view in relation to, and among, the respondents.

5.2. Key actors in the formulation of National Health Policy in South Africa

During **Phase 1**, key informants in this study, from both government and the HPSR community, identified a total of 27 different categories of **key actors and groups of actors** influencing health policy development in South Africa. These were: the Minister of Health, National Health Council, other Government Ministries, National DoH, Ruling Party, Parliament, International Agencies (WHO, UNAIDS, UNICEF), Civic Organisations, NGOs, Health Professionals, Statutory Health Councils, Private Sector, Researchers, Cabinet Of South Africa, Political Parties, Media, Academia, Patient Groups, Donors, Local Communities, Universities, Provincial DoHs, Politicians, Tripartite Alliance, Trade Unions, Civic Leaders, and Local Government. **Figure 5.1.** below summarises key informant responses, indicating the frequency with which different actors were identified by respondents.

Figure 5.1: Key Actors in National Health Policy Development in South Africa



Source: Drawn by the researcher from 15 key informant responses, both policy-makers and researchers

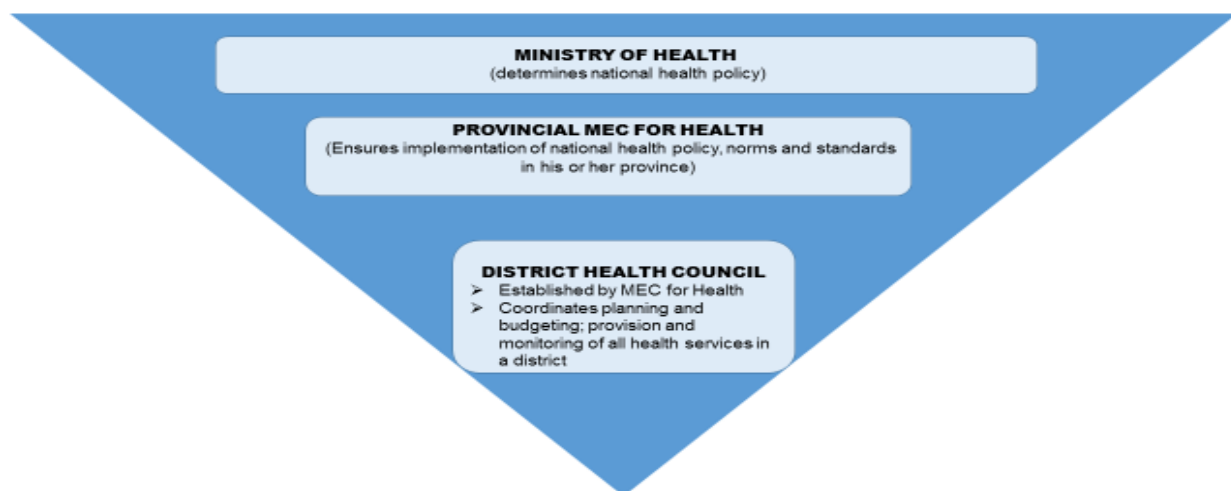
Overall, respondents from the provincial sphere of the health system identified a total of 20 key actors in health policy-making, while the key informants from the national sphere of the health sector and researchers identified 10 categories of actors each. Researchers identified a total of 14 policy-maker groups. This difference between respondents might reflect the fact that the provincial sphere of the health system is responsible for the coalface of service delivery, and thus interacts with far more stakeholders than their national counterparts.

As reflected in **Figure 5.1**, four categories of actors were most frequently identified across respondent groups, suggesting that they are recognised as particularly influential in health policy formulation in the country. These were the Minister of Health, the National Health Council (NHC), other Government Ministries (e.g. National Treasury and the Department of Public Service and Administration), the National DoH, and the ruling ANC. The identification of the Minister of Health, the NHC, and the national sphere of the health system as key role players in health policy-making in the country reflects the distribution of formal power in policy development. Indeed, the legislative framework in South Africa distributes the authority to determine

policy in what **Figure 5.2.** below suggests is an “**inverted pyramid**”, whereby power is concentrated at the national level, while subnational levels are assigned responsibilities mainly for policy implementation (not policy development). In terms of the Constitution of the Republic of South Africa, Act 108 of 1996, health services are a functional area of concurrent national and provincial legislative competence. However, the National Health Act 61 of 2003 provides a further delineation of the roles of the different spheres of government. This Act assigns the responsibility to determine policy to the Minister of Health. Section 3(1)(c) of the Act empowers the Minister to “**determine the policies and measures necessary to protect, promote, improve and maintain the health and well-being of the population**”. All respondents interviewed converged around the fact that the Minister of Health is the policy champion or major sponsor in national health policy development.

With respect to provinces, Section (25)(1) of the National Health Act 61 of 2003 assigns responsibility to the Member of the Executive Council (MEC) for Health (equivalent to provincial Minister of Health) to “**ensure the implementation of national health policy, norms and standards in his or her province**”. This is also reflected in **Figure 5.2.** below. The District Health Council, finally, is supposed to drive district-level coordination of service provision, though these councils are not yet well established or fully functional in all provinces.

Figure 5.2: Cascade of authority for health policy-making in South Africa, in terms of the National Health Act of 2003: The inverted pyramid



Source: Derived from the National Health Act 61 of 2003; design by the researcher and reviewed by the thesis supervisor

The implications of the inverted pyramid are that the Ministry (and Minister) of Health has the ultimate powers in national health policy formulation. However, the Ministry is cognizant of the fact that policy implementation happens in provinces, and that Provincial MECs for Health and Heads of Department (HoDs) must be key allies, if successful policy implementation is to be achieved. The National Ministry of Health has therefore adopted a collaborative policy development process, through the National Health Council (NHC), in which Provincial DoHs, the South African Military Health Services (SAMHS), and the South African Local Government Association (SALGA) participate. Respondents from the provincial sphere of the health system stated that it was progressive that provincial representatives participated in national policy development processes, as they are closer to the ground than the national policy-makers and have more experience of community issues and concerns.

There is widespread recognition across respondents that actors outside government play important roles in influencing the policy agenda *prior* to a policy issue entering the formal policy-making processes. Key informants from the provincial sphere of the health system suggested that civil society structures are the main policy influencers outside government, particularly NGOs with a national footprint and Community-based Organisations (CBOs). Respondents perceived these structures as being in touch with communities on a daily basis and as most often being directly affected and afflicted by a particular issue. They also suggested that alliances were often established between civil society formations and researchers, through which evidence is shared and used for problem identification and agenda setting, which entails community and stakeholder mobilisation. However, with respect to NGOs, once a policy issue enters the formal policy-making processes in the National Health Council (previously the Health MinMEC), the role of the NGOs becomes less prominent, as the subsequent steps in policy-making are driven by technocrats and bureaucrats within the health system. Major policies are, however, published for public comment for a 90-day period, allowing other actors to make inputs.

Senior bureaucrats from the national sphere of government who were interviewed expressed concern that in the current set-up, communities were not directly involved in formal policy-making. These bureaucrats believed that ordinary South Africans are still disempowered or inactive and do not contribute meaningfully to formal health policy-making processes. These respondents further asserted that information on policies under development was not readily made accessible to community members or ordinary citizens, in a manner that enlists meaningful contributions from communities. As one national respondent noted:

"I think often people have said that that the [policy] triangle would not be complete if in the centre we don't have communities, you know. Even though in practice I don't think we synthesise a lot from communities as much as we do from organised civil society formations" (senior bureaucrat, national sphere of the health system).

Referring specifically to the development of the national drug policy, the key informant continued:

“The public, interestingly, were presented with the information in a manner which didn’t help them make up their minds, so despite the information we presented in the media, the complexity of the information and the interplay of the different interests did not garner the public support that one would have thought would have come through because this is a purely beneficial policy to the general public. So you would’ve thought South Africans in their numbers would have argued through radio, TV, writing letters to the media to say we think that this is a great policy we going to have huge benefits from it. But largely because they clearly did not understand the benefits to themselves and sometimes they feel disconnected from the policy process that they have no role in that process...” (senior bureaucrat, national sphere of the health system).

Key informants from the provincial sphere of the public health sector positioned communities as important role players in health policy-making processes. This was by virtue of the fact that they were consulted during policy-making processes. However, communities and civil society organisations do not have a formal role in these steps once an issue is brought onto the formal agenda of the health sector. This is despite the fact that these actors were identified as key actors in policy-making (see **Figure 5.1**). Various United Nations (UN) agencies were identified by respondents as influencing policy-making processes in South Africa, including the WHO and United Nations Joint Programme on AIDS (UNAIDS). These agencies were seen as playing a major role in the development of new health policies or the amendment of existing policies, as is further discussed in Chapter 6 examining the experience of the PMTCT policy.

While the respondents from the provincial sphere of the health system concurred with their national counterparts about the role of UN agencies in policy-making, they also expressed exasperation that at times the policies and guidelines of the UN agencies are imported by the national sphere of the health system and implanted in South Africa without local realities being fully considered. All six HoDs interviewed were unanimous on this sentiment and were not only considering the PMTCT policy. HPSR researchers interviewed also concurred with respondents from the provincial sphere of the health system that the views of UN agencies were at times blindly accepted in the country. One researcher stated that:

“What I mean by that is that WHO will say something and then we will just implement it and we’ll follow it, and WHO has been critiqued for not necessarily making the most evidence-based policy. In the past it was a very expert driven, driven by experts which is sometimes more anecdotal than evidence-based. So just because WHO says you should do something, doesn’t mean it’s a good idea...The relationship between WHO and National Department, and particularly, I mean you know WHO makes very generic type of policy for lower- [and] middle-income countries, and South Africa is sometimes quite different actually” (HPSR Researcher)

Thus, while the contribution of UN agencies to policy-making and health programme design is appreciated by the national sphere of the health system, the provincial sphere would like this to be adapted to the local contexts and their unique features. Researchers also caution against wholesale importation of policy proposals from the WHO and other UN agencies.

5.3. Formal policy formulation processes in the South African public health sector

The national policy formulation process within the National Department of Health (DoH) is outlined in Figure 5.3, drawing on my insider knowledge. This excludes the development of legislation, which goes through a different process that includes presentations to the Social Protection and Human Development Cluster, consisting of Directors-General (DGs) from social policy departments, Cabinet Committees, Cabinet, and Parliament.

This is a **formal and top-down** process that starts with the identification or acknowledgement of a policy gap by a Chief Director or a DDG in charge of one of the Branches of the Department. Across government departments in South Africa, including the National DoH, a branch consists of several Chief Directorates. The gap could have been identified during the implementation of current health policies, health programmes, or interventions or from a need to produce a local adaptation of the policies of the UN. A branch could also receive a directive from the DG to develop a certain policy to address an identified gap. Provinces also have their own processes of policy formulation.

The responsible National DoH Branch produces a submission to the DG in which a new or amended policy is proposed. The policy proposal should outline the policy intent, expected health benefits for all South Africans, the financial, legal, social, and political implications of the proposed policy, the source of funding, and the administrative capacity of the health sector to implement, monitor, and report on this policy. Once the draft policy has been approved for circulation by the DG, the National DoH Branch circulates the draft policy to members of senior management for comment, and requests feedback within a specified time frame. Senior management consists of Directors, Chief Directors, DDGs, and the DG. The draft policy is also presented to a meeting of the National DoH management committee for discussion.

Once the policy thrust has been approved by the management committee, the National DoH Branch obtains approval from the DG to present the draft policy to the TECH-NHC. The TECH-NHC is established in terms of Section 23 (5) of the National Health Act of 2003, which empowers the NHC to create one or more committees to advise it on any matter. The TECH-NHC consists of the DG of the national sphere of the health system and the nine HoDs from the provincial sphere of the health system. It provides technical advice to the NHC.

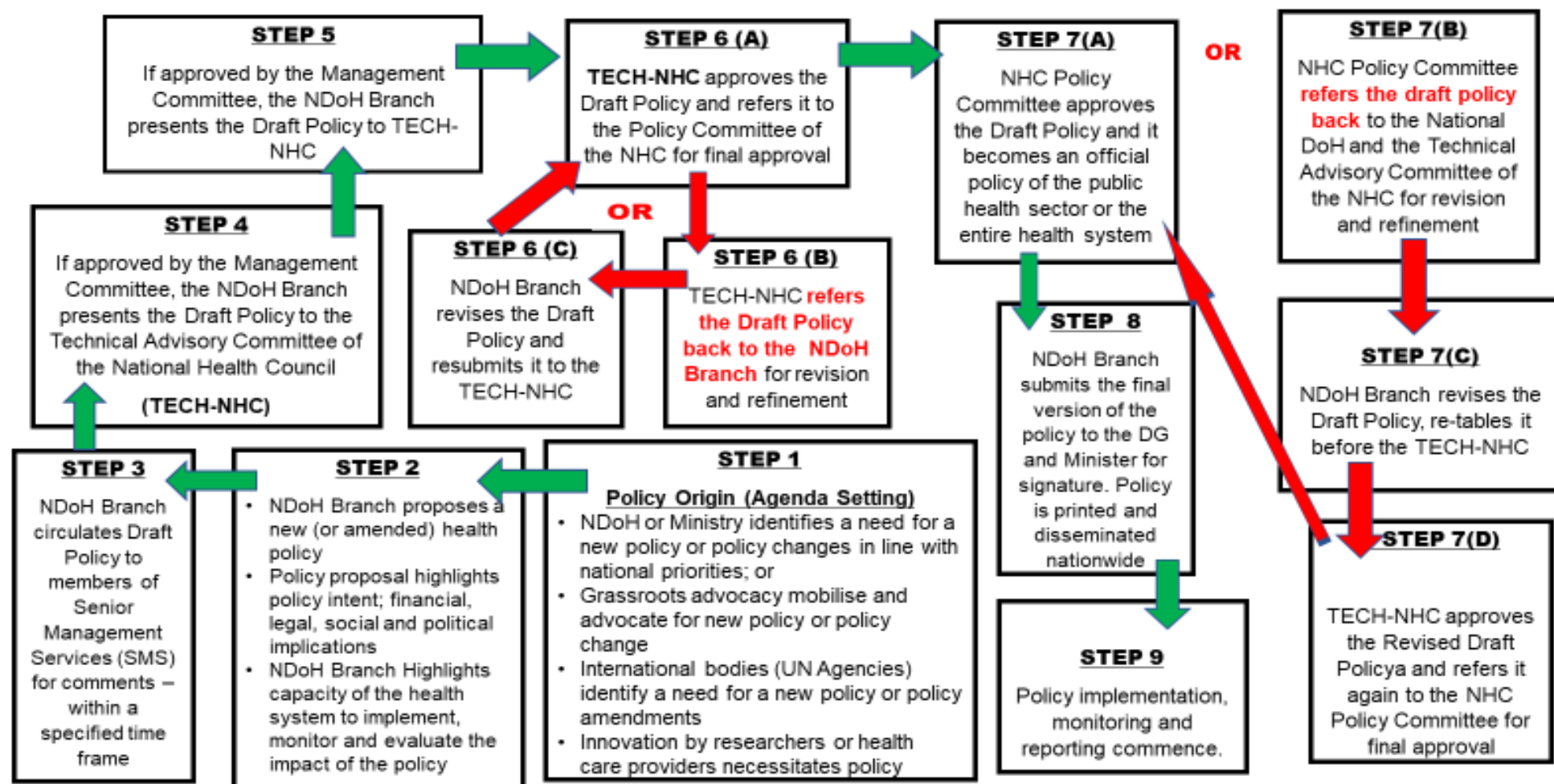
The TECH-NHC can either approve the draft policy for submission to the Policy Committee of the NHC for final approval or refer it back to the National DoH for further refinement. If the draft policy is referred back to the Department, the relevant Branch will revise the policy and re-submit it to the TECH-NHC at a later stage. If the TECH-

NHC approves the draft policy, it then refers it to the Policy Committee of the NHC, which consists of the Minister of Health and the nine Provincial MECs for Health. The NHC Policy Committee can either approve the draft policy or refer it back to the National DoH and TECH-NHC for further refinement. If the Policy Committee approves the draft policy, it becomes an official policy of the public health sector or entire health system, depending on whether it applies to the public sector only or is applicable to the private sector too. The relevant National DoH Branch submits the final version of the policy to the DG and the Minister for signature. The policy is printed and circulated throughout the health sector. Policy implementation commences, coupled with monitoring and reporting to the Technical and Policy Committees of the NHC on progress.

If the Policy Committee of the NHC refers the draft policy back to the Department and the TECH-NHC, the relevant Branch will revise the policy and subsequently re-submit it to the TECH-NHC. The TECH-NHC will review and approve the revised draft policy and refer it once more to the NHC Policy Committee for final approval. If the Policy Committee approves the draft policy, the process outlined above then unfolds. This implies that the relevant National DoH Branch will submit the final version of the policy to the DG and the Minister for signature. The policy is printed and circulated throughout the health sector.

As an “insider-researcher”, I developed a graphic representation of the key steps involved in the development of national health policy in South Africa, led by the Ministry of Health, based on my insider knowledge of the health system. **Figure 5.3.** below reflects the pathways to policy formulation in the national sphere of the health system.

Figure 5.3. Pathways to Policy-Formulation in the Public Health Sector



Source: The diagram (**Figure 5.3.**) was designed by myself based on insider-knowledge; as well as continuous review and inputs from the thesis supervisor. The legend to this figure is on the next page.

Legend to Figure 5.3.

- A *Branch* is a component of the National DoH headed by a Deputy Director-General (DDG) who reports to the Director-General (DG) of Health. The DG is the equivalent of the Permanent Secretary for Health in other countries.
- Senior Management Services (SMS) in the South African context refers to Directors; Chief Directors; DDGs and DGs of government departments.
- The *Technical Advisory Committee* of the public health sector is the senior most management structure of the public health sector. It consists of the National DG of Health; Provincial Heads of Department (HoDs) of Health; South African Military Health Services (SAMHS) and the South African Local Government Association (SALGA);
- The *National Health Council (NHC)* is a political structure chaired by the Minister of Health, which comprises the MECs for Health in the 9 Provinces; DG of Health, Provincial HoDs of Health, SAMHS and SALGA;
- **Green arrows** reflect a progressive movement of a draft policy throughout the stages of policy-making in the TECH-NHC and fully-fledged NHC.
- **Red arrows** reflect a decision by the TECH-NHC and the NHC to refer a draft policy back to the National DoH supervisor.

The initial schematic representation of the national policy-making process was validated through discussion with key informants, that is, the DDGs in the national sphere of the health system. DDGs have authority in this process by virtue of the fact they are the heads of the Branches that undertake the technical work to produce draft health policies for consideration by the health sector.

Although the depicted process is largely accepted, two further steps were noted:

- (a) If the policy proposed by the health sector has financial implications, such as hospital user fees, National Treasury has to be consulted.
- (b) If the proposed policy has major implications for Human Resources for Health, then the concurrence of the Department of Public Service and Administration (DPSA) must be obtained.

The diagram was then adjusted as reflected in **Step 5A in Figure 5.4 below**.

Key informants from the research community acknowledged that the policy-making processes in the public health sector are well structured and commence within the national sphere of the health system. They then proceed with the submission of the draft policy to the NHC, and in an iterative manner culminate in policy approval by the NHC.

As reflected in **Step 3 in Figure 5.4**, once approval has been obtained, the responsible National DoH Branch circulates the draft policy to members of senior management for comment, and requests feedback within a specified time frame. The draft policy is also presented to a meeting of the National DoH management committee for discussion. Once the policy thrust has been approved by the management committee, the National DoH Branch obtains approval from the DG to present the draft policy to the TECH-NHC. This was established in terms of Section

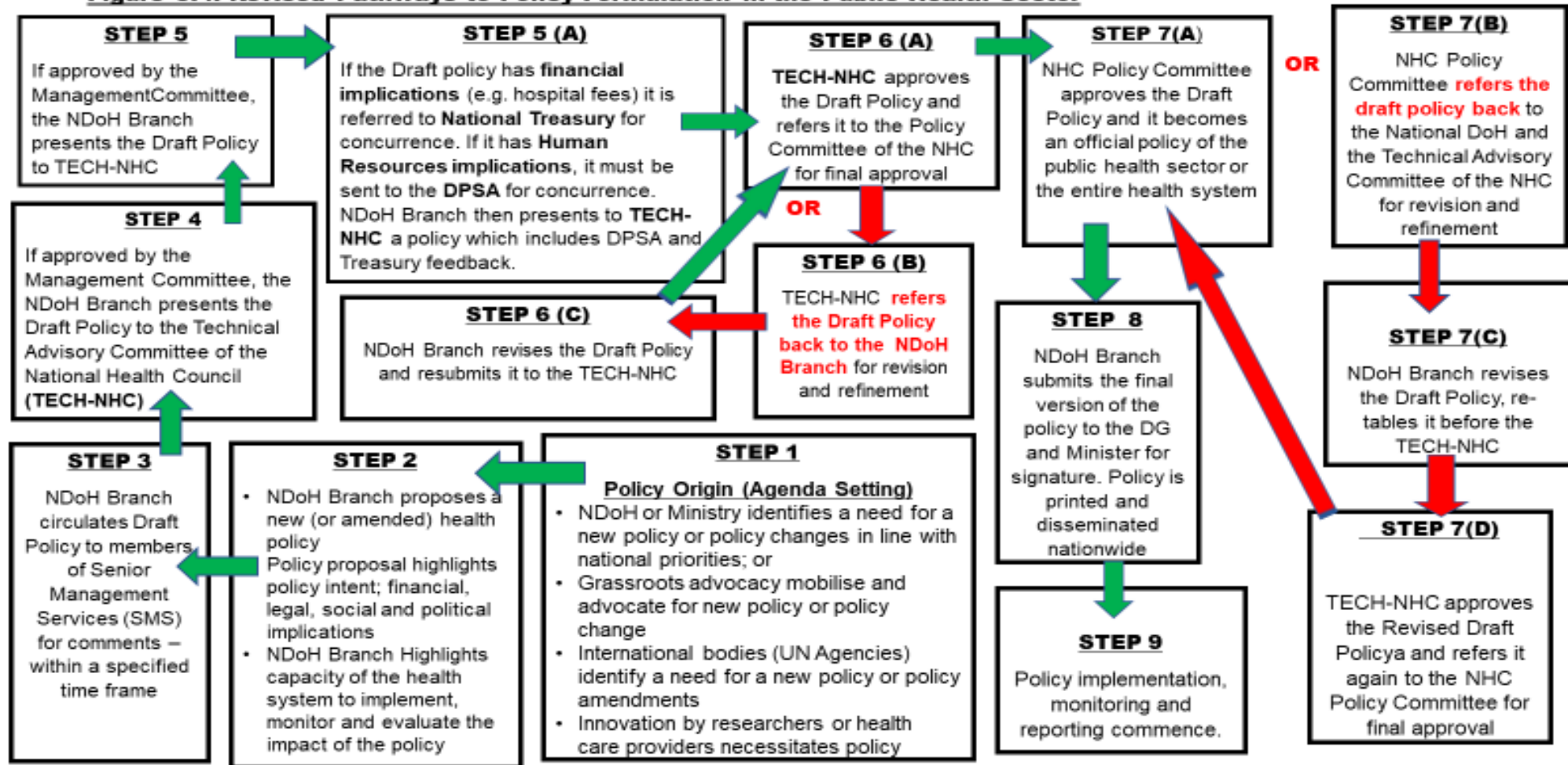
23 (5) of the National Health Act of 2003, which empowers the NHC to create one or more committees to advise it on any matter. The TECH-NHC consists of the DG of the national sphere of the health system and the nine HoDs of the provincial sphere of the health system. It provides technical advice to the NHC. As already indicated, if the proposed policy has financial implications, it is referred to Treasury, and if it has Human Resources implications, it is referred to the DPSA.

The TECH-NHC can either approve the draft policy for submission to the Policy Committee of the NHC for final approval, or refer it back to the National DoH for further refinement. If the draft policy is referred back to the Department, the relevant Branch will revise the policy and re-submit it to the TECH-NHC at a later stage. If the TECH-NHC approves the draft policy, it then refers it to the Policy Committee of the NHC, which consists of the Minister of Health and the nine Provincial MECs for Health.

The NHC Policy Committee can then either approve the draft policy or refer it back to the National DoH and TECH-NHC for further refinement. If the Policy Committee approves the draft policy, it becomes an official policy of the public health sector or entire health system depending on whether it applies to the public sector only or it is applicable to the private sector too. The relevant National DoH Branch submits the final version of the policy to the DG and the Minister for signature. The policy is printed and circulated throughout the health sector. Policy implementation commences, coupled with monitoring and reporting to the Technical and Policy Committees of the NHC on progress.

If the Policy Committee of the NHC refers the draft policy back to the Department and the TECH-NHC, the relevant Branch will revise the policy and subsequently re-submit it to the TECH-NHC. The TECH-NHC will review and approve the revised draft policy and refer it once more to the NHC Policy Committee for final approval. If the Policy Committee approves the draft policy, the process outlined above then unfolds, and the final version of the policy is approved. All steps are again reflected in **Figure 5.4 below**.

Figure 5.4. Revised Pathways to Policy-Formulation in the Public Health Sector



Source: The diagram (Figure 5.4.) was designed by myself based on insider-knowledge; as well as continuous review and inputs from the thesis supervisor

Legend to Figure 5.4.

- A *Branch* is a component of the National DoH headed by a Deputy Director-General (DDG) who reports to the Director-General (DG) of Health. The DG is the equivalent of the Permanent Secretary for Health in other countries.
- Senior Management Services (SMS) in the South African context refers to Directors; Chief Directors; DDGs and DGs of government departments.
- The *Technical Advisory Committee* of the public health sector is the senior most management structure of the public health sector. It consists of the National DG of Health; Provincial Heads of Department (HoDs) of Health; South African Military Health Services (SAMHS) and the South African Local Government Association (SALGA);
- The *National Health Council (NHC)* is a political structure chaired by the Minister of Health, which comprises the MECs for Health in the 9 Provinces; DG of Health, Provincial HoDs of Health, SAMHS and SALGA;
- **Green arrows** reflect a progressive movement of a draft policy throughout the stages of policymaking in the TECH-NHC and fully-fledged NHC.
- **Red arrows** reflect a decision by the TECH-NHC and the NHC to refer a draft policy back to the NDoH.

5.4. National dominance and National-Provincial DoH Contestations

Some respondents emphasised that the national sphere dominates the policy formulation process. However, in terms of the National Health Act 61. of 2003, Provincial DoHs are part of the national policy-making processes. At a political level, MECs for Health constitute the NHC together with the Minister and Deputy Minister of Health. At the technical level, Provincial HoDs of Health are members of the TECH-NHC and also attend the fully fledged NHC to support their MECs. Against this backdrop, and based on my personal observations of the vigorous debates that occur during policy-making processes in the TECH-NHC and NHC, this study sought to examine the causes of contestation about policy priorities between the national and provincial spheres of the health system. According to key informants from the national sphere of the public health sector, a reason for contestations was uncertainty on the part of subnational spheres of government arising from the fear that new policies may necessitate changes in the organisation of work in the provinces. National respondents argued that provinces rarely contested policies based on the evidence that informed a particular policy. As one national policy-maker stated:

“Contestation is usually based on a particular structure or arrangement and any policy proposal that upsets the current arrangement will bring uncertainty to the system, to the individuals and so based on that, there is then contestation linked to that and I think much of what we have had to do, is try and reassure people that the change in policy is not intended to bring uncertainty to themselves, but to improve the system... I have yet to have a contestation where a provincial department brings evidence of an alternative approach to the delivery of care than that being proposed, so

that our discussion is at that level about the evidence, and what the evidence shows and whether the policy is linked to the evidence” (senior bureaucrat, national sphere of the health system).

However, my own observation is that when new policies arise, the reaction of provinces can be classified into two categories, namely: (a) provincial DOHs support, adopt, and implement the new policy, and (b) provincial DOHs modify the proposed new policy and implement an amended version appropriate to their own context and working environment. The reaction of provincial DOHs depends on the policy proposals at hand. Key respondents from the HPSR community concurred with my observations, and stated that it was not helpful for the national sphere to suggest that all provincial departments resist policy proposals on the basis of uncertainty or lack of resources; instead, as I have observed, departments look at the feasibility of the new policy proposed in their own settings. My own observations from the NHC and TECH-NHC are that divergent views between provincial DOHs and in relation to the national sphere result in compromises needing to be made to secure sufficient consensus to enable adoption of the new policy proposal.

Responses from the provincial sphere of the health system about policy contestations can be categorised into two broad strands: (1) the perspective that there are **no contestations** between the national and provincial spheres of the health system, and (2) the view that there are **serious contestations** between the national and provincial spheres.

Perceived ideological coherence within the ruling party seemed to be the fundamental anchor of the viewpoint that there were **no** contestations. Proponents of this view contended that both the national and provincial spheres of the health system were implementing policies of the same ruling party in South Africa, the ANC, which were processed through the NHC, a collective decision-making structure. However, richer perspectives emanated from those who identified major contestations in policy-making. The first reason for contestation advanced was that the national sphere of government has a tendency of handing priorities down to provinces without providing the necessary resources to ensure successful policy implementation. The cascading of nationally-driven policies to provinces without supportive funding for implementation leads to these policies being ‘unfunded mandates’. Also, provinces have a better understanding of the realities on the ground .

The second reason related to the piloting of new programmes. Concerns were articulated that the national sphere of the health system tended to develop pilot programmes, fund them for a limited pilot period, and then expect provinces to take these over, again creating unfunded mandates. This issue is discussed in detail in Chapter 7, which presents findings about the development of the National Core Standards policy. The third reason cited was that the national sphere has a proclivity to appoint senior managers on contract at provincial level for each vertical programme, at Chief Director level. This practice not only bloats the Provincial Head Offices, whereas actual implementation occurs at district level and below, but again entails the expectation that provincial DOHs will fund the posts, which compounds the challenge of unfunded mandates. Another sentiment expressed by some provincial policy-makers was that the national sphere of the health system should

refrain from 'micro-managing' provinces, and focus on its strategic leadership role in the health system. One key informant from the provincial sphere, in a province governed by the ruling ANC, stated:

"There is a tendency by the National Department who want to do what we do. Remember provinces are responsible for implementation...National is responsible for stewardship, really guidance and support and probably even development of regulations or policy development. Now every time there is an emerging crisis in the health sector, or an emerging problem... they have a tendency, should I say a tendency to want to also do implementation. There are many examples I can give you. They need to monitor but they can't interfere" (senior bureaucrat, national sphere of the health system)

Coincidentally, this view of provincial disempowerment was shared by several managers from the provincial sphere of the health system. The HPSR researchers concurred with this view and articulated experiences from their interactions with subnational levels of the health system around policy development process. One of the researchers stated that:

"When you talk to other people at the provincial level, they don't seem to feel like they have had much input into the finalisation of particular policies. So national tells them, national decides and they have to follow that or implement it. So we did look specifically at one of the areas where that came out, one was in the study we did on the occupational specific dispensation, where it didn't seem like there was a lot of input and consultation at the provincial level and then there was a sort of national policy and the provinces were then expected to implement it. So you know, they were only really involved once the policy had already been decided at the national level, and then there were all sorts of difficulties with trying to work out what the actual national policy was, and the provinces were left to interpret that in various ways" (HPSR Researcher)

The tension around the funding of nationally determined policy priorities was also identified even by those provincial policy-makers who stated that there were **no** policy contestations between the spheres of government. These key informants expressed dissatisfaction in relation to resource allocation for the implementation of particular policies. Key respondents from the national sphere of the health system acknowledged that at times the national political leadership would announce new health policies before the commencement of the policy process. The major contestations between the two spheres of the health system were, then, not about policy content, but about the financing of new policy priorities and sequencing of policy processes. Key informants from the HPSR community used the example of the Western Cape province, which is not governed by the ruling party, to confirm that contestations about policy priorities did occur between the national sphere of government and the provincial sphere. My own observation is that while the Western Cape DOH does indeed challenge national policy where they disagree with it, once convinced by evidence to accept national policies, they implement them effectively (for instance, the Ideal Clinic Programme).

On the whole, key informants agreed that the NHC, chaired by the Minister of Health, was the platform within which consensus on policy content is developed, and in which policy contestations are addressed. One policy-maker from the national sphere indicated that if the Minister was convinced that something needed to be done, he usually took it upon himself to convince his colleagues. HPSR researchers concurred with the perceived dominance of the Ministry and the national sphere of the health system in determining national policy. Once researcher stated that:

“...Quite a lot of time it seems like the National Department already made up their mind and then there might have been a sort of more consultative process and getting input on the content, but the main decisions had already been made primarily and then there was sort of help around developing some of the detail of the policy, but the sort of big policy decisions had already been decided to some extent. So, but of course the content is in the detail, so you know that process I think in general there is at least some attempt to engage with other stakeholders. It might be province, it might be researchers or academics or international experts, local experts.” (HPSR Researcher)

5.5. Role of evidence in the development of national health policy

The consistent theme emerging from **Phase 1** of the study is that the national sphere of the health system uses evidence in the development of clinical policies and guidelines, but not in the development of health system policies. This view was expressed by all three categories of key informants, namely the national policy-makers, those from the provincial sphere of the health system, and the HPSR researchers. This suggests that the use of evidence in the formulation of national health policy is uneven, inconsistent, and policy-specific.

Although all four technical policy-makers (technocrats) from the national sphere of the health system indicated that evidence was used in national health policy development, in various ways, they noted that this applied mostly to the development of clinical policies and guidelines. Technocrats in charge of Branches that develop clinical policies (such as for TB, HIV, Maternal and Child Health, and pharmaceutical use) stated that, following international best practice, the hierarchy of evidence influenced the health sector. In other words, the first step is to look for a systematic review of relevance to a clinical intervention or guideline, and one respondent noted the department worked closely with the South African Cochrane Centre. If this cannot be found, the Department looks for a published randomised controlled trial (RCT), then an observational study or a case control study, and various case studies linked to that. Opinion pieces, newspaper articles, and anecdotal evidence are considered, scientifically, the lowest form of evidence. One of the policy-makers from the national level stated:

“So the rules about decision-making in policy, relating to evidence, is that you start at the top and move down the ladder in terms of the best evidence until you come to the point where you have evidence of an appropriate level to choose. So you don’t just start anywhere and say this is the evidence; you need to start at the top and say is there a meta-analysis relating to this issue, there isn’t one” (senior bureaucrat, national sphere of the health system).

Another policy-maker concurred, and provided an illustration:

“So if you take the HIV environment there has been a lot of local research that has guided the way in which we make policy on specific things. I’ll give you one example. When the Africa Centre together with CAPRISA did the phylogenetic study to look who is infecting who, you know to answer that question, you know we came up with that triangle of young women who are HIV positive infecting young men about the same age, who then infect much younger women” (senior bureaucrat, national sphere of the health system).

However, for non-clinical policies, the national perspective was that an evidence-informed process was a “foreign approach” to decision-making. One key informant in the National sphere of the health system stated:

“When you get into an environment where evidence-based decision-making is a foreign approach to making decisions, it becomes far more difficult to persuade people that evidence is the basis on which we must conclude this discussion, anecdotes and personal views become a dominant way of influencing policy and I think that’s... that is where it becomes very important that as a department or a sector we need to, to embrace evidence-based decision-making as a basis on which policies are developed as a rule, so in other words if I say I want to change this policy, I have to say what evidence do I have that is different from what’s there and that’s better” (senior bureaucrat, national sphere of the health system).

All six representatives of the provincial sphere of the health system interviewed were members of the TECH-NHC, which provides technical advice to the political leadership. Three different perspectives emerged from these interviews. The first, which was a minority view expressed by two respondents only, was that the national sphere of the health system does use evidence in health policy-making, although not consistently. The second and third views were equally common, expressed by four HoDs each. The second view, also reflecting national sphere respondents, was that evidence is used, but only for the development of clinical policies, not for health systems policy. The third view was that evidence was simply **not** used in the development of health policies. Two respondents suggested that this was demonstrated by the fact that the national sphere does not know that their policies are irrelevant to provinces and that the national department often develops system-wide policies on the basis of very narrow evidence from small operational research studies. These three divergent views are reflected in **Table 5.1. below**.

HPSR researchers concurred with respondents from the national and provincial spheres of the health system that evidence was frequently used in the development of clinical policies and guidelines, but less so in the development of health system policies. The PMTCT policy was cited as one evidence-based policy, as discussed in detail in Chapter 6. The role of UN agencies, such as the WHO and UNAIDS, in providing the evidence that informs the regular update of clinical guidelines was specifically highlighted. One researcher stated:

“So there’s any number of examples on that, for example HIV treatment guidelines are updated on a regular basis by WHO and usually South African government follows suit either quite closely or in some cases a year or two after they are covered. And PMTCT would be one of those cases where WHO guidelines have played a significant role in informing the development of policies in South Africa” (HPSR Researcher).

Table 5.1: Three different perspectives on the use of evidence in health policy formulation in the South Africa health sector

PERSPECTIVE 1: Evidence is used in health policy development	PERSPECTIVE 2: Evidence is used in clinical policy development but not in health systems policy-making	PERSPECTIVE 3: Evidence is NOT used in the development of health policies
➤ Research evidence from WHO is used in the development of health programmes ➤ Evidence is used in policy-making but not consistently	➤ Only clinical policies have a research element ➤ Health systems policies often do not have supporting evidence – it is difficult to obtain evidence to develop a referral policy	➤ Research is very often based on narrow, small aspects and you have to translate that onto a [health] system. You cannot impose a micro issue onto an entire system. You have to use the whole system to absorb new findings. ➤ National DoH does not use evidence in policy-making. If they did, they would know that most of their policies are irrelevant to provinces, and would not impose them on provinces. ➤ Provinces accept and implement policies developed by the National DoH. It is the national department that must use evidence. ➤ Universities seem not well-equipped to do health systems research. Most academics have never worked for government.

In contrast, policies such as the Re-engineering of Primary Health Care and the development of Clinical Specialist Teams were said to have been developed without a strong evidence base. One researcher noted:

“... the things that I think are weak in South Africa, and I suppose I’m thinking about things like the Primary Health Care Re-engineering, because to me that seems to me a very evidence-absent type of policy process. That’s quite a big important policy space, you know around the specific components of primary health care and engineering, like school health services or the ward-based outreach teams or the districts specialist teams. You know, all of those are quite important policy interventions as part of primary health care engineering, and for me not a lot of use of evidence, either in terms of the options available, the likely effectiveness of those particular strategies, the financial implications and therefore the cost effectiveness of those options” (HPSR Researcher).

HPSR researchers suggested that this lack of evidence use was because health system issues are far more complex than clinical issues, and require large system-level changes. They are also not as standardised as the treatment guidelines or drug regimens that UN agencies share with all countries, and so require a different policy formulation approach to that for clinical policies. The researchers also stated that the National DoH did not have the systems or the machinery to inculcate a culture of evidence-based policy.

The role of UN agencies, such as the WHO and UNAIDS, in providing the evidence that informs the regular update of clinical guidelines was highlighted. One researcher stated:

“So there’s any number of examples on that, for example HIV treatment guidelines are updated on a regular basis by WHO and usually South African government follows suit either quite closely or in some cases a year or two after they are covered. And PMTCT would be one of those cases where WHO guidelines have played a significant role in informing the development of policies in South Africa.” (HPSR Researcher)

A final point noted by the respondents from the HPSR community was that in its policy-making, government was largely influenced by multinational agencies, and did not always draw on local research institutions. This was perceived by the respondents as a missed opportunity, because local NGOs and research institutions possess a wealth of knowledge and expertise. One researcher stated:

“Certainly government should base its policies on evidence, it doesn’t always do that. But NGOs, academia, researchers do play an important role in providing the new information about health matters and they also play an important role in the implementation of policy and giving feedback on

policies and how they should be tweaked or changed in the light of the realities on what's going on the ground. And they do this by doing research, they provide documentation, they provide policy briefs in a lot of cases, which are the direct results of their research, and an astute government should pick up on those things and use them in the policy-making process" (HPSR Researcher).

Finally, my own views are that provincial respondents interpreted evidence in a narrow sense and therefore judged that evidence is not used in the development of health system policies, whereas I have seen various different forms of evidence used in health systems policy development, including operational research and best practices from other countries. However, I agree with the HPSR researchers that the development of health systems policies is extremely complex. My experience suggests that the development of health systems policies has to be context-specific, and evidence cannot be transferred from other settings easily.

5.6. Different forms of evidence used in policy-making

Finally, Phase 1 of this study also explored the different sources of evidence used in health policy-making in South Africa. This is reflected in **Figure 5.5.** below. A total of **11** different sources were identified by respondents as commonly used in policy-making circles. The five most commonly reported sources (three responses each) were: (a) published meta-analyses, (b) RCTs, (c) empirical evidence from the WHO, (d) Statistics South Africa surveys, and (e) evidence from UN agencies. In addition, two respondents each noted: (a) evidence from the South African Cochrane Centre, (b) WHO empirical evidence, (c) routine information systems, (d) case study materials, (e) anecdotal evidence, (f) Statistics South Africa surveys, and (g) evidence from UN agencies and universities. Overall, these sources can be grouped as: (1) meta-analyses, surveys, and data, (2) evidence from authoritative organisations, (3) case study materials, and (4) experiential and anecdotal evidence.

With respect to the sources cited by respondents from the national and provincial spheres of the health system, key informants from the national sphere and HPSR researchers identified ten sources of evidence in total. On the other hand, respondents from the provincial sphere of the health system only noted eight sources. Six sources of evidence were noted by all three groups. Provincial respondents did not identify the South African Cochrane Centre, case study material, and anecdotal evidence. National respondents did not identify experiential evidence, and researchers did not identify routine information systems. However, taken together, these responses suggest that policy-makers draw on both scientific research and routine data, and use both formal and informal evidence, rather than only relying on research ranked most highly in the hierarchy of evidence. A list of commonly cited sources of data used by health policymakers is reflected in **Table 5.2.** below.

Table 5.2: Sources of data used by Health Policy-makers in South Africa as cited by different categories of respondents (Source: interviews)

1	Published literature (using meta-analysis)
2	Randomised Controlled Trials (RCTs)
3	South African Cochrane Centre evidence
4	WHO empirical evidence
5	Experiential evidence
6	Routine information systems
7	Case study materials and experimental designs
8	Anecdotal evidence
9	Statistics South Africa surveys
10	Evidence from UN agencies
11	Universities – drawing from their own research studies

What is consistent between the list of 11 sources of evidence, and findings from empirical studies, is that policy-makers use not only empirical literature, but also other sources of evidence, including routine information systems, experiential evidence, anecdotal evidence, and survey data. In their empirical work in the UK and Ghana, Oliver, Lorenc and Innvaer (2014) concluded that the use of research within policy formulation has become “divorced from a broader perspective on policy-making” (p. 2). Along with Oliver et al. (2015), they also concluded that policy-makers use diverse sources of evidence, and only those regarded as superior in terms of the so-called hierarchy of evidence.

5.7. Final reflections on policy-development processes in the South African Public Health Sector

This study did **not** seek to establish whether evidence is used in health policy-making in South Africa. This was taken for granted. Rather, the study sought to establish who uses what evidence at what stages of policy formulation and, ultimately, why these forms are selected for use. Several common themes emerged from Phase 1 of the study. A total of 27 stakeholders were identified as contributing to health policy-making in South Africa. These stakeholders are not necessarily related to each other, but all have an interest in national health policy, pointing to the complex and messy nature of policy-making.

The schematic diagrams illustrating the policy-making process developed in this study (Figure 5.3 and Figure 5.4), which was validated with technocrats, is one of the first attempts nationally to reflect the stepwise processes by which health policy is developed in South Africa.

There was considerable divergence between policy-makers about the use of evidence in health policy formulation, with some key informants indicating that it is used, others saying only partially used, and yet others indicating that it is not used at all. A common theme, however, was that evidence is used for the development of clinical policies and guidelines, but not equally so for the development of health system policies. This divergence speaks to the lack of a documented and well-known system through which evidence of any type is funnelled into policy-making processes.

This point was noted by both national and provincial technocrats, independent of each other, and was also articulated by HPSR researchers in South Africa.

At the same time, a wide range of evidence, not only scientific research evidence, was identified as being used at some time in health policy formulation. My own experience is that all draft policies presented to the Management Committee of the national sphere of the health system includes a set of references reflecting the literature consulted. However, whether the sources of data used are authoritative or current is variable across policies, and various sources are consulted.

5.8. Conclusion

The perspective expressed by some respondents that the provincial sphere accepts and implements policies developed by the national sphere of the health system, and that it is therefore the national sphere of the health system that must use evidence in policy formulation, reflects the risks associated with centralised policy-making. When the centre is too strong, the periphery can take a backseat. Evidence-informed policy is then regarded as the sole and exclusive responsibility of the centre, in this case the national sphere of the health system. However, my own judgement is that the subnational spheres of government, provinces, and local government also participate in policy-making processes through the TECH-NHC and the NHC itself. The South African Military Health Services (SAMHS) also participates in both the TECH-NHC and the full NHC, as do I. Therefore, the provincial sphere of the health systems and all other formations represented in the TECH-NHC and the NHC have a collective responsibility to promote the use of evidence in the development of health policies.

CHAPTER 6: THE USE OF EVIDENCE IN THE DEVELOPMENT OF THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT) POLICY

6.1. Introduction

This chapter presents the study findings explaining the development of the PMTCT policy during 2001 and 2002. Using a force field analysis framework derived from Gilson et al. (2012), it considers the key policy actors and networks of actors involved in this policy process, and their positions on the policy at different times. Drawing also from the framework of Shiffman and Smith (2007), it further illustrates critical factors influencing this complex process, including how policy actors exercised power and the use of evidence within it.

The first call by civil society organisations for the development of a PMTCT policy and programme for South Africa occurred in 2001 during the Mbeki administration, when the Ministry of Health was under the leadership of Dr. Tshabalala-Msimang. This year (2001) was a period of political consensus (or more correctly, acquiescence) about the government's position on PMTCT within the then Health MinMEC, currently known as the National Health Council (NHC). The year 2002, however, was characterised by increasing defiance among Provincial MECs of Health, supported by their Premiers, who broke rank from the national government's opposition to the development and expansion of the PMTCT. The Constitutional Court judgement of **2002**, which directed government to roll-out the PMTCT programme nationally, was the final decision on this matter. As will be illustrated in this chapter, the development of the PMTCT policy was a bottom-up, high politics, and highly contested process. The main protagonists were the government of South Africa on the one side, and a coalition of civil society, researchers, and academic institutions on the other side.

In this chapter, the years **2001 and 2002** are considered separately, and the powerful political actors and key events of these two years are treated separately. The **post-2002** period is also considered, but was relatively uneventful, and was characterised by an increase in the number of health facilities that provided PMTCT services, in accordance with the court judgement on PMTCT.

In terms of structure, this chapter consists of six sections. The first component presents the evolution of PMTCT policy during 2001. This section describes the relative harmony and acquiescence that existed in the Health MinMEC in 2001. Key actors and actor power, as well as evidence, issue characteristics, and ideas prevailing in 2001 are discussed. The second section of the chapter focuses on the year 2002, which is defined as the breakthrough period for the PMTCT policy. As is the case with the previous section, key actors and actor power, and evidence, issue characteristics, and ideas in 2002 are discussed in this section. The third component deals with the evolution of an evidence-informed PMTCT policy post-2002. It also reflects on the political changes that occurred in September 2008 and their positive influence on the implementation of the PMTCT policy. The fourth section reflects the PMTCT policy outcomes. The fifth section provides a set of reflections on the PMTCT policy. The sixth and final section presents the conclusions of the chapter.

6.2. The Original Phase of the evolution of PMTCT – Year 2001: A period of relative policy coherence and acquiescence within the Health MinMEC

Table 6.1 below summarises the key factors influencing the policy process in this period, using the Shiffman and Smith (2007) framework. These factors are then explained further in the sections below.

Table 6.1: Summary of factors that affected the national agenda setting for PMTCT in 2001 – the first year of the development of the PMTCT Policy and Programme

Elements	Description	Factors shaping policy priorities
Political Context	• The political environment during the period 1999-2004 was characterised by the political dominance of President Mbeki within the political party and in government, as a leader elected unopposed, a son of a senior leader of the ANC, and a perceived intellectual in his own right. • The National Executive Committee (NEC) of the ANC had issued a statement in 2001 supporting the President's and Minister's views on HIV/AIDS and therefore on PMTCT. This served to consolidate the Ministers' power.	• The ANC was a dominant political party in South Africa in 2001, having won the 1999 national government elections with an overwhelming majority of 67,5% of the national vote. • The NEC PMTCT statement ensured compliance with the political directives – by all leaders and members of the ruling party. • This emboldened the National Minister to achieve a degree of consensus within the Health MinMEC.

Elements	Description	Factors shaping policy priorities
Actor Power	• The Minister of Health, who was the main antagonist in the evolution of the PMTCT policy, derived her power from various sources, namely: ○ her seniority in the ruling ANC as a member of the NEC ○ her membership of the Cabinet of South Africa ○ the power of the Minister as the Chairperson of the Health MinMEC ○ her long history with and loyalty and proximity to the President	• The Minister of Health used her actor power to establish coalitions and alliances of powerful actors to shape the development of the PMTCT programme and the use of evidence in this process. • The Minister of Health was capable of uniting the Health MinMEC behind her position on PMTCT, and created a coalition and alliance with the 7 MECs in the ANC governed provinces constituting the majority in the MinMEC. The 8th MEC was an ANC member but was located in KwaZulu-Natal province, politically controlled by the Inkatha Freedom Party. • The Minister of Health created a specific ANC alliance which included only herself and the 7 MECs of Health in ANC governed provinces. This alliance convened caucus before the actual formal MinMEC which included the MEC of Health in the Western Cape, politically controlled by the Democratic Alliance. • A degree of policy community cohesion was achieved within the Health MinMEC, as an alliance, to delay the national roll-out of PMTC, based on the Minister's views on the matter and loyalty of the Health MECs in the 7 provinces governed by the ANC in 1999-2004. • The MECs in the ANC governed provinces agreed with the Minister of Health, or silently acquiesced, to protect their political careers from ruin. They faced a Minister who was not only a Cabinet Minister but also a member of the NEC, and a close confidante of President Mbeki. • The MECs also faced a challenge that the ANC NEC had issued a statement supporting the positions of both Minister Tshabalala-Msimang and President Mbeki on PMTCT and generally on the country's response to HIV/AIDS.

Elements	Description	Factors shaping policy priorities
Ideas	• Sufficient consensus initially within the Health MinMEC that South Africa did not have enough evidence to inform and guide the roll-out of PMTCT policy programme. • The consensus between the national Minister of Health and Health MECs in 2001 enabled the Minister of Health to sustain the power she commanded in the early phases of the PMTCT policy.	• Ironically, the internal frame used with the Health MinMEC was that more evidence was needed to roll-out PMTCT – ironic in that it was framed as an evidence-based approach, yet it ignored the existing evidence for political expediency. • The external framing of this issue, which was that existing evidence was insufficient to enable the national roll-out of the PMTCT programme, did not succeed in convincing civil society, the research community, academic institutions, and the media. This was the opposing frame. • An opposing frame, which is described later in this chapter, came from MECs within the Health MinMEC who supported the development of the PMTCT policy. • However, civil society, the research community, academic institutions, and the media vociferously opposed the notion that there was insufficient evidence to scale-up PMTCT, and supported the need for a national roll-out of PMTCT.
Issue characteristics	• The Health MinMEC of 2001-2002 was consistently provided with emerging evidence on the efficacy of nevirapine in reducing mother-to-child transmission of HIV. • However, the Health MinMEC of 2001-2002 was also aware of the counter-evidence from the AIDS dissidents who denied the causal link between HIV and AIDS.	• Several research studies existed to show the severity of the problem, which included the work of the Wits Reproductive Health Unit and the University of KwaZulu-Natal, which could be used to monitor progress. These indicators also showed the severity of the burden of mother-to-child transmission. • Emerging evidence demonstrated that the establishment and roll-out of PMTCT was an effective intervention to implement to address the problem. However, there were voices within both the policy elites and technical policy analysts that argued that the existing evidence was being “overplayed” as it was insufficient. •

6.2.1. Key Actors, Actor Power, and Political Context

The key policy elites involved in the PMTCT policy in 2001 included the Minister of Health and Members of the Executive Councils (MECs) of Health in the nine provinces, who constituted the NHC, chaired by the Minister. The key technical analysts were the senior health bureaucrats in the National DoH, that is, the Director-General (DG), Deputy Directors-General (DDGs) and Chief Directors managing programmes, as well as executive managers in the provincial health departments, who constituted the then Provincial Health Restructuring Committee (PHRC). This is reflected in **Box 6.1.** below.

Box 6.1: Policy Elites during the development of the PMTCT Policy in 2001

In the development of the PMTCT policy in 2001, there were nine sets of important actors:

- President Mbeki
- NEC of the ANC
- Minister of Health and the MECs for Health
- Portfolio Committee on Health in Parliament
- NEC of the ANC
- Technical policy elites (senior government bureaucrats in the National and Provincial Departments of Health)
- Research community or research institutions and independent researchers
- Frontline health care workers in the public sector
- Civil society (health activists in NGOs and CBOs)

However, as the force field analysis in **Table 6.2** shows, the key political actors in 2001, who held the highest relative level of power, were the most opposed to the policy, and acted to prevent policy formulation at this time. In contrast, those actors who were supportive of the policy, including senior civil servants, all held relatively low power.

Table 6.2: Force field analysis of the development of the PMTCT Policy in 2001

RELATIVE POWER	HIGH SUPPORT	>>	NON-MOBILISED	<<	HIGH OPPOSITION
High					• President of South Africa • Minister of Health MECs of Health in the Eastern Cape, Free State, Gauteng, Limpopo, Mpumalanga, and North West • Some researchers (followers of Duesberg theory on AIDS)
	• MEC of Health in the Western Cape Province		• MEC of Health in Gauteng Province • MEC of Health in KwaZulu-Natal Province		
Middle	• Technical Policy Elites (Bureaucrats) in the national and provincial spheres of government				
	• Schools of Public Health and Family Medicine in academic institutions • Research organisations • Independent researchers				
Low	• Civil Society, including health activists in NGOs and CBOs supporting people infected with or affected by HIV/AIDS and their families • Coalition of civil society organisations				

President Mbeki played a dominant political role in South Africa in 2001. He had been elected ANC President unopposed at the 1997 conference of the ruling party in Mafikeng. He was also a son of Govan Mbeki, one of the political leaders who was sentenced to life with Nelson Mandela in 1963 at the Rivonia Treason Trial. Some key informants in this study stated, moreover, that he discouraged other political leaders within his own party from challenging him through his intellect. He read a lot, gathered his own evidence on issues, and formed strong opinions and judgements. A key informant stated:

“Every time we went to the Cabinet retreats, with exception of a few ministers, you just felt that a lot of the Ministers were intellectually overwhelmed by him” (Former senior bureaucrat, national sphere of government).

*“Ja, I think there were two things, first of all remember TM [Thabo Mbeki] was reading a lot on this thing, right. So TM was domineering but I want to qualify TM’s domineering. Because TM read a lot, I think intellectually some people would first of all **not** want to challenge him”* (Former senior bureaucrat, national sphere of government).

The key informants also stated bluntly that some of the Cabinet members who were afraid of challenging the President were actually “not the best appointment he could have made to Cabinet”. They had been chosen on the basis of loyalty to the President more than capability. One key informant stated:

“the second issue quite honestly is that I think some of the problems that we began to see even under President Jacob Zuma maybe on a larger scale, especially the issues of people not being the best appointments, started then, people chosen not so much around just their full capability but also issues of loyalty coming in to weigh far much more...who’s on my side, that sort of thing” (Former senior bureaucrat, national sphere of government).

President’s Mbeki’s long-standing scepticism about the causal link between HIV and AIDS, and about antiretroviral drugs (ARVs), underpinned his position on PMTCT in 2001. Indeed, it is well documented that President Mbeki had been influenced by a group of researchers known as AIDS dissenters, who promoted the view that HIV does not cause AIDS and that ARVs were toxic. Led by Prof. Peter Duesberg (based at the University of California, Berkeley), Prof. David Rasnick, and a journalist, Cecilia Farber, the now discredited and rejected Duesberg hypothesis (Wikipedia, 2023) argued that recreational and pharmaceutical drugs were the real cause of AIDS, and that HIV was a harmless passenger virus (Duesberg, 1991).

The political scientist, Anthony Butler (2005) states that “in 1999 incoming health Minister Manto Tshabalala-Msimang – like Dlamini-Zuma a medical doctor and member of the drafting committee for the 1994 AIDS plan – seemed initially to support wider use of ARVs to prevent mother-to-child transmission (MTCT) of HIV. It was in this context that Thabo Mbeki, now President, launched broadsides in 2000 against the conventional intellectual foundations of AIDS health policy, questioning the causal relationship between HIV and AIDS, and positing the potential toxicity of antiretroviral

AZT. He convened a presidential advisory panel to scrutinize further the scientific orthodoxy, and wrote a letter to fellow world leaders asking for the socio-economic, as opposed to purely viral, causes of AIDS to be investigated. His skepticism was also reflected in the composition of the National Aids Committee (SANAC), which excluded leading researchers, the MRC and the MCC, while including voices considered 'dissident' by mainstream biomedical researchers" (p. 594). In the same vein, Nattrass (2008) asserts that "Mbeki launched his first broadside as President when, in October 1999, he informed the National Council of Provinces that AZT was 'toxic' and asked the Health Minister to find out 'where the truth lies'. This resulted in the setting up of the Presidential AIDS Advisory Panel (half its members orthodox scientists, the other half AIDS denialists) the following year" (p. 161). Nattrass (2008) continues: "The Presidential AIDS Advisory panel served as a means for Mbeki and his Health Minister to portray AIDS science and policy formation as deeply contested, and contestable. This, in turn, provided them with the space to resist the introduction of AZT and other ARVs on the grounds that 'more research was needed' into their toxicity and effectiveness" (p. 163).

The President's scepticism on the causes of AIDS led to what key informants in this study identified as the politicisation of the PMTCT policy issue. They judged that the Minister of Health's major interest was to avoid contradicting President Mbeki's views. Her friendship with President Thabo Mbeki was almost 40 years old by 2001. In an obituary for Tshabalala-Msimang in the UK newspaper, The Guardian, on 7 January 2010, Beresford (2010) wrote that Mbeki and Tshabalala-Msimang had left South Africa together in 1962 to join the ANC in exile. Beresford (2010) stated that: "she [Tshabalala-Msimang] matriculated from the Inanda seminary in 1959 and took a BA at Fort Hare University, then asked the African National Congress (ANC) if she could go overseas for military training. She was told by the local ANC leader, Govan Mbeki, to educate herself first. She duly left South Africa, in November 1962, with Mbeki's son, Thabo, among other political refugees. The future health minister and the future president found themselves incarcerated in a Zimbabwean (then Rhodesian) prison cell together, before being allowed to continue their journey into exile".

According to key informants, despite their friendship, President Mbeki also asserted power over Minister Tshabalala-Msimang. A case in point cited by key informants was that in 1999, as the then Deputy President of South Africa, Mbeki had responded to a Parliamentary question, without consulting the health sector, and indicated that ARVs were toxic. This was contrary to the established government practice, which was that The Presidency normally consulted with the relevant department first, prior to responding to a Parliamentary question that focused on the work of that line department.

As reflected in **Table 6.2.**, the Minister of Health was also supported by a majority of the members of the then Health MinMEC in her position on PMTCT. Key informants who were senior bureaucrats in 2001 reported that the Minister lobbied Provincial MECs before MinMEC meetings:

"But there were MECs that you got a sense sometimes, I mean of course you get a meeting and you realise that the Minister had had a pre-meeting or pre-consultation with some of the MECs to the exclusion of those who are known to be opposed to her position. Some politicians were sympathetic

but remained silent to protect their positions” (former senior bureaucrat, provincial sphere of government). The positions adopted by members of the Health MinMEC in Provinces governed by the ANC NEC were to concur with the Minister, or to silently conform” (Former senior bureaucrat, national sphere of government).

Although the Health MECs from Gauteng and KwaZulu-Natal recognised the urgent imperative to implement the PMTCT programme in South Africa, as ANC members they simply did not command sufficient power within the Health MinMEC, and their voices were ineffective or drowned out. Only the MEC of the Western Cape province, which had already piloted the PMTCT programme in 1998 based on the emerging existing local and international evidence and in defiance of the national policy position, openly expressed divergent views and policy positions from those of the Minister of Health.

The Minister’s political power was partly derived from her close friendship with the President, but she was also, in her own right, a senior political leader within the ANC by virtue of her position as a member of its NEC and a Cabinet member. According to ANC policies, the “National Executive Committee is the highest organ of the ANC between National Conferences and has the authority to lead the organisation, subject to the provisions of this [the ANC] Constitution” (ANC, n.d. a). The NEC is therefore the highest decision-making body of the ANC in between its conferences, which take place every five years. The ANC NEC of 1997-2002, including Minister Tshabalala-Msimang, had been voted into office by 3,000 delegates at the party’s 50th Conference at the University of North West, Mafikeng Campus, in December 1997. Tshabalala-Msimang’s election into such a position of responsibility in the ruling party illustrated popularity among the 3,000 members of the organisation. This was her main source of political power.

Statements issued by the NEC of the ANC in 2001 supporting the President’s and Minister’s views on HIV/AIDS, and therefore on PMTCT, were another source of the Minister’s power. On 3 December 2001, the South African newspaper, the Mail & Guardian, reported that the NEC of the ANC had “agreed that government’s approach [*i.e. Minister Tshabalala-Msimang’s approach*] to mother-to-child transmission of HIV is correct, given that so little is currently known about the longer term effects of the drug” (Mail & Guardian, 2001). Stated differently, the NEC supported the Minister’s position that there was insufficient evidence to inform the roll-out of PMTCT in South Africa. It was also reported in the media that the ANC NEC had criticised the Treatment Action Campaign (TAC) for litigating against government on the use of nevirapine (Mail & Guardian, 2001). This court case is discussed later in this chapter. The NEC statement not only empowered Minister Tshabalala-Msimang but also ensured the compliance (if not agreement) of all leaders and members of the ruling party, that is, the Health MECs in the ANC-governed provinces, with the political directive to oppose PMTCT.

The technical policy elites (Grindle & Thomas, 1989) supporting PMTCT (**Box 6.1, Table 6.2**) included the Deputy Directors-General (DDGs) responsible for the Strategic Health Programmes Branches, as well as Chief Directors directly managing the HIV/AIDS Programme. A key interest for this group was concern for mothers and their babies, and saving lives. A key informant commented:

“Deaths of babies meant something had to be done urgently, without any clear agenda set, but this had to be done to save babies. Paediatricians who were seeing babies dying played a crucial advocacy role, and called for PMTCT to be developed and implemented. Health professionals also experienced the impact of HIV/AIDS at a personal level, in their own families.” (Former senior bureaucrat and clinical expert, provincial sphere of government, and former hospital CEO during 2001-2002).

However, these technical policy elites only had middle-level relative power because, despite their knowledge and the evidence, they did not have the political power needed to determine policy. Key informants in this study stated that the efforts of these policy elites were stifled in 2001. As one noted:

“Programme managers were skilled and technically competent, but they were also evidence-brokers. What also assisted was that the Technical MinMEC included Provincial Heads of Department who were qualified health specialists in their own right, who strongly advocated for PMTCT. The Director-General and the Deputy Directors-General at the time were very supportive. The HoDs in the Technical MinMEC would refer us to other experts that they knew of, who would assist in strengthening our policy proposal. If the policy was presented to MinMEC, they either say ‘no, this policy is premature’ or ‘yes, change this and that’ and come back with a revised policy’, or yes, in principle we agree with the policy in principle...” (Former senior bureaucrat and clinical expert, national sphere of government).

Despite acknowledging the available evidence, senior bureaucrats in the health system also did not publicly challenge government’s refusal to roll-out PMTCT at this time. Key informants noted three reasons for this position. First, the bureaucrats respected the fact that, in the end, it was **not** government officials who made policy, but politicians. As ‘deployees’ of the ruling party within government, they were also loyal to the ANC. Second, some key informants felt that the senior bureaucrats had not amassed enough evidence to convince the political leadership about the effectiveness of PMTCT, and that the existing evidence at the time was simply not sufficiently compelling to influence their political principles. This disagreement itself further empowered the national Minister and the Health MinMEC to ignore the emerging evidence, as discussed further in section 6.2.2.

Third, they felt that, overall, the country’s HIV/AIDS response was broadly based on principles and science that they agreed with, and on their understanding of the epidemic. Indeed, the ANC NEC statement of 02 December 2001 had confirmed that the country’s response was based on the assumption that HIV causes AIDS: “The ANC is committed to treatment programmes which are responsible, effective and sustainable...The [NEC meeting] reiterated that government’s strategy should be based on the assumption that HIV causes Aids...It further supported ongoing scientific enquiry to address the many areas in which our knowledge of the syndrome, its development and its treatment are still deficient” (Mail & Guardian, 2001). However, it is well known that in 2001 the country had not yet started providing

antiretrovirals as part of the national response to HIV/AIDS. This only began in 2003/04.

Finally, their natural allies, other supporters of PMTCT such as civil society organisations (e.g. the TAC), CBOs supporting people infected with or affected by HIV/AIDS and their families, and a coalition of civil society organisations and Schools of Public Health and Family Medicine in academic institutions, also had relatively low power at this time. Although they vociferously supported the need for a national roll-out of PMTCT, the political power of the PMTCT opponents prevailed at this time.

6.2.2. Evidence, Issue Characteristics, and Ideas

In terms of the issue characteristics of PMTCT, by 2001 credible evidence existed to show the severity of the problem at hand. Studies conducted by researchers at the Reproductive Health Unit at the University of the Witwatersrand (WITS) and Chris Hani-Baragwanath Hospital, as well as paediatricians at the Universities of KwaZulu-Natal and Cape Town (UCT) all clearly showed the severity of the burden of mother-to-child transmission. Large numbers of infants and young children were dying from AIDS-related illnesses (Barron et al., 2013; Simelela & Venter, 2014). This evidence was irrefutable. In addition, in terms of solutions, evidence of the efficacy of a single dose of nevirapine in preventing mother-to-child transmission of HIV was emerging from around the world, despite the counter-evidence from AIDS dissidents. As reflected in **Table 6.3** below, evidence emerged from the Uganda: HIVNET 012 randomised trial, from PMTCT guidelines from UN agencies (WHO, UNICEF, and UNAIDS), from routine data collated from public health facilities in South Africa, from clinical observations by medical and nursing professionals and health experts (e.g. child health specialists/paediatricians), and from local operational research studies in South African public sector health facilities.

Table 6.3: Summary of the use of evidence in the evolution of the PMTCT Policy in 2001

Main sources of evidence	Uganda: HIVNET 012 randomised trial
	Guidelines from UN agencies (WHO, UNICEF, and UNAIDS)
	Research studies presented at international conferences on HIV/AIDS
	Routine data collated from public health facilities in South Africa
	Clinical observations from medical and nursing professionals and health experts (e.g. child health specialists/paediatricians)
	Local operational research studies in South African public sector health facilities
	Counter-evidence from the AIDS dissidents

However, despite this evidence-base, the Minister of Health argued that more evidence was needed, whereas, in fact, she was opposed to the emerging evidence. As noted, the critical reason for her opposition was understood to be her loyalty to the President. Loyalty and allegiance are important in political settings. Minister

Tshabalala-Msimang was more loyal to President Mbeki than she was to an evidence-informed approach to policy development. As stated previously in this chapter, the loyalty and friendship between President Mbeki and Manto Tshabalala-Msimang spanned close to 40 years and remained intact even during the turbulent times of the HIV/AIDS controversies. According to the key informants in this study, one of the illustrations of this loyalty of the Minister of Health to President Mbeki was that when, in August 2003, the National DoH tabled a Cabinet Memorandum presenting a case for the national roll-out of the antiretroviral programme in the country, the Minister refused to sign it. According to key informants in this study, the Minister:

*“had refused to sign the Cabinet Memorandum, as required by Cabinet rules, because she was **not** certain where President Mbeki’s mind was on this issue. However, at the insistence of Dr. Frank Chikane, the then Director-General (DG) in the Presidency, and Advocate Mojanku Gumbi, the President’s legal advisor, the Minister relented [and signed the memorandum]”* (former senior bureaucrat, national sphere of government).

Several high-ranking technical policy elites who were key informants in this study confirmed that the emerging evidence on the efficacy of PMTCT in 2001 should have been sufficient to guide action and intervention. They asserted that the PMTCT programme had started in a context of somewhat limited but systematically growing evidence, and by 2001 judged that the available evidence was sufficient to support the implementation of the PMTCT programme. They further argued that as more evidence became available, it would still have been possible to modify the emerging PMTCT policy, as other countries were doing across the globe. One former senior bureaucrat in the provincial sphere of government stated that *“many clinicians, paediatricians and researchers undertook different efforts to gather evidence, including attending conferences at their own cost, and conducting operational research studies at their places of work. The clinical evidence they gathered suggested that PMTCT worked...”*. However, this key informant also went on to note that *“...this led to tensions between politicians, administrators and clinicians”*.

This group of technocrats in the national sphere of government then sought to continuously amass more evidence of the efficacy of PMTCT, working in collaboration with the scientific community. One key informant stated:

“Existing evidence was brought into the process of proposing a new policy... When more evidence of the effectiveness of PMTCT based on nevirapine became available, highly skilled programme managers in the National DoH embraced it. They were also active in research networks outside government which had an interest in these matters. Programme directors were assisted by policy development experts who guided them in policy formulation”. (Former senior bureaucrat national sphere of government).

The Health MinMEC of 2001, chaired by the Minister, was, then, consistently provided with emerging evidence on the efficacy of nevirapine in reducing mother-to-child transmission of HIV.

However, as already noted, *“there was contestation between those who supported PMTCT and those who opposed it. Tensions occurred between administrators, politicians and clinicians”* (former senior bureaucrat, provincial sphere of government and former hospital CEO). Another key informant alluded to political influences over the use of evidence when noting that *“when nevirapine came onto the scene we embraced it and said we would not allow the grass to grow under our feet in terms of implementation. However, we had to balance the technically sound approach with the politically appropriate viewpoints”* (former senior bureaucrat, national sphere of government). Yet another suggested that while the emerging evidence was not fully sufficient, there was an imperative to act. This key informant stated:

“...I think there was and therefore...sometimes there was a national tendency for people to overplay what already was known even though some of the work was beginning to show some evidence but the evidence was not as conclusive as some people were wishing other people to believe at the beginning. So the debate started, and so the debate also shifted to say okay if the evidence is not that clear but there is no harm, so if there’s a remote chance that by doing something you could help these babies, why would you hold that back unless you can demonstrate that the type of intervention that is suggested would cause harm” (former senior technocrat, national sphere of government).

Indeed, already in 2000, the public health sector in South Africa had initiated a pilot project of PMTCT in two health facilities in each of the nine provinces, amounting to a total of 18 sites. The pilot sites consisted of 193 health facilities in total (hospitals, midwife obstetric units, community health centres, and clinics), which covered approximately 6090 antenatal bookings per month, translating to about 9% of the total number of country-wide bookings (McCoy et al., 2002). In 2001, the National DoH commissioned the Health Systems Trust (HST), a NGO, to evaluate the 18 pilot sites. In its PMTCT evaluation report, the HST asserted:

*“The initial focus on two learning sites per province has given national and provincial management the opportunity to learn from their experiences, as well as improve the PMTCT guidelines. There have been many lessons learnt, as well as the development of training and IEC materials and tools to support programme management. With this in mind, there are now **no** good reasons for delaying the gradual and phased expansion of PMTCT services”* (McCoy et al., 2002).

This report also offered recommendations about implementation specific to each province,

Three former senior bureaucrats articulated a feeling of powerlessness in relation to the PMTCT issue, because the evidence-based advice they provided to political leaders on the need to implement a national PMTCT programme was rejected. One key informant stated that *“it was becoming one of those situations where the HODs would all be crying because it didn’t matter what technical advice they were giving to their MECs, there was another logic at the political level, which defied scientific evidence”* (former senior technocrat, national sphere of government). This sense of

powerlessness is significant, because senior bureaucrats are expected to be the advisors of political leaders.

By 2001, it was, then, no longer justifiable to delay the national scale-up of this programme on the basis of ‘insufficient evidence’. As reflected in **Table 6.3** above, an array of evidence was available, suggesting that PMTCT was an effective intervention. However, after weighing her options, the Minister of Health apparently concluded that it was more feasible to ignore the emerging evidence than to risk her political position in Cabinet and in the NEC of the ruling ANC. Several articles in the South African literature on PMTCT (McCoy et al., 2002; Barron et al., 2013; Simelela & Venter, 2014) also assert that, whereas the government of the day was provided with scientific evidence confirming the efficacy of a PMTCT programme using nevirapine to reduce the transmission of HIV from mother to child, government’s pace of uptake and implementation was tardy and ineffectual.

In 2001, the Minister purposefully framed the key challenge with PMTCT as the lack of sufficient evidence to guide the roll-out of the PMTCT policy programme. The Minister also took advantage of the disagreements between the orthodox scientists and AIDS dissenters. One key informant stated:

“And also there was a lot of scientific evidence that was being brought up by other groupings, indicating that whatever that is being suggested as a possible remedy for the situation was either toxic or with side effects and so on” (Former senior bureaucrat, provincial sphere of government and former hospital CEO).

In the Health MEC, the Minister then argued that there was not enough incontrovertible evidence to inform the national roll out of the programme, and argued that very little was known about toxic side effects of ARVs. This argument was used to persuade the MECs to support her position.

6.3. The Breakthrough Year 2002: Paradigm shift, Political dissonance, Provincial defiance and the Constitutional Court judgement

Already towards the end of 2001, the hegemony of the Minister of Health within the Health MinMEC began to crumble and opposition by civil society organisations to her policy positions rapidly escalated. Civil society structures mounted a legal challenge to force government to rapidly roll out the PMTCT programme, contending that failure to do so was a violation of the Constitutional rights of South Africans. Government lost the case in the Pretoria High Court with a scathing court judgement that “a countrywide PMTCT programme is an ineluctable obligation of the state” (Simelela & Venter, 2014). Government unsuccessfully appealed this judgement directly to the Constitutional Court, arguing that it amounted to interference by the judiciary in policy-making, which was the preserve of the Executive (Cabinet). In 2002, the Constitutional Court ruled in favour of the litigants (The Treatment Action Campaign), ordering government to ensure the national roll-out of the PMTCT programme.

Table 6.4 summarises the key factors influencing the policy process in this period, again using the Shiffman and Smith (2007) framework. These factors are explained further in the sections below.

Table 6.4: Summary of factors that affected the PMTCT policy process in 2002 – the second year of the development of the PMTCT Programme

Elements	Description	Factors shaping policy priorities
Political Context	The period 2002 was characterised by the weakening of influence by the Minister of Health and the President on the ANC NEC. The ANC itself became divided on the issue of HIV/AIDS, including PMTCT.	- The Constitutional Court judgement of 2002 emboldened members of the ANC NEC who believed that the country's HIV/AIDS response and the PMTCT programme must be expanded nationally based on existing evidence and on the court judgement. - Key informants in this study reported that in 2002 the ANC NEC became divided on the issue of the country's response to HIV/AIDS in general, and PMTCT in particular.
Actor Power	- Weakening political power of Minister of Health despite her seniority in the ruling ANC. - Political support from Provincial Premiers emboldened several MECs. - There was ultimate dissonance among the MECs, commencing with MECs in the non-ANC governed provinces, followed by MECs in the ANC governed provinces breaking rank. - The Minister of Health was no longer capable of uniting the Health MinMEC behind her position on PMTCT.	- Minister of Health was no longer capable of uniting the Health MinMEC behind her position on PMTCT, and her coalition and alliance with the 7 MECs in ANC controlled provinces collapsed. - As more evidence and good quality evidence emerged, power dynamics shifted with the Health MinMEC. Evidence became a source of power for Health MECs and empowered MECs based in provinces that were rapidly producing the empirical evidence to be courageous and act in accordance with their conviction. - Loyalty to the Minister of Health was replaced with pragmatism and action, based on evidence and support from Provincial Premiers. - Emerging evidence proved that the position of the Minister of Health was defective, as it was motivated by loyalty to the President, rather than on evidence. - The High Court judgement of 2002 came as a relief to those MECs who wanted to implement PMTCT but were afraid of defying the Minister. It liberated them to also start rolling out PMTCT.
Ideas	The prior consensus within the Health MinMEC that South Africa did not have	In 2002, more evidence supporting PMTCT was generated from the 18 PMTCT pilot sites established by

Elements	Description	Factors shaping policy priorities
	enough evidence to inform and guide the roll-out of the PMTCT policy programme was undermined as Schools of Public Health and Family Medicine as well as Departments of Obstetrics Gynaecology and Paediatrics in leading universities produced more and more evidence of the efficacy of PMTCT.	government. The local media disseminated this evidence. • The internal frame used with the Health MinMEC that more evidence was needed to roll out PMTCT became a double-edged sword. As more evidence was made available, the original internal frame became defective and depleted, and could no longer be used. • Civil society embraced the emerging and ever-growing evidence, which was generated by academic institutions, research institutions, and independent researchers. • The opposing frame, originally advocated by the Health MECs in the Western Cape, and later Gauteng and KwaZulu-Natal, gained ascendancy. • Ultimately, the Court Judgement of 2002, ruling in favour of civil society and other litigants, became the final arbiter by directing government to immediately roll out the PMTCT programme.
Issue characteristics	• More and more babies in South Africa were dying from AIDS in 2002. • Growing, good quality evidence about the efficacy of nevirapine in reducing mother-to-child transmission of HIV became available. • As the magnitude of the problem escalated, the evidence demonstrating the efficacy of the solution also increased.	• Several research studies showed the severity of the problem, including the work of the Wits Reproductive Health Unit and the University of KwaZulu-Natal, which could be used to monitor progress. These indicators also showed the severity of the burden of mother-to-child transmission, in 2001, when the problem was bigger, and in 2002 when the evidence base of the solution also increased significantly. • The establishment and roll-out of PMTCT was an effective intervention to implement to address the problem, as demonstrated by increased evidence in 2002. • In 2002, the confluence of several linked factors resulted in the acceptance of PMTCT. These factors included the results of the Health System Trust's PMTCT survey commissioned by government, which supported the roll-out of PMTCT, as well as the court judgement.

Table 6.5: Force field analysis of key stakeholders in 2002 – the second year of the development of the PMTCT Policy and Programme (2002) and stakeholders' position in relation to the policy

RELATIVE POWER	HIGH SUPPORT	>>	NON-MOBILISED	<<	HIGH OPPOSITION
HIGH	• High Court and Constitutional Court • MECs of Health in the Western Cape Province • MECs of Health in Gauteng Province • MEC of Health in KwaZulu-Natal Province • MECs for Health in the Eastern Cape, Free State, Limpopo, North West, and Northern Cape Provinces				
	• Technical Policy Elites (Bureaucrats) in the national and provincial spheres of government				
MIDDLE	• Schools of Public Health and Family Medicine in academic institutions • Research organisations • Independent researchers				
	• Civil Society, including health activists in NGOs and CBOs for HIV/AIDS and their families				
LOW					• President of South Africa • Minister of Health • Followers of Duesberg theory • MEC for Health in Mpumalanga Province

6.3.1. Key Actors, Actor Power, and Political Context in 2002

As reflected in the force field analysis in **Table 6.5**, the Constitutional Court judgement of 2002 instructing the Minister to scale up the PMTCT programme nationally shifted the balance of power away from the President of South Africa, the Minister of Health, and AIDS dissidents. In contrast, Health MECs who had supported the development of the PMTCT policy, taking along other MECs, Civil Society, including health activists in NGOs and CBOs, and academics and researchers, gained power.

This shift in the balance of power in 2002 can be traced back to two events in 2001 (**Table 6.4**). Firstly, there was the legal challenge mounted by civil society structures to force government to rapidly roll out the PMTCT programme, contending that failure to do so was a violation of the Constitutional rights of South Africans. Secondly, there was political dissonance within the ANC itself.

The resort-to-justice route was the last option for the coalition of civil society organisations, research institutions, concerned clinicians, health activists, and academics. These groups had previously made individual and collective efforts to gather relevant evidence to demonstrate the efficacy of PMTCT, yet their appeals to government for action had fallen on deaf ears. One key respondent stated:

“If I recall those years we had a quite number of groups, some of them were just clinicians and some of them were civil society organisations that were pushing government to do something about the policy” (former senior bureaucrat and clinical expert, provincial sphere of government)

The coalition of PMTCT supporters argued in Court that it was unethical to implement the programme in only 18 pilot sites, and that there was enough evidence from Uganda and other African countries demonstrating that single dose nevirapine was safe and effective. They were victorious in their litigation in the lower courts in 2001, with the Pretoria High Court presenting a scathing judgement that “a countrywide PMTCT programme is an ineluctable obligation of the state” (Simelela & Venter, 2014, p. 249). The Government then appealed this judgement directly to the Constitutional Court, arguing that it amounted to interference by the judiciary in policy-making, which was the preserve of the Executive (Cabinet). However, in 2002, the Constitutional Court upheld the judgement of the lower court, ruled in favour of the litigants, and ordered government to ensure the national roll-out of the PMTCT programme across the country.

In parallel, according to key informants in this study, from late 2001, the formal South African government position on HIV/AIDS had divided the National Executive Committee (NEC) of the ANC. As one key respondent noted:

“This was no longer a technical discussion in the health sector, but had become a political issue and people were taking sides” (former senior bureaucrat, national sphere of government).

The divisions within the NEC created fertile ground for dissent from Health MECs, even in provinces governed by the ANC, as described in detail below. Within the Health MinMEC, even those who originally supported the Minister of Health started

speaking out in public – including the MEC of Health in KwaZulu-Natal at the time, Dr. Zwelini (Zweli) Lawrence Mkhize, and the MEC of Health in Gauteng Province, Dr. Gwen Ramokgopa,. Provincial DoHs in these provinces joined the Western Cape Province in supporting PMTCT. One of the key informants in this study stated:

“And again what was happening once the National Minister and also unfortunately at that time....at some point they came to be dissenting MECs and one of them was Zweli, in fact Zweli, at some point started not attending MinMECs, and he was not hiding the fact that part of the reason is that he doesn’t agree with the decisions being taken. So people like that, at some point Gwen Ramokgopa, when they wanted to start the pilots in Gauteng, remember Gwen was also feeling The pressure because the biggest research.... at least Zweli and Gwen were in an awkward situation that the biggest research areas where there was depth of research capacity on HIV/AIDS [were in their provinces]...” (former senior bureaucrat, national sphere of the health system).

The political context of each of these three provinces was an important factor influencing MECs to speak out. In terms of the South African Constitution, it is the Premiers who form the Provincial Executive Councils or Provincial Cabinets by appointing MECs. These MECs are therefore primarily accountable to their Premiers. In terms of cooperative governance, they are required to collaborate with the National Ministers.

The Western Cape province had already started implementing PMTCT in high burden settings such as Khayelitsha in Cape Town. As asserted by Schneider et al. (2010), “in the Western Cape, the political stance was driven by attitudes towards the national ruling party (African National Congress) on the part of the opposition party (Democratic Alliance) governing the province. Already in 1999, this province implemented the WHO recommendations emerging from the Thai-CDC short course AZT trial for PMTCT, and added nevirapine to the regimen when the Ugandan HIV Net012 study results were published” (p. 7).

In KwaZulu-Natal, meanwhile, by 2002 the ANC-aligned MEC for Health was able to proceed with his desire to implement the PMTCT programme after successfully lobbying the then Premier of KwaZulu-Natal, Lionel Mtshali, who was a member of the Inkatha Freedom Party (IFP). With the Premier’s support, and in defiance of the national Minister of Health, the Health MEC approved the use of nevirapine for PMTCT in health facilities across the province even before the Constitutional Court judgement. This development was reported in various media houses. On **30 January 2002**, News24 reported that *“the KwaZulu-Natal Provincial Cabinet on Wednesday reached consensus on a three-month roll-out plan to make nevirapine available at state hospitals and clinics in the province. The decision followed an announcement a week ago by Premier Lionel Mtshali that nevirapine would be available to all HIV-positive pregnant mothers in the province by April. He has been condemned for his decision by national Health Minister Manto Tshabalala-Msimang, who is increasingly facing criticism over her stance on the nevirapine issue”* (News24, 2002). Although the Health MEC had for some time wanted to commence with the PMTCT programme, the announcement by the IFP-appointed Premier provided the political

support needed to act. An important technicality was that the MEC could **not** defy the Premier. One key respondent in this study asserted:

“I think they gave him [KZN MEC of Health] a reprieve, an escape route, because I think in his heart he wanted to give the treatment, because I know he trained at McCords hospital and McCords hospital was giving treatment and they were having USAID funding and they were giving they were giving the treatment. He was close to his hospital where he used to work... He wanted to give the treatment but he had to correctly align himself with the policy of his party [ANC]. I think that was his dilemma and the escape route was provided by the provincial situation that he could address his inner feelings” (former senior bureaucrat, provincial sphere of government).

Similar developments occurred in Gauteng Province in **February 2002**, when the province broke rank from the national Ministry of Health. On **18 February 2002**, media houses reported that the Premier of Gauteng, Mbhazima Shilowa, had announced that *“all public hospitals in Gauteng will provide the anti-retroviral drug nevirapine to prevent the transmission of HIV from mother to child”* (South African Press Association [SAPA], 2002). He was further quoted as having stated that *“during the next financial year, we will ensure that all public hospitals and our large community health centres provide nevirapine for the prevention of mother to child transmission (MTCT)”* (SAPA, 2002). This coincided with the release by the Health Systems Trust (HST), a NGO working in the health sector, of an evaluation report from 18 PMTCT pilot sites nationally, which had concluded that there was no reason to further delay the national scale-up of the PMTCT programme.

Other media houses reported that *“Mbhazima Shilowa, Premier of South Africa's Gauteng province, yesterday announced that his government will make the antiretroviral drug nevirapine available to all HIV-positive pregnant women at public hospitals in an effort to reduce vertical HIV transmission, a move that defies national policy set forth by Shilowa's own party, the African National Congress”* (KFF Health News, 2002).

In Gauteng, Premier Shilowa's direct defiance of the national Minister of Health again enabled the Health MEC to commence PMTCT roll-out throughout the province. Commenting on these developments, Schneider et al. (2010) observed that “in Gauteng, political support came from an ANC aligned provincial premier who had sufficient political capital within the ruling party to chart an independent course on AIDS in the province. The Premier was instrumental in supporting the early use of ART in this province, chaired high-level multi-sectoral provincial HIV teams and a Provincial AIDS Council, and secured a large budget for the provincial HIV programme from the provincial equitable share” (p. 7).

The Constitutional Court decision was then welcomed by those MECs who supported PMTCT implementation, even though, ordinarily, the executive arm of the state would have felt that the Judiciary was interfering in their scope of work. As key informants in this study noted, these MECs just stated that *“there is a court judgement, we cannot defy the courts, we have to follow the court judgement”* (former senior bureaucrat, national sphere of government). In other words, the MECs were relieved that they could carry on with the implementation of the PMTCT policy.

Ultimately, the Cabinet of the Republic of South Africa released a statement on **17 April 2002** supporting PMTCT roll-out. The statement indicated that “on anti-retroviral treatments in general, Cabinet noted that they could help improve the conditions of PWA’s if administered at certain stages in the progression of the condition, in accordance with international standards. However, because these drugs are too costly for universal access and, because they can cause harm if incorrectly used and if the health systems are inadequate, government will continue to work for the lowering of the cost of these drugs, and intensify the campaign to ensure that patients observe treatment advice given to them by doctors” (Government Communication and Information Services [GCIS], 2002). It further stated that “research on the use of Nevirapine against mother-to-child transmission will continue, at the same time as government implements the temporary ruling of the Constitutional Court. In the meantime, the Department of Health is working on a Universal Roll-out Plan to be completed as soon as possible, in preparation for the post-December 2002 period” (GCIS, 2002). This very carefully crafted statement marked the emergence of a turning point, a shift in the mindset of Cabinet. Prior to that point, excessive focus had been placed on the toxicity of ARVs, and there was reluctance to accept that these drugs do work, even when evidence was produced. From April 2002, the public health sector worked to define the specific circumstances under which ARVs work, which were defined to include good supervision, security of supply, training of health care providers, and monitoring, among others.

The Cabinet Statement of **09 October 2002** then affirmed that “by June over 101 000 women had visited facilities attached to the 18 research sites – 63 000 accepted voluntary counselling and testing. Nevirapine was dispensed to 10 043 women and 6 947 babies. Training in the Universal Roll-Out plan has started in all provinces. Health facilities for testing are being upgraded. Funds will be availed for the roll-out. After the Constitutional Court judgement all provinces received guidelines for implementation of the PMTCT package and will expand services according to their differing capacities. Already KwaZulu/Natal, Gauteng, Northwest and Western Cape have extended coverage to a significant number of their health institutions and other provinces are following suit” (GCIS, 2002b).

6.3.2. Evidence, issue characteristics and ideas

The growing body of evidence in support of PMTCT had growing influence over time, offsetting the Minister’s argument that there was insufficient evidence to support its nation-wide roll out. As reflected in **Tables 6.4 and 6.5**, the South African research community played a key role in generating this evidence, particularly scholars from Schools of Public Health and the Departments of Obstetrics and Gynaecology and Paediatrics in Medical Schools in various universities. Key informants in this study accorded the members of the research community a place of honour for their contribution to the development of the PMTCT policy during 2002. As one key informant stated, *“an advocacy group emerged consisting of concerned clinicians, researchers and civil society groups – calling for PMTCT. They made individual and collective efforts as clinicians, researchers to gather evidence at their own cost”* (former senior bureaucrat and clinical expert, provincial sphere of government and former hospital CEO during 2001-2002).

Civil society structures were also credited for readily accepting the evidence that was emerging from local and international contexts, and lobbying for the development of the PMTCT policy. Former senior government bureaucrats who were in office in 2002, key informants in this study, noted that when the Treatment Action Campaign (TAC) won its case against government in the High Court in 2001 and subsequently in the Constitutional Court in 2002, this judgement was welcomed by most senior technocrats. This was because they had been frustrated by political interference in the use of evidence to develop and implement the PMTCT policy nationally.

These senior government bureaucrats had a difficult balancing act during the litigation process. Some reported that the task of drafting the affidavit opposing the litigation by the TAC required them to be very careful in their arguments because they were articulating what policy-makers had decided, not what they necessarily agreed with, as medical professionals. This created an ethical dilemma. As one former senior bureaucrat stated:

“But you know there are certain affidavits where you draw a lot on your own experience, but in this particular case I think if anybody read those affidavits, you’ll find that was actually far much more...a dry articulation of what are the decisions, what was considered by the MinMEC... Precisely, it was one of those most difficult moments. I remember discussing it with the lawyers...You know one of the things, in all of that debate though, what was very interesting was that all that was happening was a delay in initiating a treatment programme” (former senior bureaucrat, national sphere of government).

In the same vein, other former senior bureaucrats from the national sphere of government defined the Constitutional Court judgement of 2002 as a blessing, as the political resistance to the adoption and implementation of the PMTCT was no longer reasonable, and could not be sustained any further. Indeed, they argued that without the court judgement, empirical evidence alone would not have decided or settled the PMTCT debate in South Africa. The legal judgement added power and legitimacy to the available evidence and enforced the implementation of an evidence-based PMTCT policy. Some respondents believed that the turning point would still have come, but significantly later.

By 2002, the growing knowledge about PMTCT also became a major source of power for Provincial Health MECs. This was in contrast to 2001, where political power was more important given the Health Minister’s senior leadership position within the ANC. The MECs who defied the national Minister and started implementing PMTCT were based in provinces where there was an overwhelming depth of research capacity on HIV/AIDS, in various academic institutions and schools of public health. Expertise on PMTCT in Gauteng was at Wits University and Baragwanath Hospital, and in KwaZulu-Natal the expertise was at the University of KwaZulu-Natal and CAPRISA. Key informants cited the names of eminent scientists who they considered as pioneers of the evidence that led to the development of the PMTCT programme.

One key informant stated that:

“On PMTCT it [expertise] was in Baragwanath Hospital, this unit was led by Glenda Gray. But generally you had Slim Karim and Jerry Coovadia in KwaZulu-Natal, they were putting pressure on Zweli [MEC Mkhize], and obviously Zweli had come to be persuaded that we need to do something. So even the MinMEC was not completely united (former senior bureaucrat, national sphere of government).”

The Western Cape Province, meanwhile, had its own local research capacity at UCT and the University of Stellenbosch. In addition, during 1999-2004, Gauteng, KwaZulu-Natal, and Western Cape Provinces also had strong Heads of Department (HoDs), who possessed strong clinical and technical skills in addition to their administrative leadership skills. As more evidence emerged from research studies supporting the need to save babies by establishing a PMTCT policy and programme, Health MECs in these provinces were then emboldened to break rank from the national Ministry of Health. Consistent with the old adage that knowledge is power, evidence became a source of power for the Health MECs who were members of the ANC. The findings of this study point to the fact that key policy elites had acquired knowledge about the efficacy of a nevirapine-based PMTCT programme, which Balane et al. (2020) define as stakeholders' understanding of the policy. They fully understood the policy goals of the programme, as well the evidence base on which it was founded and anchored. They also had adequate knowledge of the work of AIDS dissidents led by Dr. Duesberg, but were not persuaded by the dissenters and instead sought to forge ahead with the implementation of PMTCT. One key informant stated:

“I think I remember well at that time Gauteng started, at the hospital where I was as a CEO, and we were given an instruction by our MEC at the time, that we had to start the programme and it was very haphazard because we didn't really have the guidelines, there had to be quick pushing of Midwives and clinicians to go for training quickly to be able to administer the drugs properly. It was policy development in reverse... Where the circumstances were just pushing, and the policy started abruptly like that and there was no clear agenda that was set but everybody knew in the medical world and the nursing world that something has to be done, because the nurse would be seeing the patients and everybody was aware of the need to do something. Granted, nothing could be done for adults at that time, even though the advocacy was there that something had to be done” (former senior bureaucrat provincial sphere of government and former hospital CEO).

In the foreword to the National DoH's *Policy and Guidelines for the implementation of the PMTCT Programme*, which Minister Tshabalala-Msimang signed on 10 February 2008, the Minister's persistent ambivalence about the PMTCT programme was still self-evident. The Minister stated that:

“After much discussion between policy makers and scientists, the Department of Health introduced the prevention of mother-to-child transmission of HIV (PMTCT) programme in 2001. The programme was first piloted to explore the impact of the use of nevirapine both with respect to its side effects as well as the operational requirements of the programme. The Department had concerns about the use of

monotherapy and the possibility of resistance to a single drug as well as the lack of clarity on infant feeding options. The presentations by the scientific community also suggested that the use of monotherapy needed further research. But whilst these discussions were taking place, the Constitutional Court ordered otherwise, in 2002, the implication of which resulted in the expansion of the Nevirapine use without adequate requisite preparations” (Tshabalala-Msimang, 2008, p. 4).

By monotherapy, the Minister was referring to the single dose nevirapine that was administered to the mother at the onset of labour and to the newborn baby within 72 hours after birth.

6.4. PMTCT policy evolution during 2002-2008

Table 6.6 below summarises the factors that affected the evolution of the PMTCT policy after the Constitutional Court judgement, until 2008/09. This was a period of sustaining the implementation of a now-accepted policy.

The controversies around PMTCT largely dissipated in 2002. The national Ministry of Health (grudgingly) provided political oversight for the implementation of the national PMTCT programme, while Health MECs steadfastly implemented the PMTCT programme across provinces.

In September 2008, the ruling ANC recalled President Thabo Mbeki from office, having lost confidence in him, as evidenced by his defeat nine months earlier at the ANC conference in Polokwane in December 2007. The ANC argued that it did not want two centres of power, in which there was a newly elected President of the ruling party, Jacob Zuma, and a different President of the country, Thabo Mbeki. President Mbeki accordingly resigned from Office and Kgalema Motlanthe, who had been elected Deputy President of the ANC at the December 1997 conference, assumed office as President of South Africa. Motlanthe’s appointment as President created a new political climate which was extremely conducive for the evolution of the PMTCT policy. First, Motlanthe removed Minister Tshabalala-Msimang from Office, and replaced her with Ms. Barbara Hogan, a former political prisoner on Robben Island, who had become an activist for social justice and a civil society member. Second, Minister Barbara Hogan immediately signaled a break from the past tradition of the Ministry of Health by declaring publicly in her first few days in office that “HIV causes AIDS” and that this belief would henceforth guide South Africa’s response to the epidemic. Minister Hogan rapidly expanded PMTCT and ARV programmes, and the Health MinMEC continued to embrace PMTCT as a national policy and had high levels of cohesion.

Table 6.6: Summary of factors that affected the national agenda setting for PMTCT from 2002 onwards (Shiffman & Smith, 2007)

Elements	Description	Factors shaping policy priorities
Political Context	• Changes occurred in the political leadership of the ruling ANC in 2007 and in the Presidency in 2008. In May 2009, Jacob Zuma was elected President of South Africa. • Aaron Motsoaledi was appointed as Minister of Health in 2009. • Motsoaledi spearheads an evidence-based approach to HIV/AIDS broadly and to PMTCT specifically.	• Changes in the political leadership of the ruling party and the country enabled new and constructive approaches for addressing HIV/AIDS and for expanding the PMTCT programme. • Minister Motsoaledi sustained the belief that HIV causes AIDS, and established an evidence-based national response to HIV/AIDS. This was a continuation from the approach adopted by Minister Barbara Hogan in September 2008. • Implementation of both the PMTCT programme and the ARV programme was scaled up. • Partnerships and alliances between government and civil society on HIV/AIDS are continued and sustained.
Actor Power	• A new policy community emerged in the health sector in September 2008, which supported the national roll-out of the PMTCT programme. • The Health MinMEC, as the policy community in the health sector, embraced PMTCT as a national policy, and had high levels of cohesion. Their support for PMTCT was voluntary and not coerced by a court judgement. In fact, they viewed the judgement as an “enabler”.	• In December 2007, Thabo Mbeki surrendered the Presidency of the ANC to Jacob Zuma. • In September 2008, Mbeki was removed from Office and replaced by Kgalema Motlanthe. • Motlanthe removed Manto Tshabalala-Msimang from the Health portfolio and appointed Ms Barbara Hogan, a social justice activist, as Minister of Health. • Manto Tshabalala-Msimang became a Minister in the Presidency. • The Health MinMEC and Technical MinMEC of 2008-09 became effective guiding institutions for the implementation of PMTCT, providing effective coordinating mechanisms for all 9 provinces, and providing PMTCT to all eligible women to save children.

Elements	Description	Factors shaping policy priorities
Ideas	Under the Zuma Administration, the framing of South Africa's response to HIV/AIDS was based on a clear, well-articulated premise that HIV causes AIDS.	After his appointment, President Zuma immediately acknowledged HIV/AIDS as among the most important challenges facing South Africa. Zuma announced new policy changes on World AIDS Day, 1 December 2009, demonstrating unprecedented political leadership on HIV/AIDS.
Issue characteristics	- As the new incumbents of their respective portfolios, President Zuma and Minister Motsoaledi were eager to accelerate the national implementation of the PMTCT policy and programme, to save the lives of South African babies. - Progress towards PMTCT was accelerated, based on the evidence that a PMTCT policy and programme anchored on nevirapine was effective in reducing mother-to-child transmission. - Further enhancements of the PMTCT programme were announced in President's Zuma speech on World AIDS Day, 1 December 2009.	The problem of mother-to-child transmission of HIV was still high in 2009. It was estimated that over 100,000 babies had been infected with HIV acquired from their mothers during the first decade of democracy, 1994-2004, a period of AIDS denialism. This spurred on the incoming President and Minister to act with speed to roll out the PMTCT programme.

This new policy direction on HIV/AIDS and PMTCT was strengthened when Jacob Zuma was elected President of South Africa in May 2009. President Zuma appointed Dr. Aaron Motsoaledi as Minister of Health. Motsoaledi believed in the scientific and globally accepted approaches to HIV/AIDS, and PMTCT heralded a new environment in South Africa, which marked the beginning of the end for AIDS denialism. President Zuma immediately acknowledged HIV as among the most important challenges. On World AIDS Day, on 1 December 2009, President Zuma made a watershed announcement that "Antiretroviral Treatment (ART) would be provided to pregnant women with a CD4 count of 350 or less to enhance maternal survival. ART would also be provided to people co-infected with TB and HIV with a CD4 count of 350 or less. Treatment would be initiated on all children less than one year of age who test positive for HIV, irrespective of their CD4 count. This initiative should contribute significantly to reducing the morbidity and mortality rates associated with TB and HIV and AIDS" (Annual Report of the National Department of Health 2009/10, p. 2).

Zuma's statements brought urgency and a renewed focus to the HIV response (Barron et al., 2013).

Although the speech delivered by the President on 1 December 2009 was prepared by the National DoH almost in its entirety, delivery by the newly elected President gave it significance. This President had won the overwhelming support of his own party, the ANC, at the Polokwane conference in December 2007 (amassing 2,329 votes from the 4,000 voting delegates (SAHO, 2017), translating into 58,2% of the votes), as well as 65,8% of the national vote in the elections held on 22 April 2009. This was acclaimed even by the international media (Smith, 2009).

From 2009 onwards, Minister Motsoaledi continued to support evidence-informed interventions to combat HIV/AIDS, other sexually-transmitted illnesses, and TB. In the same manner as Minister Tshabalala-Msimang had relied on President Mbeki for political support for her stance on PMTCT and HIV/AIDS broadly, Minister Motsoaledi relied on President Zuma's support. The main difference was that while the Mbeki-Tshabalala-Msimang alliance was based on what many researchers described as AIDS denialism, the Motsoaledi-Zuma alliance was established on a common belief in an evidence-based approach to HIV/AIDS, which the global community had accepted as the most effective and helpful approach. The re-alignment of political forces in South Africa, from the Mbeki to the Zuma Administrations, had positive spin-offs for the use of evidence in policy-making in South Africa.

By 2010/11, the growth of the PMTCT programme was tangible. The 2010/11 Annual Report of the National DoH stated that, "from the prevention of mother-to-child transmission (PTMCT) programme, there were major improvements. A total of **79.4%** eligible HIV-positive pregnant women were placed on HAART, which exceeded the target of **70%**. This also exceeded the **76.6%** recorded in 2009/2010" (DoH, 2010a, p. 42). The reporting further stated that "during the reporting period, the PMTCT programme reflected improved outcomes, including improved coverage and sustained declines in transmission rates. The number of PCR tests done on babies aged two months increased in all provinces between 2008 and 2010. At the same time, the HIV positivity rate amongst babies decreased in all provinces between 2008 and 2010, with major decreases in KwaZulu-Natal, Free State, Limpopo, Mpumalanga and the Northern Cape" (DoH, 2010a, p. 42).

Over time, evidence became the basis for PMTCT policy adaptations. As reflected in **Table 6.7**, the policy evolved from the use of the single-dose nevirapine administered to mothers at the onset of labour (childbirth) and a single dose given to infants within 72-hours of birth to reduce the risk of transmission of HIV to newborn babies, through several iterations in 2008, 2010, and 2015. The policy intent was to significantly reduce and eventually eliminate the risk of early mother-to-child transmission of HIV, measured in 6-week-old babies, through the provision of nevirapine to mothers. The policy subsequently evolved from the provision of nevirapine only, to lifelong triple ART, which was provided for all HIV-positive pregnant and lactating women (DoH, 2019). **Table 6.8**, meanwhile, summarises the evidence used to support these policy adaptations.

Table 6.7: Summary of the evolution of the PMTCT Policy in South Africa post-2002

Period	Chronological Amendment to the PMTCT Policy Guidelines
2001-2002	• Single dose nevirapine, monotherapy • South Africa's PMTCT policy stated that HIV-positive mothers should try and avoid breastfeeding
2008	• 2008 South African PMTCT guidelines offered dual therapy consisting of (a) maternal AZT prophylaxis from 28 weeks gestation and through labour and a single dose nevirapine (sdNVP) or ART if CD4≤250 cells/μl or Stage IV disease, and (b) all infants received single dose nevirapine and AZT for 7 (or 28) days. • 2008 South African PMTCT guidelines were based on the WHO 2006 PMTCT policy where it was found that longer treatment was better. • However, the 2008 guidelines did not include breastfeeding as a form of extended prophylaxis. The policy accentuated the need to start mothers early on treatment, introducing triple therapy from a CD4 cell count of 250.
2010	• 2010 South African PMTCT guidelines offered maternal AZT prophylaxis from 14 weeks with FDC/TDF in labour and sdNVP or ART if CD4≤350 cells/μl or Stage III/IV disease. All infants received six weeks nevirapine or for one week after breastfeeding stops (Goga et al., 2012, p. ix). • This was known as PMTCT Option A • 2010 Guidelines advocated for a public health approach to HIV and to PMTCT instead of focusing only on reducing transmission. Reducing transmission had to be coupled with improving child health. • Guidelines incorporated WHO guidance that it was not helpful to have babies who were HIV-negative, but then dying from diseases such as diarrhoea and pneumonia. • 2010 guidelines incorporated global evidence that showed that avoiding or stopping breastfeeding early was dangerous for child health. It might prevent transmission but in terms of HIV-free survival, it did not benefit children. These guidelines therefore advocated for breastfeeding of babies by mothers who were HIV-positive.
2013	• Provided continued guidance towards a reduction in the vertical transmission of HIV • Provided algorithms for keeping women and children healthy, improving their quality of life, and reducing mortality • Algorithms for provider-initiated counselling and testing for women and infants • Routine clinical care for HIV positive pregnant women • PMTCT Regimens • Establishing exclusive breastfeeding • Mother-Infant follow-up
2015	• 2015 Policy Guidelines introduced birth testing, based on South African data, from the NHLS. • Previous Guidelines stipulated that babies should be tested for HIV at six weeks and then six weeks after breastfeeding cessation, in 18 months. • NHLS data showed that the period of highest risk of transmission is the first six months of life. Birth testing enabled identification of a large proportion of HIV-infected babies to initiate them on treatment as soon as possible.

Table 6.8: Summary of the use of evidence in the evolution of the PMTCT policy post-2002

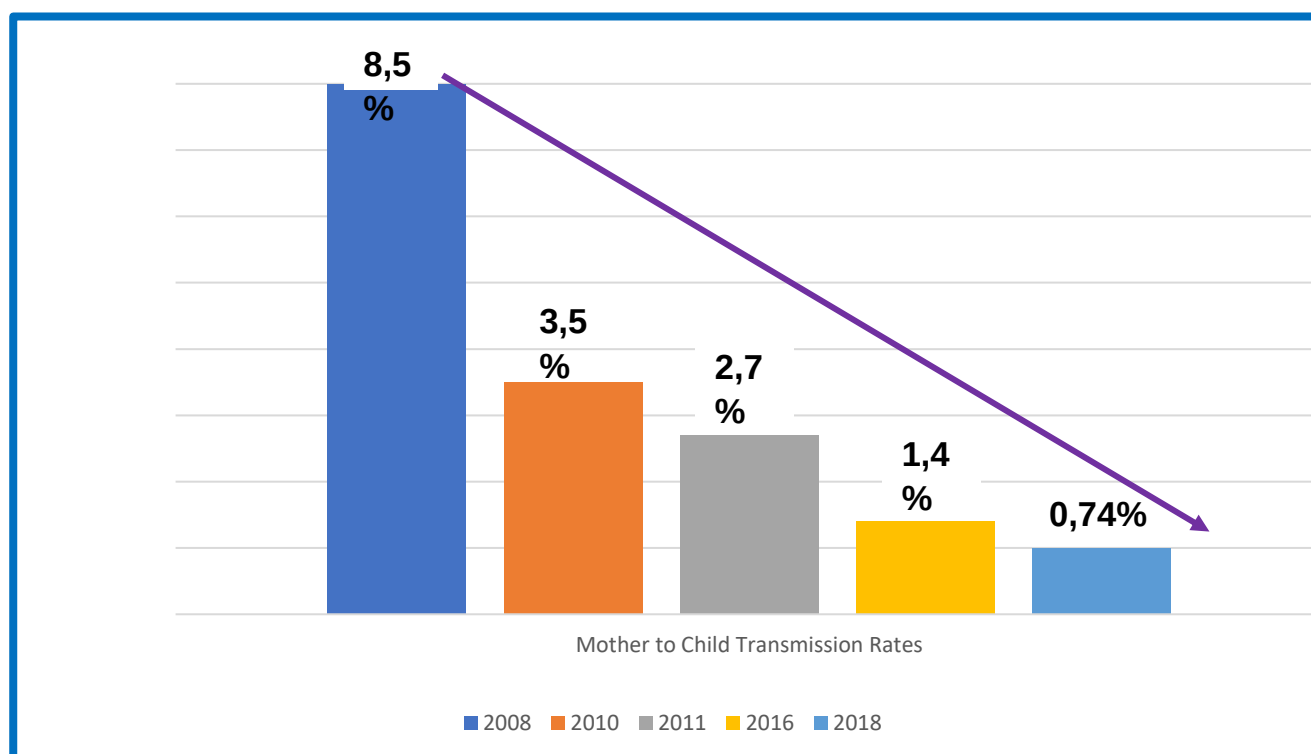
Version of PMTCT Policy Guidelines in South Africa		Primary Source of evidence
1	2008 PMTCT policy guidelines	Local South African studies, e.g. Sherman, G.G., Jones, S.A., Coovadia, A.H., Urban, M.F., and Bolton, K.D. (2004). PMTCT from research to reality – results from a routine service. <i>South African Medical Journal</i>, 94(4), 289–292.
2	2010 Policy Guidelines	- Kesho Bora study conducted by the WHO with the French National Agency for Research on AIDS and Viral Hepatitis (ANRS), the US Centers for Disease Control and Prevention (CDC) in Burkina Faso, Kenya and South Africa - WHO HIV/AIDS Programme, antiretroviral drugs for treating pregnant women and preventing HIV infection in infants - Recommendations for a public health approach
3	2013 Policy Guidelines and 2015 Policy Guidelines	- Local PMTCT evaluation studies conducted by South African research institutions, including the South African Medical Research Council (MRC) - School of Public Health, University of the Western Cape - Centers for Disease Control (CDC) and Prevention - PEPFAR - National Institute for Communicable Diseases/National Health Laboratory Service in South Africa - Wits University Paediatrics HIV Diagnostics - UNICEF - Expertise from the National DoH

6.5. PMTCT policy outcomes

The implementation of the 2008 PMTCT policy in South Africa has yielded desirable results. South African literature shows that, as a result of implementation of PMTCT post-2002, the rates of mother-to-child transmission of HIV decreased significantly. The real beneficiaries of PMTCT were South African babies and their families, as the rates of mortality among babies declined significantly. This is reflected in **Figure 6.1**.

The MRC conducted systematic studies of mother and baby pairs to periodically monitor the effectiveness of the PMTCT programme in reducing perinatal transmission of HIV from mothers to infants, measured at 4-8 weeks after infant birth. In 2008, the MRC found the mother-to-child transmission rate to be on average **8,5%** nationally. Two years later, in **2010**, the MRC PMTCT study found that the mother-to-child transmission rate had decreased substantially to **3,5%**. A follow-up MRC PMTCT study in **2011** found that the transmission rate had decreased further to **2,67%**, compared to the 2010 and 2011 rates. The success of the implementation of the 2015 PMTCT Option B+ policy was seen in the reduction of the risk of early mother-to-child transmission of HIV, measured in 6-week-old babies, from 25-30% prior to 2001 to an estimated **1.4% in 2016/17** (DoH, 2019). As of the end of 2018/19, the health sector reported the national mother-to-child transmission rate to be **0.74%** (DoH, 2019).

Figure 6.1: Reduction in Mother-to-Child Transmission Rates of HIV over the period 2008-2018



Source: Designed by the researcher based on data from Goga et al. (2013) and Annual Reports of the National Department of Health 2016 and 2018.

6.6. Final reflections on the use of evidence in the development of the PMTCT Policy and Programme

The first key reflection from the PMTCT case study is that the use of evidence in policy-making in the South African health sector was heavily influenced by powerful political actors. How and why evidence was used was closely associated with the personalities that occupied political office during different eras. The use of evidence was also shaped by the alliances and coalitions that the powerful political actors developed and nurtured over time. This is consistent with both the conceptual and empirical literature examined in Chapter 2.

In the Ministry of Health in South Africa, the development of the PMTCT policy and the use of evidence in this process unfolded differently between the periods of 2001 and 2002, when the incumbent of the Office of Minister of Health was an AIDS denialist, supported by a Head of State who harboured similar views. The framing of the evidence of the efficacy of a nevirapine-based PMTCT policy and programme in reducing the burden of HIV transmission differed during these two periods. The AIDS denialists that provided information to the President and Minister of Health during the period 2001 framed the issues in a manner that prevented the use of emerging scientific evidence. Actor power (Shiffman & Smith, 2007) was concentrated in the President and the Minister, and the source of this power was their influential positions

within the ANC NEC, as well as their framings of the issues at hand. In 2001, the President and the Minister were powerful, and their framing of issues was the dominant view. However, this subsequently changed in 2002.

With respect to the availability of evidence to inform policy, there were at least seven diverse sources of evidence about the efficacy of PMTCT that were at the disposal of policy-makers in 2001. There were reflected in **Table 6.3**. The evidence converged to demonstrate that nevirapine-based PMTCT was safe enough to do “no harm”, which is the first principle in medicine. Beyond doing no harm, the emerging evidence had begun to demonstrate the efficacy of PMTCT. However, the alliance and coalition of political leaders in the Health MinMEC, including the Minister, portrayed the real problem (Shiffman & Smith, 2007) as the lack of sufficient evidence to implement the PMTCT programme. Reflecting back on this period of denialism and lack of use of evidence, Dr. Mamphela Ramphele, the former Director of the World Bank and former Vice Chancellor of UCT, stated that “just like Brazil, South Africa had the depth of scientific know-how and economic resources to deal a mortal blow to the disease. However, unlike Brazil, which unambiguously tackled the pandemic early on, South Africa continued to give out confusing messages and advice to people already overwhelmed by the trauma of the disease” (cited in Bateman, 2005, p. 464).

The context in which policy is developed is also an important determinant of whether evidence will be used or not. The political support that the Minister of Health enjoyed in 2001 ensured that she suffered no consequences from the President at the time for not using evidence from the seven sources cited in **Table 6.3**. above. On the contrary, she was rewarded with another term of office as Minister of Health in 2004.

A second key reflection from this case study is that specific groups of powerful actors, their alliances, and coalitions are not permanent features of the policy-making environment. They change over time as they are shifted sideways by new political developments. The use of evidence in health policy-making unfolded differently during the period 2008-2015, following the change of powerful political actors. This occurred when the previous leadership was replaced with incumbents who believed that HIV causes AIDS, and who readily accepted and rapidly used evidence from local and global research institutions and the UN agencies to produce sequential iterations of the PMTCT policy guidelines and to keep abreast of international developments.

The defiance by Health MECs in two ANC-governed provinces in 2002, Gauteng and KwaZulu-Natal, of the position adopted by the national Minister of Health illustrates the contestability of evidence and of the policy processes in which this evidence is used. As the existing body of evidence increased, it became a powerful source of knowledge for these MECs and, in turn, a significant source of power, confidence, and assertiveness. It changed the original framing of the PMTCT issues as articulated by the Ministry of Health. Furthermore, the defiance by these two provinces, informed by the rapidly emerging evidence of the efficacy of PMTCT, illustrates that power is derived not only from the office that a political leader inherits or is appointed into, but also from the personal attributes that an incumbent brings into a public office. In this case, both MECs brought into their portfolios not only political popularity, but also vast knowledge of the fields of medicine and public health,.

6.7. Conclusion

A key lesson from the policy process case discussed in this chapter is that evidence alone is **not** sufficient to influence health policy-making processes. This is also consistent with the literature. In the case of the development of the PMTCT policy and programme, civil society and the judiciary played an important role in compelling policy-makers in the health sector to use the existing evidence to scale up the PMTCT programme nationally. Evidence from the 18 PMTCT pilot sites in South Africa, and other global evidence, enabled the courts to compel government to take rational decisions about the lives of South Africans. The courts gave weight to the evidence that existed in 2002 about the efficacy of PMTCT. Ironically, the 18 PMTCT pilot sites had been designed by the health sector, but when evidence emerged from these pilots, government was reluctant to embrace it. The advocacy role of civil society and the independent judiciary provided an enabling environment for evidence to be used in the national roll-out of the PMTCT programme. Evidence became a source of power in 2002, not political power but judicial power, when the Constitutional Court of the country ruled that sufficient evidence existed for the national roll-out and scaling-up of the PMTCT policy and programme in South Africa.

With evidence alone and without the Constitutional Court judgement, the national roll-out of PMTCT in South Africa would have been achieved much later than it occurred.

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CHAPTER 7: THE USE OF EVIDENCE IN THE DEVELOPMENT OF THE NATIONAL CORE STANDARDS POLICY

7.1. Introduction

This chapter presents the study findings explaining the formulation of the 2011 National Core Standards policy, a regulatory, health systems policy, rather than a service delivery policy (as is the case with PMTCT). It again uses a force field analysis framework derived from Gilson et al. (2012) to consider actor positions and relative power at different times, and the framework of Shiffman and Smith (2007) to consider how policy actors exercised power and used evidence.

The policy processes of the National Core Standards policy in 2011 were not as contested and controversial as the development of the PMTCT policy. It did not involve active campaigns by civil society and other stakeholders agitating for the development, finalisation, and adoption of the policy, nor did it entail a demonstration of people's power resulting in litigation against the state. Unlike the PMTCT process, the development of the National Core Standards was a top-down, low politics or low-key process. Although it did entail internal contestations within the health sector, these were finally resolved with sufficient, although not total, consensus. The policy was published in 2011 to provide guidance to the entire health system, including both public and private sectors.

Nonetheless, as will be discussed, the policy process was rendered complex by changes in powerful political actors – first in 2008 and once more in 2009. The original efforts were led by Minister Tshabalala-Msimang in 2007/08 and focused only on piloting a set of core standards in 27 facilities. The removal of President Mbeki from office by the ANC in 2008 resulted in Minister Tshabalala-Msimang also being removed from the health portfolio, and replaced by Minister Barbara Hogan. The latter was then substituted by Minister Aaron Motsoaledi in 2009. These leadership changes had a significant bearing on policy development and the use of evidence during this process.

This chapter is structured into six sections. The first section presents the policy development timeline of the National Core Standards policy, tracing its origin from the Reconstruction and Development Plan (RDP) of 1994, up to the production of reports of the Office of Health Standards Compliance (OHSC) in 2016/17 and 2018/19. The second section offers insights into the political context of policy development during the period 2009-2014. The third section presents the policy formulation dynamics and lends insight into the actors and actor dynamics, framing of the problem and the solution, including ideas and issue characteristics, and evidence-related contestations during policy formulation. The fourth section reflects the outcomes of the policy process. The fifth section provides a set of reflections on the National Core Standards policy. The sixth and final section presents the conclusions of the chapter.

7.2. Policy Development Timeline

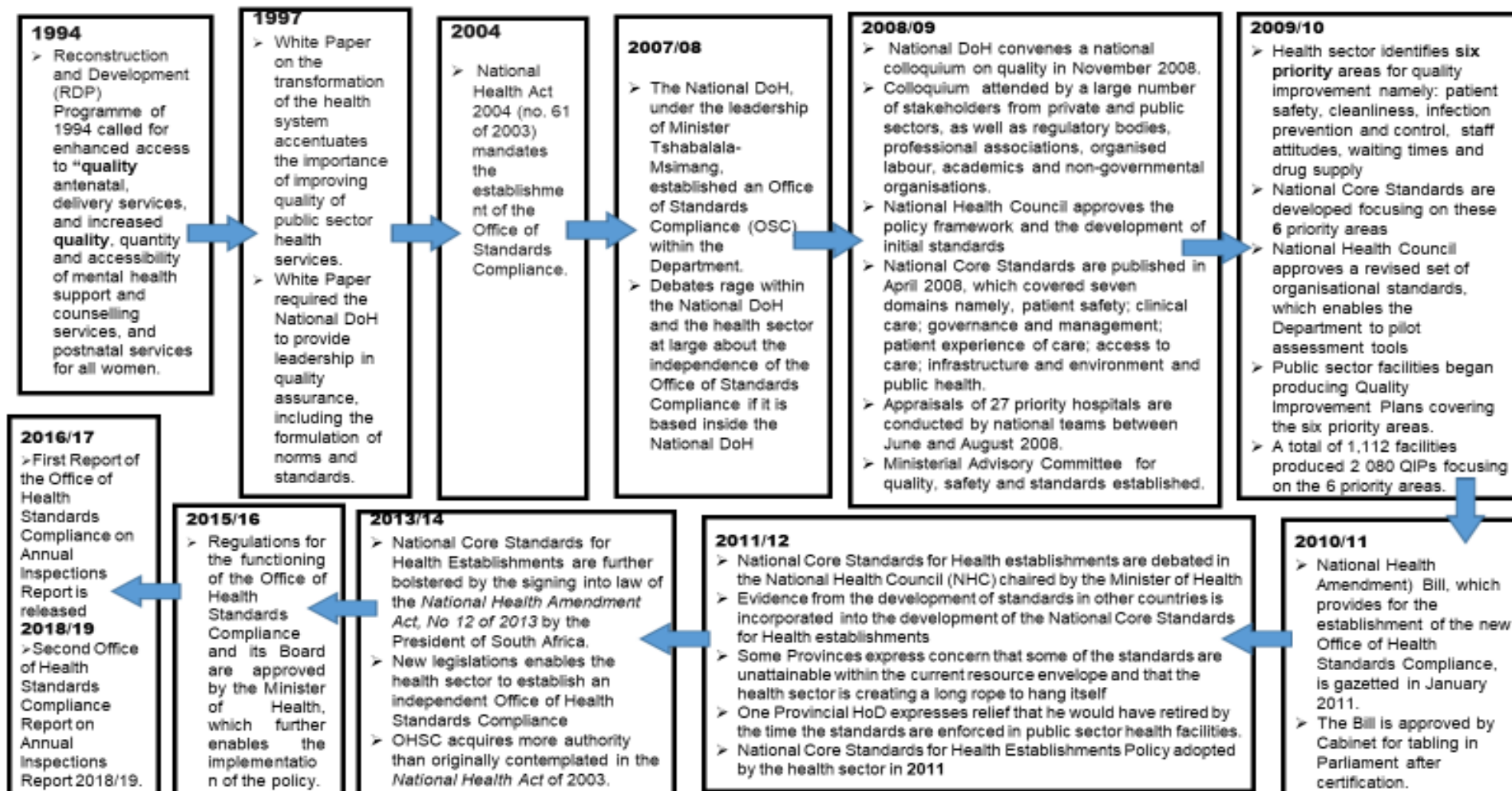
As reflected in **Figure 7.1** below, the legal and political mandates that necessitated the development of the National Core Standards for Health Establishments policy predate the actual development of this policy by almost two decades. These include the Reconstruction and Development Programme (RDP) of 1994, the major goal of which was to improve the quality of life of all South Africans, including through improving the quality of health services. The RDP of 1994 called for enhanced access to “**quality** antenatal delivery (section 2.12.6.2) and increased **quality**, quantity and accessibility of mental health support and counselling services, postnatal services for all women (section 2.12.7.2) (ANC, 1994). This is reflected in **Figure 7.1**.

Subsequent to the RDP of 1994, the White Paper on the Transformation of the Health System of 1997 and the National Health Act, No. 61 of 2003, provided a further mandate for the development of the policy. The 1997 White Paper accentuated the importance of improving quality health services in the public sector. It stated that the Department of Health had a responsibility to: “(a) Provide leadership in the formulation of health policy and legislation, including the development of an NHS [National Health System]; (b) Provide leadership in quality assurance, including the formulation of norms and standards” (DoH, 1997, p. 7/19). The White Paper also called for the establishment of a Health Services Directorate which would be “responsible for developing norms and standards for basic packages of health services, their delivery and the quality of care and developing systems and methodologies for quality assurance and the maintenance of good quality care” (DoH, 1997, p. 8/19).

This vision was carried into the National Health Act, No. 61 of 2003, which mandated the establishment of the Office of Standards Compliance (OSC). Recognising the importance of improving the quality of health services in the country, Section 78 (1) of the Act mandated the Director-General of the national health department to establish an OSC, which must include a person who acts as ombudsperson in respect of complaints in terms of this Act. The Act prescribed a total of 11 functions (section 78(2)(a) to (m)), which must be performed by the OSC. Key among these functions were that the OSC must:

- (a) Keep the Minister informed of the quality of the health services provided throughout the Republic as measured against prescribed health standards
- (b) Advise the Minister on norms and standards for quality in health services
- (c) Advise the Minister on norms and standards for the certificate of need processes
- (d) Recommend to the Minister any changes which should be made to the prescribed health standards
- (e) recommend to the Minister new systems and mechanisms to promote quality of health services.

Figure 7.1: Key milestones in the development of the National Core Standards policy



Source: The diagram (**Figure 5.3.**) was designed by myself based on insider-knowledge; literature review, as well as continuous review and inputs from the thesis supervisor

The legal provisions of the National Health Act were further taken up by the National DoH in 2007/08 and 2008/09 in the form of 27 pilot sites for National Core Standards. During this process, the core instruments and processes for measuring quality were piloted. Beyond the piloting phase, formal policy development commenced in 2009/10, and was completed in 2010/11, under the leadership of Minister Motsoaledi and Deputy Minister Sefularo (see **Figure 7.1**).

7.3. The dynamics of the policy formulation process 2007/8-2010/11

7.3.1. Political context

The final stage of developing the National Core Standards for Health Establishments policy was motivated by several developments in the broader political environment, outside the health sector. Following the 2009 elections, the Presidency as the highest executive structure of government and national government department had adopted the Medium-Term Strategic Framework (MTSF) 2009-2014 as a plan for implementing the electoral mandate for the 5-year term of office of the democratic government. Among its core national priorities, the MTSF 2009-2014 included the need to improve quality of care. Globally, nations of the world were working towards the Millennium Development Goals (MDGs), which had to be attained by 2015. South Africa was lagging behind in several health-related MDGs, and strengthening of the health system, including through the improvement of quality care, was imperative.

In May 2009, Minister Motsoaledi and Deputy Minister Sefularo were appointed by President Zuma to revive and revitalise an ailing health system. When Minister Motsoaledi assumed office in May 2009, the ANC and government adopted a 10-Point Plan for improving the health system over the 1999-2004 electoral cycle. Ranked 3rd in the 10-Point Plan, improving the quality of health services was among the most important priorities, and accelerating the development of the National Core Standards was a critical strategic intervention. This function was mostly delegated to Deputy Minister Sefularo.

At the same time, the Presidency adopted an outcomes-based approach to raise the bar on government's service delivery performance. Its 2009 Green Paper on Performance Monitoring (The Presidency, 2009) placed emphasis on outcomes and the impact on people's lives, rather than the previous focus on only inputs and activities. The Presidency made it mandatory for all government departments to report to the Presidency on progress towards the 2009-14 Medium Term Strategic Framework (MTSF), which itself included improving health care quality. Overall, then, the wider political climate exerted much pressure on the health sector to improve the quality of health services, including through the production of the National Core Standards.

In 2009, the health sector had adopted a 10-Point Plan for improving the health system over the period 2009-2014. In this Plan, the improvement of quality of care was ranked highly. The 10-Point Plan was also embodied in the National Strategic Plan of the National DoH for 2010-2012 and so influenced the development of health policies and the delivery of health services in the first 5-year term of office of Minister Motsoaledi. In terms of legislation, Chapter 3 of the National Health Act, No. 61 of

2003, empowered the Director-General of Health to, “in accordance with national health policy issue, promote adherence to, norms and standards on health matters...” (Section 21(2)(b)).

As already discussed, South Africa is a quasi-federal state, and some provinces have been led by parties other than the ANC. From 2009, the Western Cape province was under the governance of the Democratic Alliance (DA), giving the Health MEC and HoD of Health the latitude to express diverse views during policy development processes led by the National DoH. They were not constrained by loyalty to the ruling party, nor by anxieties about defying the hierarchy of the ruling party. In terms of the Intergovernmental Relations Framework (IGRF) Act of 2005, spheres of government are discouraged from litigating against one another and encouraged to resolve their differences within government avenues. The Western Cape did **not** exercise the legal option in 2009/10 and 2010/11, during the development of the National Core Standards. Rather, they contested issues that dissatisfied them internally, within the confines of the TECH-NHC and the NHC, the formal health policy-making structures of the health sector. They played their legitimate role in policy development as outlined in the National Health Act. At the same time, the national Ministry of Health still had the support of the MECs in the eight provinces which were still governed by the ANC in 2009.

Table 7.1: Summary of factors that affected the national agenda setting for the National Core Standards for Health Establishments policy in 2007/08

Elements	Description	Factors shaping policy priorities
Political context	- Political events and cycles impacted on Minister of Health appointments - Improvement of quality of care was ranked highly in the 10-Point Plan adopted by government in 2009-2014, which in turn impacted on the National Strategic Plan of the National Department of Health for 2010-2012	- Three Ministers of Health served over this period, each bringing a different perspective and orientation to this policy formulation process. - The appointment of Minister Motsoaledi and Deputy Minister Sefularo in 2009 created a new enabling environment for the development of core standards. - The 10-Point Plan created an important enabling environment for the Minister and Deputy Minister to mobilise the health sector across provinces to support the development of the National Core Standards for the health sector.

Elements	Description	Factors shaping policy priorities
Actor Power	Despite changes, senior political leadership supported and drove this policy process – given the imperative of improving the quality of public services	- Minister Tshabalala-Msimang used her influence in the National Health Council to advocate for the creation of 27 pilot sites for core standards. Her powers were buttressed by the new National Health Act, No. 61 of 2003. - This Minister also advocated for the establishment of an internal Office of Standards Compliance, which would ultimately report to her, and not be independent. - In 2008/09, Barbara Hogan took over as Minister of Health. She supported the development of a fully-fledged set of National Core Standards. - Although she was not very senior in the ANC hierarchy, she had power derived from the Constitution of the country, and the National Health Act, No. 61 of 2003. - The appointment of Aaron Motsoaledi as Minister of Health and Sefularo once more serving as Deputy Minister in 2009/10 enabled the latter to continue championing the National Core Standards, as he had done under Minister Hogan in 2008/09.
Ideas	Senior political leaders framed the problem in ways that catalysed action and directed the development of the National Core Standards	- In 2008/09, Minister Barbara Hogan and Deputy Minister Sefularo successfully framed the interventions to improve quality of care including through developing National Core Standards as a restoration of the dignity of the people of South Africa, particularly the previously disadvantaged majority. - Sefularo framed the poor quality of care as an attack on the dignity of the people of South Africa. Conversely, he framed the National Core Standards as a restoration of the dignity of the people of South Africa. - Without coercing the Provincial MECs, Minister Motsoaledi reminded them of the public commitments made in the 10-Point Plan for 2009-2014, which included improving the quality of care.

Elements	Description	Factors shaping policy priorities
Issue characteristics	• Ample evidence about the poor quality of health services was brought to bear on the TECH-NHC and NHC • Evidence from initial pilot sites informed policy formulation • Technocrats and bureaucrats in the national sphere of the health system provided the NHC with evidence on how poor quality of care could be improved by strengthening regulatory systems, drawing from evidence on the functioning of regulatory systems and processes in countries that provided good quality health care to their populations. • Despite the internal framing of the National Core Standards for Health Establishments policy by the national leadership of the health sector as a noble cause, contestations arose at subnational level about policy details.	• Adverse events such as the outbreak of hospital acquired infections, including the outbreak of Klebsiella in two public sector hospitals in the Eastern Cape and KwaZulu-Natal provinces, created immense pressure for Minister Tshabalala Msimang. This was an experience that Ministers who succeeded her in the Health Portfolio sought also to avoid. • Poor performance of health facilities made newspaper headlines. The national media headlines about adverse events in health facilities became the newspaper headlines on lampposts, which embarrassed the political leadership of the health sector. • The Western Cape political leadership and the administrative heads of the province (the technical policy analysts or bureaucrats) argued that the national sphere of the health sector was setting the bar “too high” and setting itself up to fail, that there was no funding for the implementation of these standards, and that the evidence gathered from overseas countries was not entirely relevant to South Africa.

7.3.2. Actor dynamics

As reflected in the force field analysis presented in **Table 7.2** below, powerful political actors who influenced the development of the National Core Standards included Minister Manto Tshabalala-Msimang (2007/08-2008/09), who directed the National DoH to pilot a set of core standards in 27 health facilities. The pilot studies were ostensibly part of gathering evidence for the development of the National Core Standards for Health Establishments. One key informant, who was centrally involved in this work, stated that:

“the main focus of the pilots was to test the inspection tools, also known as assessment tools, to ensure that they were valid, reliable and that the results they generated were replicable. The results should be consistent even when the assessment tools were used by different inspectors on different occasions. The second purpose of the pilot was to ensure that national core standards were achievable, and not a set of pipe dreams” (former senior bureaucrat, national sphere of government).

According to the key informants in this study who were former bureaucrats in the national sphere of the health system, Minister Tshabalala-Msimang supported the piloting of these initial standards, but was simultaneously **not** in favour of the development of an independent and fully-fledged OHSC that would monitor and enforce standards. The Minister, instead, wanted such an Office to report to the national sphere of government, that is, to the Minister. Hence, one of the milestones reported in the 2007/08 Annual Report of the Department of Health was the creation of an OSC within the National DoH, headed by a Chief Director. According to the published Annual Report, “the Office of Standards Compliance was also activated in 2007/08, in terms of the National Health Act of 2003” (DoH, 2008, p. 17).

Minister Tshabalala-Msimang held various sources of power. She was a member of Cabinet, the highest policy-making structure in the country, and she commanded significant power as chairperson of the National Health Council (NHC), the highest policy-making structure in the health sector in **2007/08**. As noted in previous chapters, the NHC consisted of nine Provincial MECs for Health, the South African Military Health Services (SAHMS), and the South African Local Government Association (SALGA). During 2004-2009, all provinces, including the Western Cape, were governed by the ANC under the leadership of Premiers Ebrahim Rasool and Lynn Brown. At this time, then, Minister Tshabalala-Msimang enjoyed the benefit of working with Health MECs, all of whom also belonged to the governing party, the ANC. She used her influence to secure support for the standards’ piloting process in 27 sites (health facilities) across the country. Minister Tshabalala-Msimang also derived power from national legislation for the development of quality-of-care norms and standards. The National Health Act, no. 61 of 2003, was enacted by 2007/08 and states that “the relevant member of the Executive Council must ensure the implementation of national health policy, norms and standards in his or her province” (Chapter 4, section 25 (1)). This piece of legislation empowered the Minister to determine national health policy and obligated the Provincial Health MECs to implement it.

As also indicated in **Table 7.2**, during the era of Minister Tshabalala-Msimang, the technical policy elites in the national sphere of government supported the standards pilot process, although also sought the establishment of an independent and fully-fledged OHSC, but did not command sufficient power to bring this about. It held medium-level power, as the administrative leader of the health system, tasked with policy formulation, development of legislation, setting norms and standards, and ensuring equity in the provision of health care services, in terms of the National Health Act, No 61 of 2003.

Academic institutions and research organisations provided technical support to this process. However, they had relatively low power, derived from their technical capabilities. The voices of civil society and patient groups were relatively quiet during the pilot process of the core standards in 2007/08. They were non-mobilised.

Table 7.2: Force field analysis of key stakeholders during the development of the National Core Standards for Health Establishments in 2007/08

Relative power	High Support	<<<	Non-Mobilised	>>>	High opposition
High					
	• Minister Tshabalala-Msimang • National Health Council (NHC) • Provincial MECs for Health				
Medium					
	• National DoH (Quality Assurance Chief Directorate)		• Civil society • Patient • Groups		
Low					
Research organisations	• Academic institutions • Research organisations • Non-governmental organisations				

As previously discussed, in September 2008, Barbara Hogan was appointed Minister of Health following the removal from office of President Thabo Mbeki by the ruling ANC, but her term of office only lasted until May 2009. During this short stint, Minister Hogan used her political power to support the development of a comprehensive National Core Standards policy. This is reflected in **Table 7.3** below. She enabled the technical policy elites in the national sphere of the health sector, particularly the Quality Assurance Chief Directorate, to advance the work of developing these standards. Although the latter had medium-level power, they benefitted from the latitude provided by the Minister at this time. Academic institutions and research organisations continued to provide technical support to this process, although they only had medium-level power, arising from their technical capabilities. The voices of civil society and patient groups were still voiceless during this period.

Opposition to the development of the National Core Standards at this time came from the Western Cape province, from both the MEC for Health and the senior bureaucrats (**Table 7.3**). Their major concerns were about the “Eurocentric” standards, and the fact that these were ‘unfunded mandates’, as discussed further below.

Table 7.3: Force field analysis of key stakeholders during the development of the National Core Standards for Health Establishments in 2008/09

Relative power	High Support	<<<	Non-Mobilised	>>>	High opposition
High					
	- Minister Barbara Hogan (2008/09) - Provincial MECs of Health in the National Health Council (NHC)				MEC of Health in the Western Cape
Medium					
	National DoH (Quality Assurance Chief Directorate)		Patient Groups		Senior bureaucrats in the Western Cape province
Low	- Academic institutions - Research organisations - Non-governmental organisations (e.g. COHSASA)		Civil Society		

Another turning point occurred in April/May 2009, with the election of the new President of South Africa, Jacob Zuma, and the appointment of Dr. Aaron Motsoaledi as Minister of Health and Minister Molefi Sefularo as Deputy Minister (**Table 7.4**). With political support from the new Minister and Deputy Minister, the development of the National Core Standards gained further momentum.

The iterative and continuous process of developing core standards was led by a task team consisting of officials from the National DoH and experts from diverse institutions, including NGOs such as the Hospital Association of South Africa (HASA), the University Research Company (URC), and the Council for Health Service Accreditation of Southern Africa (COHSASA). A Ministerial Advisory Committee (MAC) was also constituted to support the work of the National Core Standards team. The MAC consisted of academics, experts in standards setting, and independent researchers not affiliated to any institutions, who provided technical advice to Minister Motsoaledi and Deputy Minister Sefularo. The **2008/09** Annual Report of the National DoH noted that the health sector had established a MAC for quality, safety, and standards with three sub-committees. These sub-committees would “*inter alia* advise the department on mechanisms for monitoring the implementation of quality, as well

as the usefulness and appropriateness of quality of care indicators” (p. 56). All derived their medium-level power from their technical expertise.

An example of the contestation within policy debates at this time reflects on the specific experience around COHSASA. It had previously developed and implemented its own standard-setting processes in health facilities in different provinces, but this process had been criticised by the national Ministry as “the tail wagging the dog” (as only government has the legal powers to develop national norms and standards). Nonetheless, as an amicable way of bringing COHSASA into the policy process, the National DoH included this NGO in the MAC. However, COHSASA expressed its own concern that their pioneering work was being ignored in policy formulation, while other academics and organisations asserted that the COHSASA standards did not address South African needs. Eventually, COHSASA resigned from the MAC and the task team.

Box 7.1: Lessons learnt from the 2011 International Benchmarking Exercise of the National DoH

The 2011 international benchmarking exercise yielded crucial lessons and empirical evidence for the development of core standards in South Africa. Marshall and Jitsing (2013), two South Africans who were involved in these benchmarking exercises, state that:

- (a) It is important to distinguish between mandatory standards (supported by legislation or regulation) and voluntary standards, as they are used for different purposes;
- (b) requirements to comply with standards will not bring about meaningful improvement to patient outcomes and quality of care unless they are part of a holistic quality management system;
- (c) The purpose of having standards in a healthcare system may include an attempt to resolve problems by providing guidance on good practice, as well as a means to assess compliance to legislation;
- (d) Experts in the specific subject field as well as in the development of standards and measurement tools are needed to ensure credible standards;
- (e) A robust and recognised system of development based on expert committee consensus and best-practice evidence is the most widely accepted method of developing standards. This must be followed by a system of formal approval before being used in the public domain. The results of external quality assessment can be gainfully used to improve and revise existing standards
- (f) The funding of the development of standards will vary depending on the purpose and whether they are mandatory or voluntary standards (p. 32).

Other actors who contributed to the process of developing the core standards in 2009/10, as noted in **Table 7.3**, were provincial quality assurance managers and frontline health workers, but they still had very limited power in the process. Resistance to policy development at this time again came from Western Cape province actors (**Table 7.4**). Although eight provinces were under the governance of the ANC during the period 2009-2014, the ANC lost the Western Cape province to the DA in the 2009 elections, and the DA leader, Hellen Zille, became the Premier of the province. The Western Cape MEC and Provincial Department of Health (DoH) became more vocal in expressing reservations about the policy. Senior technical

policy analysts from the province questioned the appropriateness of National Core Standards as an intervention to assist in improving quality, and also contested the process and content of the policy. They expressed reservations about the evidence gathered by the national sphere of the health sector during an international benchmarking exercise (judging them to have emerged from higher income countries) and the lack of funding to implement the policy (criticising it as an ‘unfunded mandate’). A key informant in this study stated:

“The core standards have shown us that over a period of time it [health service delivery] has not gotten better, in fact the core standards if you see the latest report, it’s getting worse, so the core standards are not the solution. The solution is to deal with the management challenges in the health sector, to deal with the people challenges in the health sector, to face the realities of what we can do and what we can’t do, and that is difficult politics. I told Motsoaledi, we can’t do everything. So, we need to go out to the public and [honestly] say we can’t do everything. Because there’s a view that we can do everything and with a fiscus. As it is we know we can’t do everything” (former technical policy analyst, provincial sphere of the health system).

Table 7.4: Force field analysis of key stakeholders during the development of the National Core Standards for Health Establishments in 2009/10

Relative power	High Support	<<<	Non-Mobilised	>>>	High opposition
High					
	- Minister Aaron Motsoaledi - Deputy Minister Molefi Sefularo (died in 2010) - Provincial MECs of Health in the National Health Council				- Provincial MECs of Health in the Western Cape - Senior bureaucrats in the Western Cape province
Medium					
	- Senior bureaucrats in the national and provincial spheres of government - Ministerial Advisory Committee (MAC) on the National Core Standards - Non-governmental organisations (COHSASA)				

Relative power	High Support	<<<	Non-Mobilised	>> >	High opposition
Low	- Provincial Quality Assurance Managers - Frontline healthcare workers		- Patient groups - Civil society - Health managers across districts and health facilities (represented in the national consultative workshops by provincial managers)		

Ultimately, despite the ambivalence of the Western Cape provincial actors, the National Core Standards for Health Establishments were approved as national policy in **2011** and became instruments for the national Ministry of Health to use in an effort to improve the quality of care across the entire public health sector. According to key informants, the standards were also a deliberate political instrument to bring some accountability into the system. As one stated:

“And in fact, it (the National Core Standards policy) was a response from a fairly impotent national minister trying to find a way to exercise some kind of control or demand accountability from provinces who otherwise could do exactly as they pleased. And I do think that the strong emphasis on compliance arose from a very understandable challenge that faced the Ministers, Minister Hogan first and then Minister Motsoaledi. It’s that they had no other tools” (former senior bureaucrat, national sphere of government).

This was demonstrated in practice as provincial departments were required to report to the NHC on the budget for, and expenditure on, a set of apex priorities known as ‘non-negotiables’. These included inputs into quality health services, such as medicines and vaccines, which were among the six priority areas covered by the National Core Standards. Officials from provinces that under-budgeted or underspent on the non-negotiables were, as I personally witnessed, strongly berated by the Minister during NHC meeting.

Subsequent to these developments, in 2013 the National Health Amendment Act was passed which established the Office of Health Standards’ Compliance (OHSC) as a ‘juristic person’. In the South African context, a juristic person is “a social entity, a community or an association of people which has an independent right of existence under the law. It can be ‘the bearer of judicial capacities and subjective rights,’ and the accompanying legal entitlements and obligations, just like a natural person”

(Wikipedia, 2022). Section 77 (2) of the new legislation carried the provision that the Office is funded by (a) money appropriated by Parliament and (b) fees received for services rendered. Section 77 (3) stipulated that the OHSC was subject to the Public Finance Management Act 1 of 1999. With regards to the functions of the OHSC, Section 78 of the National Health Amendment Act of 2013 stated that the objectives of the office are to protect and promote the health and safety of users of health services by: (a) monitoring and enforcing compliance by health establishments with norms and standards prescribed by the Minister in relation to the national health system, and (b) ensuring consideration, investigation, and disposal of complaints relating to non-compliance with prescribed norms and standards in a procedurally fair, economical, and expeditious manner.

7.3.3. Framing the problem and the solution: Ideas and issue characteristics

As the previous section has illustrated, the development of the National Core Standards was driven by national political leadership and developed by national DOH technical policy analysts. It was essentially a ‘top-down’ process. A key political strategy was to frame the problem of focus as poor quality of care, and National Core Standards as the appropriate solution (**Table 7.1**).

First, in terms of problem framing, ample evidence existed about the poor quality of health services, and this was brought into the NHC and TECH-NHC. Among others, the severity of the quality-of-care problem was reported in successive reports of the National Committee on Confidential Enquiry into Maternal Deaths (NCCEMD), which demonstrated a high number of avoidable maternal deaths due to poor quality of care. Adverse events such as the outbreak of hospital acquired infections, including the outbreak of *Klebsiella* in public sector hospitals in KwaZulu-Natal province in 2005 (e.g. Mahatma Gandhi Memorial Hospital, where 22 babies died), created immense pressure for Minister Tshabalala-Msimang. Sidley (2006) reported that the government of South Africa had blamed the deaths of the 22 infants at Mahatma Gandhi Hospital on the “legacy of apartheid... refused to hold anyone responsible for the deaths and would also not be compensating parents who lost babies” (p. 115). This was a legacy that Ministers who succeeded her in the Health Portfolio wanted to eradicate.

The poor performance of health facilities also made newspaper headlines time and time again, embarrassing the political leadership of the health sector as the media carries the views and concerns of the public, that is, of the citizens. Common practice in South Africa is for such headlines to be placed on placards on lampposts, and a key informant judged that this was a major source of evidence in terms of this policy. When asked to cite the key data sources that influenced the development of the National Core Standards for Health Establishments, the respondent stated that “it’s that poster on the lamppost, that’s what matters” (former senior technical policy-maker, national sphere of government). The lamppost refers to newspaper headlines posted in a publicly visible way that creates pressure on the political leadership.

Second, in framing the solution, technocrats and bureaucrats in the national sphere of the health system provided the NHC with evidence on how poor quality of care

could be improved by strengthening regulatory systems. They provided evidence on the functioning of regulatory systems and processes in countries that provided good quality health care to their populations, drawing from international benchmarking studies.

The wide range of sources of evidence used to support policy formulation over time are summarised in **Table 7.5**. Study visits to the UK, France, Ireland, Canada, Australia, and Malaysia (**see Box 7.2**), funded by the national department of health, specifically supported an international benchmarking of approaches, institutions, and systems for the development of standards for health establishments.

Table 7.5: Summary of sources of evidence used in the evolution of the National Core Standards Policy in 2011

2011 National Core Standards		
Main sources of evidence to inform the development of National Core Standards for Health Establishments	1	Results from the pilot of National Core Standards
	2	Local operational research tracking the implementation and effectiveness of National Health Facility Improvement Plans
	3	Desktop reviews of standard-setting processes in other countries
	4	Routine data from the District Health Information System focusing on quality rated indicators
	5	Independent reports from organisations such as COHSASA
	6	Research reports from organisations such as the Health Systems Trust, which reflected findings on the quality of public health services
	7	Lessons learnt from study visits to the UK, France, Ireland, Canada, Australia, and Malaysia
	8	Literature from the experiences of other countries
	9	Anecdotal evidence (the lamppost)

Box 7.2: International experiences considered from document review and study tours (Marshall & Jitsing, 2013)

The UK's Care Quality Commission (CQC) regulates the quality of care provided by the NHS, local authorities, private companies, and voluntary organisations in the UK, and its work combines the regulation of healthcare with that of social care. South Africa also learnt about other regulatory bodies such the UK National Health Service Litigation Authority (NHSLA), which has Risk Management Standards to protect both patients and staff. From France, South African gained lessons about the Haute Autorité de Santé (HAS) or "National Authority for Health", established in France through legislation in 2004 as an independent public body with financial autonomy (p. 24). Marshall and Jitsing (2013) further describe the function of the HAS as to improve the quality of patient care and to "promote equity within the healthcare system. Its powers include accreditation of health professionals and medical equipment, and the certification of health establishments" (p. 24).

In Ireland, the South African technocrats learnt about the Health Information and Quality Authority (HIQA), which monitors standards approved by the Minister of Health and concerns itself largely with media coverage relating to quality (Marshall & Jitsing, 2013). One of the experiences gained

from Canada included understanding the functioning of Accreditation Canada, which generates the standards that it assesses and reviews them every three years.

From Australia, South Africa learnt about the existence of the Council on Healthcare Standards, which sets standards and ensures expert inputs and reviews them every four years. Australia also has a separate body (the Australian Commission on Safety and Quality in Healthcare) that sets standards in the area of its specific remit through an expert working group (Marshall & Jitsing, 2013). Key informant interviews further revealed that the South African team assimilated the Australian decision-making matrix into the development of a compliance status framework for the local health facilities. A lot was at stake because the OHSC had a mandate to certify health establishments as eligible to provide health services under a National Health Insurance (NHI) dispensation.

From Malaysia, the National DoH learnt about the Malaysian Society for Quality in Health, which used the Australian standards and adapted them to the local context through a process of expert consultation input (Marshall & Jitsing, 2013). In summing up the lessons learnt from international experience, Marshall and Jitsing (2013) concluded that there were many different methods used in determining a set of national standards, which were context specific.

However, political factors also influenced the policy process. When Minister Tshabalala-Msimang publicly championed the improvement of quality of care in health establishments, including the creation of the Office of Standards Compliance (OSC), she was responding to increasing pressure from the public. Although not entirely supportive of the development of a set of fully-fledged norms and standards for quality, the Minister had to be seen to be responding to the perennial challenge of compromised quality of care in the public health sector. Key informants asserted that the Minister's anxiety was that setting of national standards would expose major weaknesses in the public health sector, and drastically increase the political pressure she was already experiencing in relation to her denialist stance on HIV/AIDS. Therefore, reflecting Shiffman and Smith's definition of ideas as "the ways in which those involved with the issue understand and portray it" (2007, p. 1371), Minister Tshabalala-Msimang sought to create an OSC located with the National DoH, which would be politically accountable to her, and portrayed this as a commitment to improving the quality of health services.

The 'internal framing' from the Ministry was that this arrangement was appropriate, because the National Health Act of 2003 stipulated that the roles of Office were, among others, to keep the Minister informed of the quality of the health services provided throughout the Republic as measured against prescribed health standards, and to advise the Minister on norms and standards for quality in health services. The legislation was used both as a source of evidence of appropriateness and as a justification. However, this internal frame did not work effectively in persuading all critical actors that the location of the OSC should be inside the National Department of Health. From my position within the Department in 2007/08, I observed growing support among policy analysts within the Department that the office had to be independent and objective in order to be the overseer and critical assessor of quality across the country. The OSC had to function without fear or favour of the public and private health sectors, and could not be bound by the existing hierarchy of the National DoH. To function independently of the DoH, it was recognised that the National Health Act (No 61 of 2003) had to be amended to enable the Office of Health Standards Compliance (OHSC) to become a juristic entity.

The ascendance of Barbara Hogan into the Ministry of Health in 2008, with Sefularo as Deputy Minister, ushered in a new area characterised by a genuine commitment to setting standards. Deputy Minister Sefularo genuinely believed that the challenge of poor-quality health services in the public sector was pervasive and this was an embarrassment to the democratic government. He then sought to encourage action by framing the challenge of poor-quality service delivery as an attack on the dignity of the majority of the people of South Africa, particularly those dependent on the public sector. He argued that this dignity had to be restored, including through the setting of norms and standards for quality health services, as reflected in **Box 7.2**. This message resonated with the wider ANC call, in the period 2004-9, for the restoration of the dignity of the people of South Africa, particularly the previously disadvantaged.

A final idea underpinned the Deputy Minister's approach to the development of the National Core Standards – that this had to be a consultative process to give it legitimacy and therefore ensure that once the standards were adopted, all stakeholders would be committed to their implementation. All subnational structures of the health system were involved, inclusive of provinces, districts, health facilities, and as many frontline health workers, academic institutions, and research organisations as possible.

One of the consultative forums created under Hogan and Sefularo's leadership was a National Colloquium on Quality. As captured in the **2008/09** Annual Report of the National DoH, tabled before Parliament in September 2009, "the department also convened a national colloquium on quality in November 2008, which was attended by a large number of stakeholders from private and public sectors, as well as regulatory bodies, professional associations, organised labour, academics and non-governmental organisations. As a direct outcome of this colloquium, a concerted move towards a national quality improvement programme and the institutional arrangements that will underpin its implementation will be realised in the next planning cycles" (DoH, 2009, p. 56). The fact that the new Ministry had championed wide-ranging consultations was corroborated by key informants in this study who were involved in this process. One key informant, stated:

"...We were involved in lots of consultative process and we identified stakeholders internally and externally to make sure that at the end the work that we are doing were going to be addressing the needs of the country in terms of strengthening the health system. So basically, we didn't even leave the implementers of the standards behind because we involved the quality assurance managers from all the 9 provinces. They were part of this process because we formed what we called Quality Consultative Forums where we were meeting on an annual basis. We would come together to review the work that we had done throughout the year. The work was very engaging and at the same time, even the implementers, the people that we were expecting to implement the very same National Core Standards were involved through their managers" (former technical consultant, national sphere of government).

Box 7.3: Deputy Minister Molefi Sefularo's framing of the need for a National Core Standards policy

On **25 September 2009**, while addressing the Medical Students Conference at the University of the Witwatersrand, Johannesburg, Sefularo stated that the *"progress that we have made in transforming the health sector in the fifteen years of democracy is encouraging. However, we can and we could have done more. The health sector, private and public, is facing serious challenges. Access to services has been greatly improved. Our greatest challenge is to improve the quality of health services"* (Sefularo, 2009). The Deputy Minister thus acknowledged publicly that quality of care in the health sector was suboptimal, and government had to intervene.

In **November 2009**, Sefularo informed the people of South Africa, through the national media, that the country was in the process of adopting quality standards. This was on the margins of a 2-day Summit on the National Core Standards held in Boksburg, Gauteng province. At the Boksburg summit, Sefularo stated that *"these core standards reflect the basic requirements expected of all managers for us to provide safe and decent care in South Africa... The very first standards cover the expectation that patients are treated with respect and dignity. To those using our public services, the attitude of our staff, the environment within which they are treated and the length of time they have to wait are at the top of the list of their 'expected performance'. Unfortunately, these are often aspects where our performance is sadly lacking"* (Marrian, 2009).

Referring to the Office of Health Standards Compliance (OHSC), the Deputy Minister continued to state that *"an independent health watchdog will be introduced by April [2010] to ensure clinics and hospitals adhere to quality standards"* (Marrian, 2009). He further stated that *"we should therefore separate the authority to ensure that standards are maintained"* (Marrian, 2009). He characterised the OHSC as an entity that would be established for the sole benefit of the public and which they could therefore trust.

7.3.4. Issue characteristics: Contestations about the appropriateness of National Core Standards as a solution to the problem of poor quality of care

Issue characteristics include features of the interventions proposed to address policy problems (Shiffman & Smith, 2007). Such interventions should, for example, be *"cost effective, backed by scientific evidence, simple to implement, and inexpensive"* (Shiffman & Smith, 2007, p. 1371). However, as Walt and Gilson (2014) note, issue characteristics can themselves be contested, and generate conflict. This is reflected in the experience of developing the National Core Standards for Health Establishments policy, in which three key factors led to contestations between actors in the health sector (**Table 7.1**).

First, there was contestation between the national and provincial spheres of the health system around whether the National Core Standards policy was an appropriate solution to the identified problem of poor quality of health care. As already noted, according to key informants, some provinces argued that this was an inappropriate intervention because the major problem that needed to be addressed was poor management capacity in the public sector. Other contestations focused on policy content, with some provinces asserting that the proposed standards were *"Eurocentric"* in terms of both standards or organisational arrangements, and that the resulting National Core Standards were *"foreign"* and *"unachievable"*. They said that

the standards set the bar too high for the public sector, and that they would only be attained by the private sector. As a key informant noted that:

“Policy-makers believe that once they develop a policy, and start implementing it, it becomes reality. But this is far from the truth. A series of steps are required to take policy from having it signed and adopted by NHC to having it implemented. There is a huge lack of assessment of capacity to implement policy” (former senior bureaucrat, provincial sphere of the health sector).

The counter argument by the developers of the National Core Standards was that they knew they were learning from developed countries and had mediated this risk by setting the local South African standards at a realistic level, taking into account the inputs received from the provinces during consultation processes. These key informants indicated that the key lesson they had learnt from, for example, Australian colleagues was that standards must be achievable. The standards entailed in the National Core Standards for Health Establishments policy were therefore tested locally and continually reviewed.

The second area of contestation was around the consultation process of developing the National Core Standards for Health Establishments policy. Senior provincial key informants acknowledged that consultations had taken place, but noted that they experienced these processes as insufficient and asserted that the policy was inadequately informed by evidence from provinces and from frontline health service providers. One key informant stated:

“At a national level, I think national is so tied up with the issues that national departments are being tied up with. You know, international engagements. You know, there are so many international engagements and visits and stuff and there is also political priorities that they have to drive that you know, that actually take them away from being connected to provinces” (former senior bureaucrat, provincial sphere of government).

In addition, there was criticism that consideration was given only to the views of the most vocal stakeholders during the consultation process, including established NGOs. However, the views of the actual users of health services were not solicited. Some key informants believed that user views (patient groups) were important because the national standards were being developed to improve health care delivery at the coalface, where users interact directly with health services.

Thirdly, perhaps the most contested point between the national and provincial spheres of government was around the financing of the National Core Standards. The provincial sphere of government believed that these were an *unfunded mandate*, meaning a set of national priorities imposed by the national sphere of government onto the provincial spheres without the provision of additional resources to support their implementation, creating a burden for provinces. The Public Finance Management Act of 1999 (Section 35) states that “draft national legislation that assigns an additional function or power to, or imposes any other obligation on, a provincial government, must, in a memorandum that must be introduced in Parliament with that legislation, give a projection of the financial implications of that function,

power or obligation to the province". This extends to new national policies which provinces are obligated to implement. Scholars such as Basdeo (2012) have written extensively about the impact and dilemmas of unfunded mandates confronting local government in South Africa. With specific reference to local government, Basdeo (2012) contends that "the functions performed by each sphere of government should have a secure legal footing. Performing functions falling outside the mandate of local government impinges upon the lawfulness of their budgets, although their expenditure is not necessarily illegal" (p. 61). He further argues that "national government through various strategies imposes national mandates on provincial and local government at the expense of the latter. The incidence of unfunded mandate reflects a power hierarchy" (p. 51).

Yet, as a key informant stated:

"...the broader vision of a national health system is not clear. It's not being communicated, it's not clarified... Which are the key priorities from a limited resource base that we should be putting our resources in? Having said that, there is also a complete misunderstanding, a non-understanding of the budget realities of the country nationally, because National Department of Health, I believe does not necessarily experience the type of budget pressures that the service delivery arm of government feels. And then policy decisions are taken without an understanding of the resource implications" (former senior bureaucrat, provincial sphere of the health system).

The key informant further indicated that, in 2011, the provincial sphere of the health system had challenged the national sphere to make resources available for the implementation of the National Core Standards policy.

Fourthly, key informants decried the fact that the additional evidence deduced from the international benchmarking study was not fully used in finalising policy details. In particular, it seemed that the policy elites were not convinced that an assessment of compliance with the National Core Standards should include an assessment of health indicators in a particular facility and health outcomes in a subdistrict or district, as was identified as international practice.

The fifth and final feature of evidence contestation in terms of this policy was disagreement between political and technical actors. According to key informants, while massive lessons were learnt from both the international benchmarking project and document reviews, some of the learnings which technical bureaucrats considered extremely important were not infused into the South African version of the National Core Standards. This was because the political leadership had different views on this matter and had the power and authority to veto the proposals from the technical bureaucrats.

A critical example was the proposal to create linkages between quality standards and health outcomes, which was discarded by the political leadership. Respondents in the study stated that they had proposed that quality of care was related to health outcomes, as evidenced by the successive triennial reports of the Committee of Confidential Enquiry into Maternal Deaths (CCEMD), and therefore that outcomes should be measured as part of the tracking and tracing of the implementation of

standards. However, this was **not** accepted by the political leadership. One respondent indicated that *“there was a prior decision that the Office of Health Standards was not going to deal with that [health outcomes], so they did not. The Office was not allowed to deal with outcomes or clinical care”* (former senior bureaucrat, national sphere of government).

Other examples of how the evidence technocrats had gathered was disregarded by the political leadership are:

- (a) Technocrats had proposed two sets of standards, one set which would be mandatory, and another which would serve as guidance and not be obligatory. However, the political leadership resolved that there would be one universal set of standards, which would be mandatory.
- (b) The OHSC was positioned as a standard-setting or standard development office, instead of an office tasked with enforcing existing health policies and standards, such as infection prevention and control standards, as originally proposed by technocrats.
- (c) The proposal by technocrats was that the development of standards should include support for quality improvement initiatives to address identified deficiencies. This was disregarded, as the policy elites believed that quality assurance and quality improvement should be separated. Quality assurance should be done by independent institutions delinked from government health service delivery programmes, while quality improvement should be conducted by government to improve the quality of care provided to citizens.

The decisions made by the political leaders were not necessarily bad decisions, they were just not what the technocrats wanted. For example, two sets of standards would likely introduce massive confusion into the health system, and not guide health workers as to where to focus. It was also correct to designate the OHSC as a standard-setting office only, because the enforcement of existing health policies and standards is a role assigned to the National DoH by the National Health Act, No 61 of 2003. Third, the OHSC, as an external office, is appropriately responsible for quality assurance, not for quality improvement, which is the role of the National and Provincial DoHs.

7.4. Policy Outcomes

The National Health Amendment Act 12 of 2013 enabled the health sector to establish an independent OHSC, which would have more authority and be more effective than originally contemplated in the National Health Act, No 61 of 2003. Then, in 2015, the regulations for the functioning of the OHSC and its Board were approved by the Minister of Health, which further enabled the implementation of the policy (DoH, 2015).

By 2016, when the present PhD research study commenced, the OHSC had already conducted inspections in 696 health facilities, which consisted of hospitals, community health centres (CHCs), and clinics (OHSC, 2018). The OHSC report focused on the six Ministerial priorities adopted by the health sector in 2010/11, namely: values and attitudes, waiting times, cleanliness, patient safety, infection

prevention and control, and availability of medicines and supplies. The OHSC found that performance in terms of these six priorities did not reach the desired level of 80% compliance with set standards. Although hospitals performed better than clinics and CHCs across all six priorities, the highest average scores attained by hospitals were 69% for availability of medicines, 68% for waiting times, and 66% for values and attitudes. The scores for cleanliness were very low, and were on average 55% for hospitals, 46% for clinics, and 45% for CHCs (OHSC, 2016/17), against a target of 80% (OHSC, 2018). This reflected poor levels of performance against set standards.

In its Bi-Annual Report for April-September 2022, the OHSC stated that “during the reporting period, a total of hundred and sixteen (116) establishments were certified by the OHSC. All health establishments found to be non-compliant with the norms and standards have been issued with a compliance notice stating the areas of non-compliance and the period within which the identified breaches should be addressed” (OHSC, 2022, p. 4). This suggests that over the decade 2011 to 2021, during which the National Core Standards were adopted as national policy, and during which period the OHSC designed various tools to measure compliance with health standards, most public health sector facilities struggled to acquire and maintain the requisite standards. This could vindicate the caution by Provincial DoHs that the national sphere of government should not set the bar too high, nor make it unattainable for public health sector facilities, which would be a self-defeating exercise.

7.5. Final reflections on the development of the National Core Standards policy

The National Core Standards policy emerged in a top-down manner, championed by the Ministry of Health, in a context of pervasive poor quality of care in public sector facilities, of which there was ample technical evidence – including media headlines. The central tenet advanced in this chapter, emerging from the findings of this study, is that even when a health policy idea is conceived by the policy elites, who then provide the essential political leadership for the development of the policy, the use of evidence can still be complex.

Political leaders used policy frames to characterise the problem in ways that would catalyse action, and also drew only partly from the national and international experience around the solution. A political decision had already been made to develop the National Core Standards policy and evidence became just one of the considerations in this process, rather than the major decisive factor. Some key informants also felt that the current impact of the OHSC had been much more limited than it potentially could have been if the core standards had been linked to mandatory requirements to improve health outcomes, rather than only considering coverage targets.

A key feature of this policy process was that, even when driven by Ministers Motsoaledi and Sefularo, there was internal contestation between the national and provincial sphere of the health system. The most vigorous contestation was about the lack of funding for the implementation of this policy. The provincial sphere regarded this policy as not evidence-informed because it did not consider policy affordability or draw from provincial DoH experience. In addition, the provincial sphere argued that

some of the core standards were not appropriate for South Africa as they were imported from abroad.

The contestations around this policy can be referred to as an internal struggle of the health sector. The National Core Standards for Health Establishments policy demonstrates that political support for a health policy can be a double-edged sword. On the positive side, political support implies that technocrats and other stakeholders do not have to spend inordinate amounts of time and effort trying to convince the politicians about the need for the proposed policy; the mandate already exists. On the other hand, evidence may be cherry-picked to fit prevailing political views.

7.6. Conclusion

This chapter has illustrated that the National Core Standards was *born of necessity* and *urgency*, as the political leadership at the time acknowledged the reality of mediocre quality of care in many public health services and the need to create a quality improvement framework for the entire health sector public and private. The limited local evidence in South Africa was buttressed by international evidence, including international benchmarking studies. Policy-makers at the time recognised this as sufficient to proceed with the development of the National Core Standards. The pressure from communities clamouring for improved quality services, heightened by negative media coverage of the public sector, accentuated the need to develop a responsive policy with speed.

CHAPTER 8: DISCUSSION

8.1. Introduction

This chapter presents a discussion of the findings of this study, drawing together the findings across its two components, namely Phase 1 and Phase 2. As indicated in Chapter 3 (Methodology), **Phase 1** of the study was exploratory in nature, and examined policy formulation processes in the South African health sector. Using the Walt and Gilson (1994) policy analysis triangle framework as an overarching guide, this phase sought to understand health policy formulation processes in South Africa. Key factors explored during this phase included: key actors in policy-making, policy context, policy content, and policy process. **Phase 2** of the study entailed a deep dive into the use of evidence in health policy formulation in South Africa, and generated insight into the dynamics of policy formulation, including the use of various forms of evidence, in two policy process cases, namely the PMTCT policy and the National Core Standards policy.

8.2. Understanding formal health policy formulation processes in the South African Health Sector

This section uses the two policy process cases, the National Core Standards and PMTCT policies, to demonstrate the complexities of health policy formulation processes in South Africa. It also supplements the original *Pathways to Policy formulation* diagram described in Chapter 5, which represents the policy process as neat and logical. The sections that follow below also amplify the health policy formulation pathway by reflecting various stages at which evidence is brought to bear in this process, which are not self-evident in a generic, neat, and schematic diagram.

The starting point of the study, for both Phase 1 and Phase 2, was the definition of the concept of evidence. A key assumption and finding of this study is that evidence must be defined to incorporate a wide range of data sources, including routine information systems and expert knowledge. As stated in the introductory chapter, this study adopted the definition crafted by Bowen and Zwi (2005), who assert that evidence is “information that affects existing beliefs of important people about significant features of the problem under study and how it might be solved or mitigated” (p. 0601). Although WHO (2021) also conceptualises evidence broadly, it has a different emphasis: “Evidence is defined as factual knowledge gained through observation or experimentation in support of a conclusion” (p. 6). However, WHO (2021) also distinguishes between scientific and tacit evidence. *Scientific* or research evidence is “knowledge that is explicit, systematic and replicable, and can be judged by its methodological standards” (WHO, 2021, p. 6). Such evidence “is produced through more formal, rigorous research processes, including primary studies (primary research), synthesis of existing evidence (secondary research), and evidence products such as guidelines or evidence briefs for policy” (p. 6). In contrast, “tacit (or *colloquial*) knowledge is mostly informal, and often includes opinions, values and habits of policy-makers, clinicians, patients or citizens expressed in different forms in formal deliberative dialogues, on websites, in policy documents, reports, and other formats” (WHO, 2021, p. 6). This study embraced these various forms and sources

of evidence, which extend beyond results of research studies (Bowen & Zwi, 2005), and include sources of information, such as routine health information systems. These sources are discussed later in this chapter.

Having adopted a broad definition of evidence, the study then examined the pathways to health policy formulation in South Africa. In Chapter 5, the original schematic diagram on pathways to policy formulation in the National DoH was presented, which suggests a logical and technically rational policy-making process. To a large extent, the diagram reflects the common practices because once the formal policy formulation process commences within government, all policies follow the same development process. The development of both the PMTCT policy and programme in 2002 and the National Core Standards for Health Establishments policy in 2011 followed the same policy processes, as outlined in **Figure 8.1** below. However, as will be shown in the rest of this chapter, the formulation of the two policy process cases experienced different dynamics, including different forms of contestation about evidence. This chapter also considers how the specific characteristics of the two policies influenced policy formulation, resulting in the PMTCT policy being referred back to the technocrats by the NHC Policy Committee, which consists of the political leaders, for reformulation. This forwards and backwards movement occurred more often with the PMTCT than with the National Core Standards policy.

In Phase 1, the study found that irrespective of policy origin, all proposed policies are subjected to the same formal processes within the public health sector, which entail scrutiny and continuous refinement as the proposed policy moves from the management committee of the National DoH to the TECH-NHC and the NHC itself. The two policy process cases examined in Phase 2 illustrate that policy origin (top-down or bottom-up) influences whether a policy will be processed efficiently by the political policy elites within the defined policy structures (NHC and TECH-NHC) or whether it will be repeatedly sent back to the technical policy developers to provide ample evidence, as was the case with the PMTCT policy. this study

In both Phase 1 and Phase 2, the study demonstrated that powerful policy elites influence the use of evidence in policy-making, which in itself is inherently a political process. The two policy process cases examined in this study illustrate that powerful political actors determine how and why evidence (in its different forms) is used in health policy-making in the South African health sector. To achieve this, these actors use framing (Koon et al., 2020) as an important instrument for manipulating policy processes, as well as to exert influence over other stakeholders. While the dominant frame still holds sway, powerful policy elites maintain control over the policy process and policy outcomes. Furthermore, powerful policy actors will influence how evidence is used in policy development, either by asserting that available evidence is insufficient or by using existing evidence selectively.

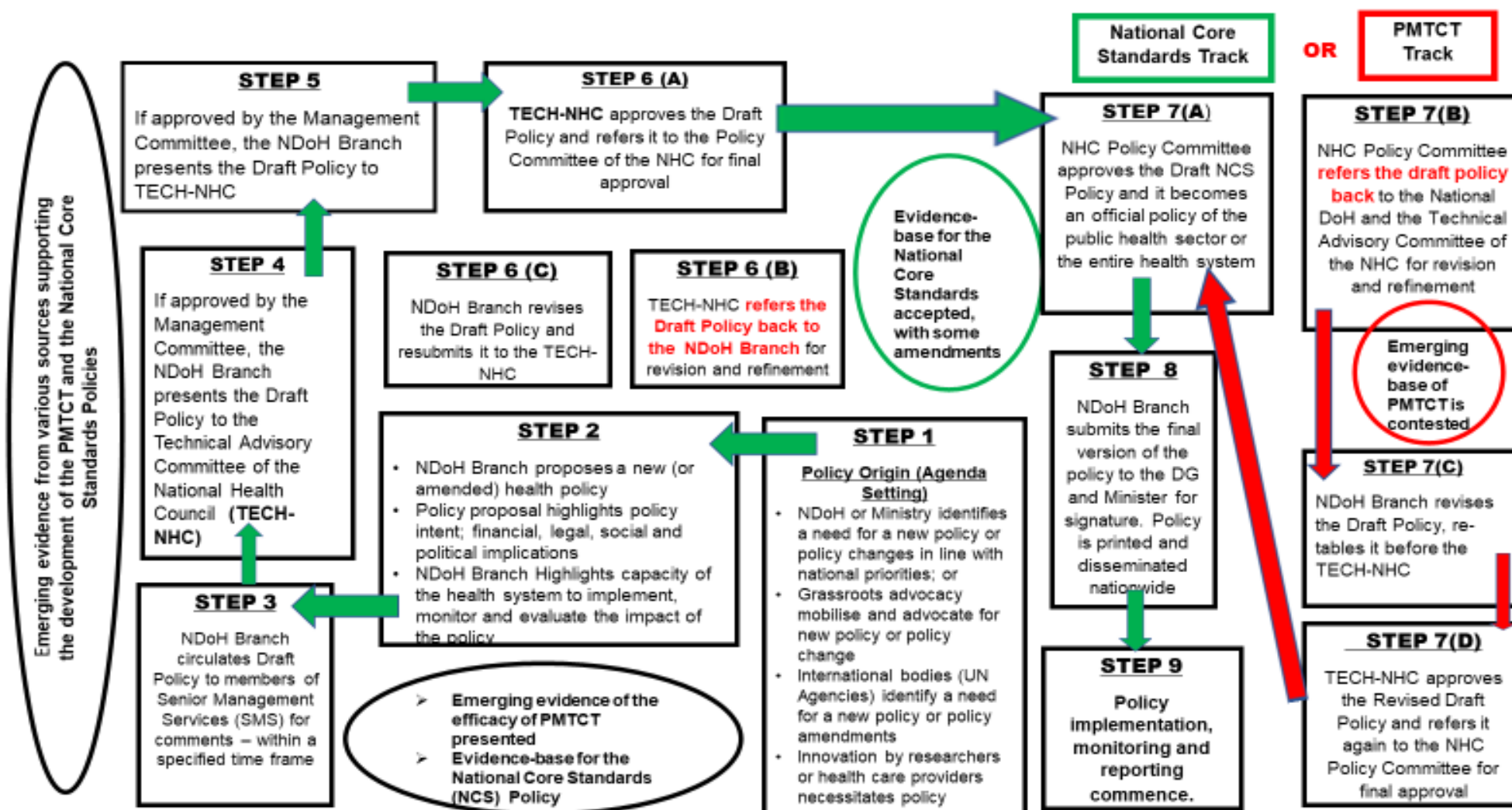
The two policy process cases examined in this study demonstrate that policy origin can take various forms, as reflected in **Step 1 of Figure 8.1**. The primary question is which actors initiate new (or revised) health policies in the South African health sector. Common practice is that a new health policy emanates from the Health Ministry (the office of the Minister) or from the National DoH. In these two cases, as in my own observations of wider experience, this formal policy-making process is led by the **policy elites** (Grindle & Thomas, 1989), who in South Africa would be both the

political leadership in the Ministry of Health and Executive Management in the National DoH. As Grindle and Thomas (1989) assert, “policy elites often initiate reforms by placing issues on the agenda of government decision making. In so doing, they may shape the debate over such issues and use technical expertise to influence discussions within and outside government” (p. 221). The aim of policy development is often to support the implementation of national health priorities adopted by the ruling ANC, with which government is tasked, or to address a gap in health care delivery, which requires the entire health sector to function in unison. As Grindle and Thomas also note, “policy elites often shape reform strategies by influencing the timing and content of proposals so they are made more politically or bureaucratically acceptable” (p. 221).

For example, in the case of the PMTCT policy, in 2001 senior technical policy elites in the national sphere of the health system presented the emerging evidence of the efficacy of a nevirapine-based PMTCT programme to the political leadership, with a view to shape the development and national scale-up of a national PMTCT programme, which would save the lives of many babies, and enhance the legitimacy of the democratic government. However, the political leadership of that era had other ideas. In the second policy process case, senior bureaucrats conducted international benchmarking exercises and study visits abroad and packaged the evidence they amassed to shape the development of the National Core Standards policy.

The stimulus for a new policy can also arise from grassroots advocacy groups, civil society, or researchers lobbying for new policies. The two case studies examined in this study are classic examples of a **top-down** and a **bottom-down** policy initiation process. The PMTCT policy originated in a **bottom-up manner** in 2001-2002. This policy resulted from advocacy from civil society organisations such as the Treatment Action Campaign (TAC), health activists, academic institutions, and research organisations, who lobbied for the national scale-up of the PMTCT programme beyond the original 18 pilot sites. The civil society activists ultimately tested their case in court and secured a legal judgement that forced government to implement PMTCT nationally. The policy was therefore a product of active lobbying by civil society and judicial intervention. However, in relation to programme policies, international bodies such as UN agencies (e.g. the WHO, UNICEF, UNAIDS, UNESCO, or UNFPA) can also adopt resolutions necessitating new or revised policies and adaptation at country level (Schneider et al., 2006). By contrast, the National Core Standards was initiated by the National DoH in 2010-11, in a **top-down manner**, following the ruling party’s and government’s observation of poor quality of care in the public sector, as commonly identified in media reporting and newspaper headlines. These experiences illuminate an element missing from Berlan et al.’s (2014) seven steps, which is policy origin, and precedes the generation of policy alternative. It is the ‘light bulb’, or agenda-setting, moment when the need for a policy is identified, before alternatives are even considered. As discussed later, it was itself found to be an influence over policy formulation in these cases.

Figure 8.1: Pathways to Policy Formulation and Evidence Use in the development of the PMTCT (2001- 2002) and National Core Standards (NCS) for Health (2010-2011) Policies (Legend to this figure is in the box below)



Source: The diagram (Figure 8.1) was designed by myself based on insider-knowledge; as well as continuous review and inputs from the thesis supervisor

LEGEND TO FIGURE 8.1.

- A *Branch* is a component of the National DoH headed by a Deputy Director-General (DDG) who reports to the Director-General (DG) of Health. The DG is the equivalent of the Permanent Secretary for Health in other countries.
- Senior Management Services (SMS) in the South African context refers to Directors, Chief Directors, DDGs and DGs of government departments.
- The *Technical Advisory Committee* of the public health sector is the most senior management structure of the public health sector. It consists of the National DG of Health, Provincial Heads of Department (HoDs) of Health, South African Military Health Services (SAMHS), and the South African Local Government Association (SALGA).
- The *National Health Council (NHC)* is a political structure chaired by the Minister of Health, which comprises the MECs for Health in the 9 provinces, DG of Health, Provincial HoDs of Health, SAMHS and SALGA.
- **NCS track (Step 7A)** denotes the policy pathway followed by the National Core Standards Policy during 2010-2011, while the **PMTCT track (Step 7B)** reflects the pathway followed by the PMTCT policy in 2001-2002 within the formal policy-making processes of the South African Health Sector.

The PMTCT and the National Core Standards policies demonstrate further that there are two main forms of policy-maker/researcher interactions that draw evidence into policy formulation. When new policies are initiated in South Africa, after the Department (or Ministry) of Health has identified a need for a new policy, the step that follows entails what Berlan et al. (2014) refer to as the “generation of policy alternatives, deliberation and/or consultation” (p. iii23). The generation of policy alternatives involves research processes, creation of technical guidance, assessing policy alternatives, and including decision-makers in research processes.

The development of the PMTCT policy illustrates the first form of policy-maker/researcher interaction, whereby civil society organisations, health activists, academic institutions, and research organisations used various forms of evidence from diverse sources to lobby policy-makers to develop this new policy. In contrast, in the development of the National Core Standards for Health Establishments policy, it was the Ministry of Health, as the drivers of policy processes, who involved research institutions in policy-making by convening workshops and colloquia where researchers presented their research experiences and products. This happened in **Step 1 to Step 5** of the health policy processes as reflected in **Figure 8.1** above.

Irrespective of how a new policy was originated, when it is presented to the Management Committee of the National DoH, it is discussed and debated, and if approved, it proceeds to the Technical Advisory Committee of the National Health Council. This is reflected in **Step 2 to Step 6** in **Figure 8.1** above. The debates, deliberations, and contestations within the National DoH and within the TECH-NHC reflect what Berlan et al. (2014) describe as “advocacy for specific alternatives; lobbying for specific alternatives; and negotiation on policy alternatives” (p. iii23). The policy development experiences of the PMTCT and the National Core Standards policies aptly demonstrate **Steps 7A and 7B** in **Figure 8.1**. These are the two final steps in the policy process, which determine if a policy will be approved by the NHC

or sent back to the TECH-NHC. **Step 7A** illustrates that if a proposed policy is approved by the NHC Policy Committee (the Minister and the Health MECs) or if it is approved with minor amendments, it becomes an official policy of the country.

Step 7B shows that if a policy is not approved by the NHC, it is returned to the TECH-NHC for revision and redrafting. This re-drafting process is undertaken by the relevant Branch of the National DoH. Once the revised policy is re-submitted to and endorsed by the TECH-NHC, it is submitted once more to the fully-fledged NHC. Once approved by the NHC, the draft policy becomes official national policy. It will be signed by the Minister and implemented. This step in the health policy formulation process constitutes what Berlan et al.'s (2014) call the "drafting or enactment of policy" (p. iii23).

Three important aspects of the stepwise health policy formulation described above and in **Figure 8.1** are whether evidence will be used in this process, factors that influence the use of evidence, and the stages at which evidence will be used. As described in detail later in section **8.2.3**, the nature of the policy issue determines whether and how evidence will be used in the policy process.

First, the National Core Standards policy followed the pathway described in **Step 7A** due to the fact that it originated in a top-down manner and was supported by the Ministry of Health. It enjoyed more support within the NHC than the PMTCT policy in 2001, before the court judgement of 2002. Therefore, the policy followed the pathway described in **Step 7A to Step 8 and Step 9**, the finalisation of the policy. However, the PMTCT policy followed the alternative route of **Step 7B**, which implies that the fully-fledged NHC referred this policy back to the TECH-NHC for revision, which at the time was still known as the Provincial Health Restructuring Committee (PHRC). This is because the evidence base that supported the PMTCT policy was contested and challenged by the fully-fledged NHC. As discussed previously in Chapter 6 and later in this chapter, the Constitutional Court judgement of 2002 provided the impetus for the final approval of the policy later in 2002. In **Step 7C**, the National DoH revised the PMTCT policy and submitted it to the TECH-NHC. In **Step 7D**, the TECH-NHC recommended that the revised policy be re-submitted to the NHC Policy Committee. After several iterations, debates, and the court judgement, the PMTCT policy was approved by the NHC. It then followed the pathway reflected in **Step 7A, Step 8, and Step 9**, which was the finalisation of the policy.

Furthermore, reflecting their different characteristics, with the PMTCT policy being a health programme, clinical policy and the National Core Standards for Health Establishments policy being a health systems policy, there were differences in evidence use in the development of the two policies. The development of the PMTCT policy was buttressed by a set of specific guidelines, often adapted from the UN agencies such as UNAIDS, WHO or UNICEF. By contrast, in the development of the National Core Standards, there were **no** norms and standards for quality that could be directly "borrowed" from other countries or from the UN agencies and transplanted in South Africa. Experiences from the National Institute for Health and Care Excellence (NICE) in the UK and Australia were brought to bear in policy development. However, given the contextual differences between the two first world countries and South Africa, there could be no direct importation of standards without due consideration to the local circumstances. These experiences illustrate that there

is no uniform approach to the development of policy, and by implication, to the use of evidence in health policy development.

The two case studies demonstrate that contestations between policy-makers over the use of evidence in policy formulation are inherent features of the policy-making process. This was particularly the case with the emerging PMTCT policy, the evidence base for which was contested by the then political leadership, and spent much time being sent back by the NHC Policy Committee in 2001. By contrast, although there was contestation about the unfunded mandates associated with the National Core Standards and the selective use of evidence by politicians, this policy spent less time before the fully-fledged NHC than the PMTCT policy. What both case studies reveal, as identified by the key informants, and which reinforces the depiction of **Stage 7** of the *Pathways to Policy formulation Diagram (Figure 8.1)*, is that when such contestations occur, proposed policies will spend considerable time moving forwards and backwards between the fully-fledged NHC policy (i.e. the politicians) and the TECH-NHC (the technocrats).

As stated in Chapter 5, in **Phase 1** of this study, a total of 27 stakeholders were identified as at some time contributing to health policy-making in South Africa, namely the Ministry of Health, other government Ministries (National Treasury, DPSA), national elites (politicians), political parties, international agencies (WHO, UNAIDS, UNICEF), civic organisations, civic leaders, NGOs, health professionals, local communities, private sector, media, researchers, and patient groups. However, the two case studies examined in this study reflect that in a **top-down** policy process, such as in the case of the National Core Standards for Health Establishments policy, a small pool of stakeholders makes decisions which affect a wider population impacted by the policy. Conversely, in a **bottom-up** policy process, a larger number of diverse stakeholders are involved and contribute to the policy process, particularly in agenda setting, as was the case with the PMTCT policy.

8.3. What evidence is drawn on in health policy formulation in South Africa?

The foregoing section identified the specific steps of health policy formulation in which evidence is used, as well as the factors that influence whether it will be used or not, key among which are policy origin and the nature of the policy. This section examines the forms or types of evidence used in the stepwise process of health policy formulation described in Figure 8.1 above, addressing the second objective of the study. The findings of this study point to the fact that once an issue enters the policy-making process, data are used across all stages of the policy process, although such data may well be contested.

This study suggests that the evidence used for health policy-making in South Africa is drawn from eight broad categories, namely: (a) published literature, (b) research evidence, (c) research synthesis (a by-product of published literature), (d) global evidence (which feeds into the guidelines released by UN agencies), (e) South African survey data, (f) anecdotal evidence, (g) routine information systems, and (h) expert evidence. This is reflected in **Table 8.1 below**.

Table 8.1: Evidence forms used in the formulation of the PMTCT and National Core Standards for Health Establishments policies

Evidence form		Generally used (Phase 1)	Used in PMTCT ⁴	Used in National Core Standards for Health Establishments
1	Published literature	✓	✓	✓
2	Research evidence	RCTs	×	×
		Local operational research studies	Results of studies by Health Sciences Faculties and Paediatrics Departments in various universities	Evidence from European countries
3	Research synthesis (a by-product of published literature)	✓ South African Cochrane Centre	✓ South African Cochrane Centre	×
4	Global evidence (which feeds into the guidelines released by UN agencies)	✓	✓ Evidence from UN agencies, including WHO and UNAIDS	×
5	South African survey data	✓	✓ Annual Statistics South Africa's (Stats SA) General Household Survey (GHS) data on HIV prevalence in the country	✓ Annual Stats SA's GHS data on patient satisfaction with both public and private health care services in the country
6	Anecdotal evidence	✓	✓ (Minister Tshabalala-Msimang's trip to Uganda)	✓ (Newspaper headlines on the lamppost)
7	Routine information system	✓	✓ DHIS data on the proportion of babies contracting HIV from their mothers	✓ DHIS data on the proportion of complaints resolved within 25 days
8	Expert Evidence	✓	✓ Presidential Advisory Committee on HIV/AIDS Established by President Mbeki in 2001, which included orthodox scientists and AIDS dissenters	✓ Ministerial Advisory Committee on the National Core Standards for Health Establishments

⁴ E.g. Guay et al. (1999)

As is also reflected in **Table 8.1**, within the eight broad categories, there were five particularly popular evidence forms among policy-makers. They were identified by key informants in Phase 1 of the study as regularly used in the health sector, and also were found to have been used in the development of both the PMTCT and National Core Standards policies in Phase 2. These were: published literature, South African survey data, anecdotal evidence, routine information systems, and expert evidence.

The other three identified evidence forms were less common and were variably used in the development of the two policy process cases, as reflected in **Table 8.1**. For instance, in the category of research evidence, although RCTs were cited by key informants in Phase 1 of the study, there were **not** used in the development of the two policy process cases. Local operational research was used in the formulation of the PMTCT and National Core Standards policies. This study found that research synthesis was reportedly used in the development of the PMTCT policy, drawing from the work of the Cochrane Centre, but was not cited in the development of the National Core Standards policy. This could be a biased observation from the key informants in the study, or may represent the dearth of synthesis work for this policy issue and type. Lastly, global evidence, which feeds into the guidelines released by UN agencies, was cited by key respondents in Phase 1 of the study, and also referenced as having been used in the development of the PMTCT policy. However, there were no similar or equivalent guidelines from the UN agencies that could be used in the National Core Standards policy, which was a health systems policy.

South Africa is not unique in terms of the broad categories of evidence used by policy-makers. The findings of this study dovetail with empirical work illustrating that policy-makers value a broad range of evidence, as shown in the work of scholars such as Burchett et al. (2015) in Ghana, West Africa. Scholars working in the UK (e.g. Oliver, Lorenc & Innvaer, 2014; Oliver et al., 2015; Oliver & de Vocht, 2017) have found, for example, that the types of evidence most regularly used in UK policy-making included local data, joint needs assessments, practice guidelines (e.g. from NICE), survey/questionnaire data, public health surveillance data, qualitative research studies, health impact assessments, systematic reviews, and experimental or trial data. However, the most frequently used sources of information were “experts in the area; government websites; NICE guidelines; review articles; online journals; websites of international organisations and websites of professional journals” (Oliver et al., 2015, p. 3).

Another key finding from this study is that the sources of evidence used by policy-makers are purposively selected to meet their needs. This is consistent with both the conceptual and empirical literature examined in Chapter 3, which identified several common traits about the sources of evidence preferred by policy-makers. Common characteristics of these sources included (a) relevance of the research topics (Burchett et al., 2015; Parkhurst et al., 2018) and (b) quick production of research results (Burchett et al., 2015). However, even the evidence that satisfies these criteria is not guaranteed to be used in policy-making. This is because consensus also exists in the literature that evidence alone does not make decisions, judgements are always required for decision-making or policy-making (Oxman et al., 2009a), and these judgements will consider a range of factors other than evidence.

As reflected in **Table 8.1** above, anecdotal evidence is one category of evidence used in South Africa and carries more significance for political leaders than is often imagined by researchers and the public. This study found that the “poster on the lamppost” can be an important source of information for political policy elites (see Chapter 7). Key informants indicated that the newspaper headlines were an important gauge for political leaders, as these reflected the citizens’ mood and attitudes towards government at any given point in time. This illustrates the importance of recognising that policy-making is sensitive to factors other than formal evidence. In fact, Cairney (2016) argues that “politicians – and, indeed, citizens and public servants – are influenced by anecdote, personal stories, emotion, and of course, lobbying, and they make decisions based on cognitive shortcuts, heuristics, principles, values, and ‘gut instinct’” (in Fafard & Hoffman, 2018, p. 4). This was certainly the case in the origin of the National Core Standards policy. Emotions, lobbying, and cognitive shortcuts were also at play in 2001 during national debates about the development of the PMTCT policy, where the evidence presented by AIDS dissidents was given primary significance over other sources of evidence.

This study found that other factors influencing the use of evidence in policy-making were that: the transmitter of the evidence must be credible, evidence must be aimed at assisting to solve the existing problems, evidence must be of good quality, evidence must be reproducible, and evidence has to be timely, as policy-makers will not wait for the evidence since they are under pressure to make policies. In this regard, the findings of this study are consistent with other South African empirical literature on factors influencing the use of evidence in policy-making (cf. Doherty, Gilson & McIntyre, 2002; Gilson & McIntyre, 2008; Rispel & Doherty, 2011). In **Phase 2** of the study, what emerged was that evidence presented to the policy-makers must be relevant not only to the policy under development, but also to the broader political goals that policy-makers want to achieve. A case in point is the effort by health policy-makers to ease the pressure exerted on government about the poor quality of frontline health services, which required a quick response in the form of National Core Standards.

Policy-makers cannot afford to wait for the results of long-term research studies to provide evidence for the development of health policies. The two policy process cases examined in this study illustrate that policy-makers work within an environment of urgency which requires that relevant evidence be readily available when it is required. As reflected in **Table 8.1**, during the development of the PMTCT policy, readily available evidence was sourced from diverse places, including the HIVNET 012 Perinatal HIV Prevention Study conducted in Uganda (Guay et al., 1999), guidelines from UN agencies (WHO, UNICEF, and UNAIDS), research studies presented at international conferences on HIV/AIDS, routine data from health facilities collected through the District Health Information System (DHIS), clinical observations from medical and nursing professionals and health experts (e.g. child health specialists/paediatricians), and local operational research studies conducted by the Reproductive Health Unit at WITS University and Chris Hani-Baragwanath Hospital, and paediatricians at the Universities of KwaZulu-Natal and Cape Town (UCT). Counter-evidence from the AIDS dissidents also influenced (and delayed) the policy-making process. In the development of the National Core Standards policy, the wide array of sources of evidence included: results from operational research such as the pilot of the National Core Standards, small studies tracking the implementation and

effectiveness of National Health Facility Improvement Plans, routine data from the District Health Information System on quality rated indicators, lessons learnt from benchmarking visits to the UK, France, Ireland, Canada, Australia, and Malaysia, and independent reports from organisations outside government such as COHSASA and the Health Systems Trust, which reflected findings on the quality of public health services. The use of diverse sources of information in policy development in South Africa is consistent with the findings of Oliver et al. (2015) and Oliver and de Vocht (2017) in their empirical work in both HICs and LMICs.

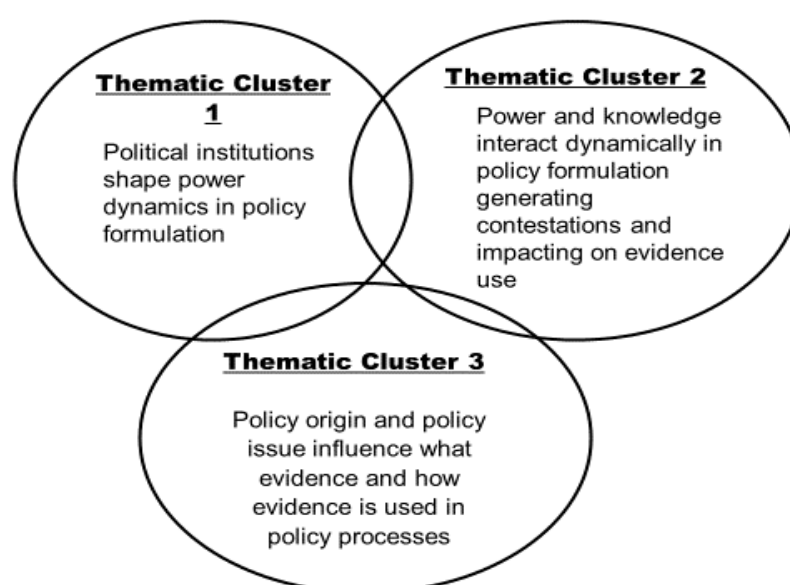
8.4. What factors influence if and how different forms of evidence are used in health policy formulation in South Africa?

The two case studies examined in Phase 2 of this study illustrate the factors that influence the use (or non-use) of evidence in the dynamic processes of health policy formulation in South Africa. Three clusters of themes emerged from a cross-case analysis of experiences in evidence use in health policy formulation. These were:

- (a) Political institutions shape power dynamics in health policy formulation;
- (b) Power and knowledge interact in health policy formulation generating contestation, and impacting on evidence use;
- (c) Policy origin and policy issue influence what evidence is used in health policy processes, and how.

Not only is each theme complex in itself, but the themes are also interlinked, as reflected in **Figure 8.2** below.

Figure 8.2: Clusters of themes from the policy development experiences of the PMTCT and the National Core Standards policies



8.4.1. South African political institutions

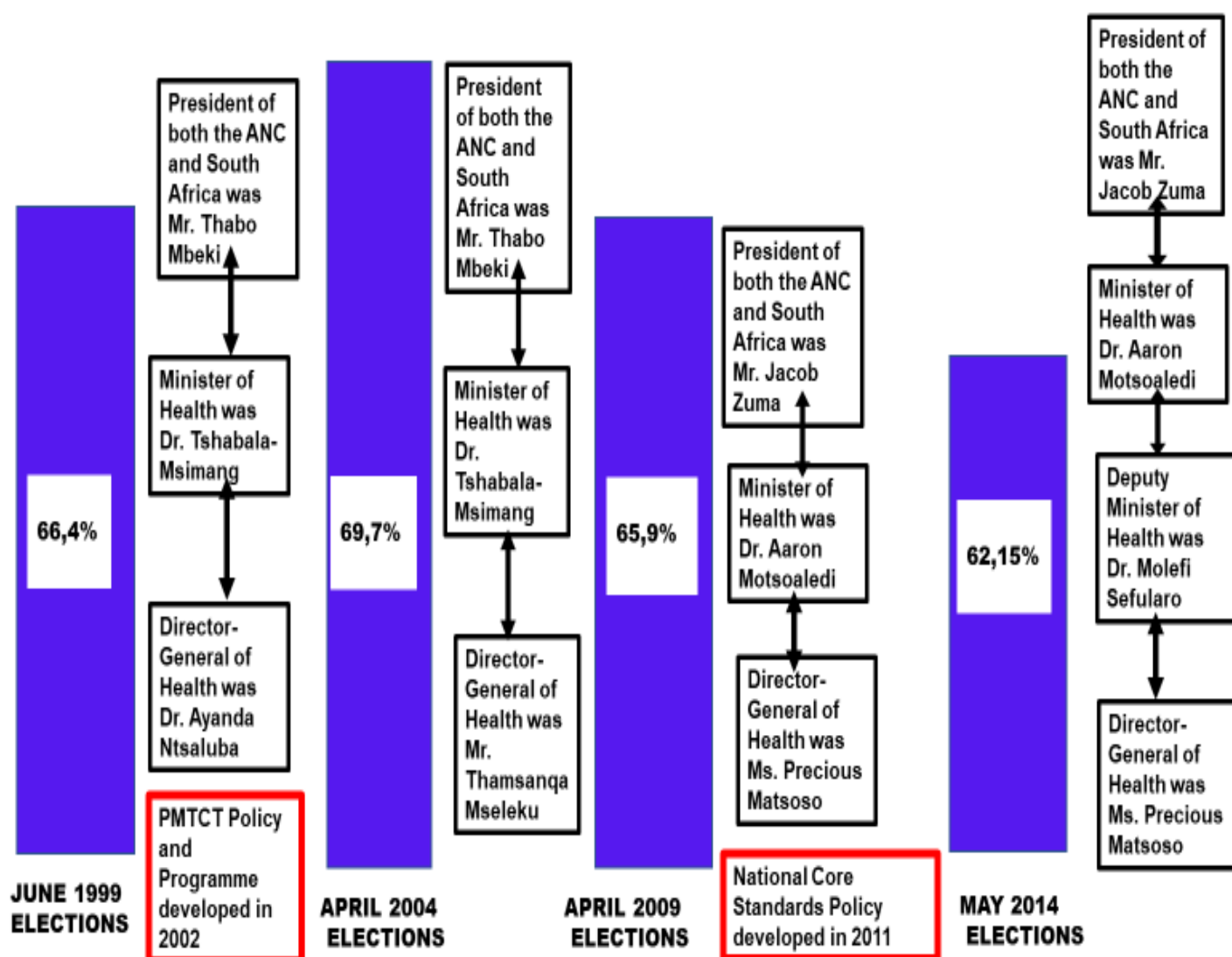
As a precursor to discussing power dynamics in South African health policy formulation, it is important to reflect on the relevant political institutions in the country. As discussed in detail in Chapter 4, South Africa is a multiparty constitutional democracy, with three arms of the State, namely the Legislature, the Executive, and the Judiciary, which are independent of each other. The national legislature consists of two houses of Parliament, the National Assembly, and the National Council of Provinces (NCOP).

It is imperative to understand the political environment from which Ministers and MECs of Health emerge, how they are deployed by their political party into government, what political and policy mandates they carry, how loyalty to their party is emphasised, and how deviation from these mandates is dealt with. In South Africa, constitutionally, national Cabinet Ministers are appointed by the President of the country, while Provincial MECs are appointed by Premiers of each province. However, given the wider political environment, Cabinet Ministers and MECs are actually indirectly appointed by the ANC and their job is, effectively, to implement the political objectives and mandates of the party. South Africa's constitutional democracy requires that national and provincial elections must be held every 5 years, and political parties are allocated seats in the National Assembly, the National Council of Provinces, and Provincial Legislatures, in accordance with the proportion of the national and provincial votes that they mustered in each election. Municipal elections are also held two years after the national and provincial elections, but they are not relevant to the two policy process cases discussed in this study.

As reflected in **Figure 8.3** below, since 1994 the ANC has won the popular vote and remains the ruling party to date after the most recent elections in 2019.

Figure 8.3: ANC Election Victories in periods that coincided with the development of the PMTCT and National Core Standards policies

ANC's share of the national vote



Source: Designed by myself based on the results of national elections published by the Independent Electoral Commission (IEC), and reviewed by the thesis supervisor

This study has illuminated the consequences of the political institutional landscape, which is dominated by the ANC, for the use of evidence for health policy-making in South Africa through the two policy process cases examined in this study (the PMTCT and National Core Standards policies). As reflected in **Figure 8.3** above, ANC election victories were followed by the election of Presidents and the appointment of Ministers.

The electoral cycles inevitably influence which individuals occupy critical policy-making positions. In addition, through its Deployment Committee, chaired by its

Deputy President, after forming a new government, the ANC has influenced the appointment of its members into key positions in government and State-owned Enterprises (SoEs).

This includes the appointment of Directors-General (DGs), who are the administrative heads and accounting officers of sectoral departments. In this manner, ANC politics influences national and provincial policy-making processes. In recent years, this *cadre deployment* policy has been strongly criticised and, in early February 2023, the opposition party, the Democratic Alliance (DA), challenged the legitimacy of the policy in the courts. It is contested that poor organizational leadership, limited capacity and corruption are intricately linked.

Even though national policy priorities are set by the ANC and government, the PMTCT and National Core Standards policies demonstrate that the change in personalities holding political office affects the space available for evidence use. Reflecting ANC influence over these appointments, **Figure 8.3** also shows that DGs have also changed with the appointment of new governments and Ministers. The compatibility (or non-compatibility) of a Minister and DG has also been a factor influencing the retention or dismissal of a DG, and therefore influencing policy-making across sectors within South Africa. Political power provides the ruling ANC with a mandate to formulate economic, social, and health policy.

Nonetheless, both policy process cases considered in this study also illustrate that powerful political actors derive their power from a variety of sources or standings within society, as well as from personal attributes. Sources of power include, as discussed in Chapter 6, seniority in the ruling ANC, political office (incumbency), proximity to the President of the country, genealogical pedigree and inheritance, academic qualification and previous track records, and personal attributes such as intellectual ability and kinship lineages. Apart from their vast knowledge of the health sector, both Minister Motsoaledi and Deputy Minister Sefularo, for example, also derived their political power from their professional power as doctors. Motsoaledi is also a nephew of Elias Motsoaledi, one of the accused in the Rivonia Treason Trial with Nelson Mandela in 1963, who was also sentenced to life imprisonment. Sefularo derived his power from his many medical and public health qualifications, from his previous position of MEC for Health in the North West province, and as a former Member of Parliament.

South Africa's judiciary was found to play an important role in the two policy case studies. Constitutionally, the judiciary is independent from the legislature and executive arms of the state. The judiciary consists of various levels of courts, which seek to ensure that all South Africans have access to justice, and whose roles are defined in detail in Chapter 2 of this study. The country's apex court is the Constitutional Court, and its verdicts and judgements are final. According to the Department of Justice, the Constitutional Court is the "highest in South Africa on constitutional matters, and was born out of the country's first democratic Constitution in 1994. The Constitutional Court only makes decisions about issues that have to do with the Constitution. It is also the highest court in the land since its decisions cannot be changed by any other court" (DoJ, 2022). South Africa also has a strong, vibrant, and vocal civil society, which advocates for the rights of poor and marginalised people, and which litigates against government when the need arises, to ensure that

these rights are protected. Since 1994, the South African media also enjoys autonomy, in accordance with the principle of Press Freedom.

8.4.2. Theme 1: Political institutions shape power dynamics in policy formulation

The two cases examined in this study illustrate the ways in which political institutions influence health policy decisions in the South African context. This is consistent with Parkhurst's (2017) assertion that political decisions take place within contextually specific institutional structures that direct, shape, or constrain the range of possible policy choices and outcomes. As indicated in the literature chapter, this perspective is in alignment with other eminent scholars in the policy analysis field (e.g. Parkhurst, 2017; Ettelt, Hawkins & Parkhurst, 2018; Kuchenmueller et al., 2022). It points to the importance of considering the existence and functioning of the structures which influence policy elites (Grindle & Thomas, 1989) and shape power dynamics in policy-making (Parkhurst, 2017), with impacts on whether and how evidence is used in this process. Against the previously presented background of South Africa's political institutions, the two policy process cases examined in this study highlight the central role of key political actors in policy development in 2001/02 and 2010/11, namely Minister Tshabalala-Msimang and the Health MinMEC, which comprised the Minister and the nine Provincial MECs for Health.

During the period in which the PMTCT and National Core Standards for Health Establishments policies were developed, political leaders who belonged to the ANC were, as already discussed, deployed in high-level government positions. They wielded, then, both political power and positional power in driving national policy. In the case of the PMTCT policy, political power was particularly important, in the absence of specific legislated powers. This is because when the PMTCT policy and programme were developed in 2002, Minister Tshabalala-Msimang did **not** have a specific legal mandate to impose her positional authority on provincial departments of health.

The National Health Act, No. 61 of 2003, which assigns the responsibility for the development of national policy to the Ministry of Health, had **not** yet been promulgated (and was only signed into law by the President in 2004, after the courts had made decisions about the PMTCT policy). In addition, Schedule 4 of the Constitution defined health as an area of concurrent competence between the national and provincial spheres of government, implying equivalent powers between the two spheres. The Minister therefore relied on her network of political relations, including the powerful ANC-led national Cabinet, in which she had a close ally in President Mbeki (although it can also be said that President Mbeki encouraged the Minister in her position). As indicated in Chapter 6, Cabinet statements on HIV/AIDS in 2001 and 2002 supported the policy position of Minister Tshabalala-Msimang on PMTCT and so emboldened her in her position. In addition, as reflected in Chapter 6, the Minister lobbied the ANC-aligned Provincial Health MECs to support her policy positions, using her political power. At that time, the ANC-aligned Health MECs expressed support for Minister Tshabalala-Msimang's position on PMTCT while other Health MECs concurred or just acquiesced. This experience illustrates that policy elites in South Africa are constrained by bounded rationality, a construct developed

by Herbert Simon (1946, cited in Hoffrage & Reimer, 2004), who argued that that policy-makers' rationality is bound by the reality of political factors, including political constraints. Since South African policy-makers are political deployees, deployed by the ruling ANC into their respective government positions, they owe their loyalty to the party that allocated them the positions from which they derive salaries and benefits. In some cases, a process of "reshuffling" has occurred, whereby a political office bearer is removed from office when there is a disregard of the resolutions and decisions of the ruling party.

However, as discussed in detail in Chapter 6, and later in this chapter, and despite these considerations, the situation changed in 2002 when more evidence of the efficacy of PMTCT became available. In 2002, political institutions continued to shape power dynamics in policy development, but in an opposite direction. In January and February 2002, the MECs of Health in Gauteng and KwaZulu-Natal provinces started defying the national position and scaled up the PMTCT programme in their respective provinces. In taking this action, they drew on the power and support of the provincial Premier, who is formally the person to appoint or remove an MEC, recognising that the Minister of Health could not dismiss them from their positions. The quasi-federal nature of the political system in South Africa therefore played an important role in enabling the development of the PMTCT policy. By contrast, the development of the National Core Standards policy was not as contested as the PMTCT policy, and Provincial MECs did not have to mobilise the political support of their Premiers to advance their policy positions. In fact, the development of the latter policy was neither politically charged nor emotive.

In the earlier discussion of South African political institutions, the judiciary was cited as one of the bedrocks of democracy in South Africa. The PMTCT policy process is an appropriate illustration of this. As discussed in detail in Chapter 6, in 2001, a coalition of civil society formations, community-based organisations, NGOs, including an organisation of people living with AIDS known as the Treatment Action Campaign (TAC), as well as scientists, clinicians, and researchers, took government to court to demand that the PMTCT policy and programme be scaled up nationally, to protect babies from HIV. They emerged victorious. Government appealed to the Constitutional Court in 2002 and lost the case again. The judgement directed government to roll-out PMTCT far beyond the original 18 pilot sites to the entire country, based on existing evidence. The 2002 judgement of the apex court in the country was the final nail in the coffin for the fate of the powerful actors who were opposed to the roll-out of PMTCT. Minister Tshabalala-Msimang argued that the court judgement reflected judicial overreach, since the judiciary should not interfere in policy-making, which is a preserve of the executive. However, the Constitutional Court concurred with the lower courts. The courts demonstrated the irrationality of the exercise of state power by government, which had been recalcitrant to implement PMTCT nationally. Using this test of rationality, the courts affirmed that the evidence on the efficacy of PMTCT was sufficient to support the government to act.

The court judgement also supported the re-balancing of actor power within the Health MinMEC, and demonstrated that, in a Constitutional democracy, political power must be exercised with rationality. According to key informants in this study, who were senior bureaucrats in 2002, the 2002 Constitutional Court judgement enabled most Health MECs to do what they had always yearned for, which was to implement the

PMTCT policy. This refers to the MECs who had acquiesced when the national Ministry opposed the scale-up of the PMTCT policy. They joined the MEC of Health in the Western Cape, who had implemented the PMTCT programme for several years, as well as the defiant Health MECs in Gauteng and KwaZulu-Natal.

Through the court judgements of 2001 and 2002, the judiciary affirmed that, in a constitutional democracy, power is spread outside government and political parties to ordinary citizens whose rights, including the right of access to health care, are enshrined in Chapter 2 of the Constitution, namely the Bill of Rights. In a democracy like South Africa, the separation of powers between political institutions provides the checks and balances for the will of the people exercised on their behalf by politicians and rights of citizens. The power of ordinary citizens is popularly referred to as *people's power* and is commonly defined as “political pressure exercised through the public demonstration of popular opinion” (Oxford English Dictionary, n.d.) or “the power or pressure demonstrated by the large numbers of the public in non-violent ways” (Collins Dictionary, n.d.a). In the development of the PMTCT policy and programme, people's power was demonstrated through civil society's advocacy for the programme, which included litigating against the government. The media also played a role in mobilising societal support for the policy. In the development of the National Core Standards for Health Establishments policy, there was no mass uprising by communities, no demonstration of people's power, and no court action instituted. However, the media played an influential, albeit unintended, role by reporting on the poor quality of health care services and adverse events. The newspaper headlines and lamppost posters caught the attention of political leaders in the health sector, highlighting the need for policy change. Overall, however, the latter policy was seen as essential by all role players, and its development was uncontested, except for the financial implications, as discussed later in this chapter. Thus, while both policy process cases illuminate how political power impacted on policy processes, only the PMTCT illuminates the potential of people's power. People's power was able to be exercised due to the huge negative impact of HIV on newborn babies, with tens of thousands of babies contracting HIV at birth. This spurred on diverse organisations and institutions outside government, including academic institutions, to mobilise themselves into a united front to challenge government's perceived irrational policy position on the PMTCT policy.

Turning to the use of evidence in policy-making, which is the epicentre of this study, evidence played a key role in influencing the Constitutional Court justices. Evidence on the efficacy of a nevirapine-based PMTCT swayed the judgement of the court in 2002. The court judgement also reinforced the findings from the pilot of PMTCT in 18 sites, which demonstrated that conditions in health facilities were favourable for the national implementation of PMTCT across the country. These judgements reinforced the evidence-informed approach to the development of health policy. Ironically, the establishment of the 18 PMTCT pilot sites and the evaluation of lessons learnt from these sites, conducted by the Health Systems Trust in 2002, had been commissioned by the national DoH – and then ignored. The *tactical model* (Weiss, 1979) of commissioning research studies with no interest at all in using the research results was essentially overturned by the two court judgements as they reinforced the evidence-informed approach to the development of health policy. It seems likely that without this landmark judgement, it would have taken far longer for evidence to influence the development of the PMTCT policy; at the same time, without the

evidence of the efficacy of PMTCT, and the readiness of health facilities to provide PMTCT, the court judgement would not have had any empirical basis. Therefore, the evidence and the rationality of the courts reinforced each other.

The two case studies also demonstrate that as powerful actors change, so do the opportunities for the use of evidence in health policy-making. As Oliver and Pearce (2017) note, the use of evidence must be balanced with other interests that are at play in the policy formulation processes. To illustrate, reflecting on the PMTCT policy experience in 2002, a breakthrough and turning point happened in the development of the National Core Standards which opened space for this policy to move forward. This was the change in the political leadership of government in September 2008, when President Mbeki was removed from Office by the ANC. This can be described as a function of a political system at work. The incoming President, Mr. Kgalema Motlanthe, reshuffled Cabinet, moving Minister Tshabalala-Msimang to the Presidency and replacing her as Minister of Health with Minister Barbara Hogan, a civil society activist. This change in the political landscape enabled the acceleration of the implementation of the PMTCT policy and provided the much-needed impetus for the full development of the National Core Standards policy. One illustration of the latter was the creation of an independent Office of Health Standards Compliance (OHSC), outside of the National DoH. These breakthrough moments for both the PMTCT and National Core Standards once more illustrate the fluidity of the policy-making process, and the fact that it is shaped by broader political institutions and forces.

The final South African political institution influencing these policy processes is the quasi-federal system of governance, where the national, provincial, and local government spheres are distinct but interdependent. The ANC has governed seven provinces since 1994. KwaZulu-Natal was governed by the Inkatha Freedom Party from 1994-2004, but the ANC subsequently won it back in 2004, and has remained in power since then. The Western Cape, meanwhile, has been mostly governed by the opposition party, the Democratic Party which transitioned into the Democratic Alliance, except for the period 2004-2008, when it was under ANC leadership. In the case of PMTCT, as already noted, the quasi-federal governance system enabled the Health MECs of Gauteng and KwaZulu-Natal to lobby their Premiers in 2002 to support them in their quest to expand the PMTCT programme across health facilities in their provinces. They joined the Western Cape, which had started the PMTCT programme in 1998. National/provincial contestations also occurred in the development of the National Core Standards for Health Establishments policy, although for different reasons. The first controversy centred around whether norms and standards for quality could be directly “borrowed” from other countries or from the UN agencies, and transplanted into South Africa. Since there were no guidelines from UN agencies similar to the PMTCT clinical guidelines that could be adapted to the country, the National DoH drew lessons and experiences from HICs – but provincial DoHs asserted that there should be no direct importation of standards given the very different context of South Africa. The provincial sphere of government also criticised the National Core Standards as an ‘unfunded mandate’. They argued that the policy was another example of the tendency of the national sphere to develop policies in a top-down manner without considering the financial and other implications of implementation, and without providing provinces with the additional necessary resources to ensure successful policy implementation. Although the Western Cape

province was the most outspoken about the financial implications of the National Core Standards for Health Establishments policy, this perspective was articulated even by key informants from some of the ANC-governed provinces. However, whereas in the PMTCT process, provincial autonomy resulting from the quasi-federal governance structure ultimately challenged national decision-making, this was not the experience of the National Core Standards for Health Establishments policy.

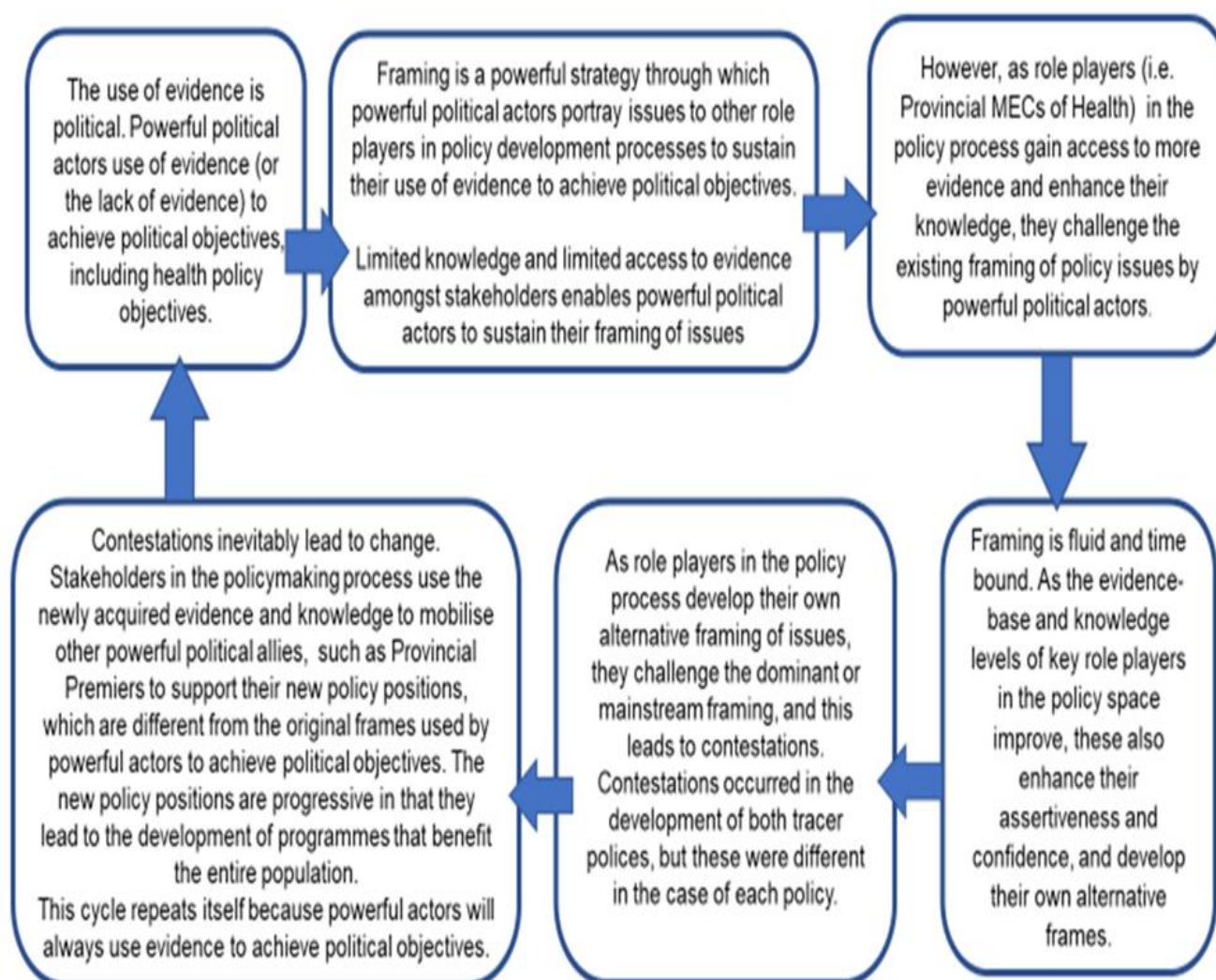
8.4.3. Theme 2: Dynamic interaction between power and knowledge in policy formulation generating contestations which impact on evidence use

As reflected in **Figure 8.4** below, the findings of this study illustrate a dynamic and fluid interaction between power and knowledge in policy formulation processes, which illustrates that the use of evidence in these processes is 'political' in several ways. The figure also suggests an inverse relationship between the power of major political actors and the levels of knowledge of other stakeholders, in that when the levels of knowledge among other stakeholders is low, powerful political actors are able to maintain control over policy processes and the use of evidence in policy formulation by framing issues in ways that meet their political goals. However, when the levels of knowledge increase among other stakeholders, they may begin to challenge the previously powerful actors and ultimately change the policy development status quo. Such contestations were shown, in this study, to advance the policy process. These points are further discussed below and reflected graphically in **Figure 8.4**.

First, the use of evidence is political in that it is the political policy elites who ultimately decide if and how evidence will be used. When civil society appealed for the development and national implementation of the PMTCT policy based on emerging local and global evidence of the efficacy of PMTCT, including from the PMTCT Evaluation Study commissioned by the health sector, the Ministry of Health asserted that the research evidence was insufficient. At the same time, the Minister of Health and the then President of the country were attracted to the evidence from AIDS dissidents purporting that antiretroviral drugs (ARVs), including nevirapine, were toxic. There was political intervention in decision-making about evidence pertaining to the efficacy of clinical drugs. Similarly, during the process of developing the National Core Standards policy, the political leadership conducted political screening of evidence and selected evidence that would be used in policy formulation.

Evidence that sought to create linkages between the National Core Standards and health outcomes was deliberately omitted. This left the technocrats, who were key informants in this study, frustrated at certain points of the policy development. The two policy process cases illustrate, therefore, that evidence is only one of the ingredients considered by policy-makers during policy-making processes, and that the dynamics and process of policy-making are affected by “circumstances unique to a particular policy initiative” (Grindle & Thomas, 1989, p. 215). Good quality evidence may be used differently from what the researchers originally anticipated, or not be used at all.

Figure 8.4: Dynamic interaction between power and knowledge in policy formulation generating contestations and impacting on evidence use



Source: Designed by the researcher based on findings of this study, and reviewed by the thesis supervisor

A second important theme emerging from this study, linked to the political use of evidence, is that the framing of issues is a powerful strategy that can influence if and how evidence is used. This is also depicted in **Figure 8.4** above. This study adopts the definition of framing advanced by Oliver and Pearce (2017), who assert that “the process of framing is an expression of power and informs the selection of evidence types which will be used in any discussion” (p. 5). Both policy process cases examined in this study illustrate that astute framing of a policy issue enables powerful political actors to influence both the policy processes and the extent to which evidence is used in these phenomena. Framing is, then, a tactic of power, a strategy of acquiring and retaining power. To illustrate, in 2001, the Health MinMEC, led by

Minister Tshabalala-Msimang, was able to delay the development of the PMTCT policy by framing the basis of their opposition to the policy as insufficient evidence of the efficacy of nevirapine in curbing mother-to-child transmission of HIV. As Koon et al. (2016) argue, by repeating this assertion, the Minister socially constructed her own version of *evidence-informed policy* and argued that the proposed PMTCT policy did not comply with this approach. The Minister therefore developed a self-fulfilling frame that asserted that she could not approve or lead a national programme without adequate evidence of its efficacy. Similarly, Minister Motsoaledi and Deputy Minister Sefularo also framed the importance of the National Core Standards policy to the entire country and underscored the potential contribution of these core standards to the improvement of quality of care in public and private health facilities. They asserted that setting norms and standards for health establishments was aimed at restoring the dignity of users of public services through the provision of good quality care. This framing was about advancing the policy, not delaying it. As reflected in Chapter 7, Deputy Minister Sefularo used public platforms to promote the National Core Standards policy, particularly in his public speeches and at national workshops.

The framing tactics used by Minister Tshabalala-Msimang, Minister Motsoaledi, and Deputy Minister Sefularo illustrate what Koon et al. (2016) refer to when they say that “by framing ideas in a particular way, actors evoke deeply held values that shift the terrain of the debate, transforming social phenomena into problems, implying a set of solutions, forming a coalition of interest and mobilising specific policy response” (p. 9). Minister Tshabalala-Msimang had shifted the terrain of debate from the sheer magnitude of the problem of mother-to-child transmission of HIV to the lack of evidence about the efficacy of nevirapine as a drug of choice for curbing this transmission. She reframed the social phenomenon of the absence of a national PMTCT programme into a problem of toxicity of all ARVs. The Minister framed her proposed solution as the collection of more evidence, including through a pilot of PMTCT in 18 pilot sites (health facilities), which was commissioned by her department in 2001, ostensibly to generate more systematic evidence of the feasibility of PMTCT in the country. However, even the evidence generated by the pilot study was not embraced and used to advance the development of the PMTCT policy. This indicates that framing can be a powerful tactic of delaying policy development process (Weiss, 1979). As indicated in previous chapters, key informants in this study reported how the Minister would meet with Health MECs from ANC governed provinces ahead of Health MinMEC meetings to establish a common position on key matters on the MinMEC agenda. This illustrates what Koon et al. (2016) refer to as “forming a coalition of interest and mobilising specific policy responses” (p. 9). The national Minister and Health MECs created an closed policy-making environment.

When Minister Tshabalala-Msimang commissioned a pilot of standards in 27 health facilities in 2007/08, she was using a strategy completely akin to Weiss’s (1979) *tactical model* of the research-to-policy interface. Weiss (1979) states that the *tactical model* occurs when policy-makers use research for purposes that have little relation to the substance of the research. In this context, it is **not** the content of the research that is used, but the fact that research is being done, which is used to deflect criticism. The pilot sites ostensibly demonstrated the Minister’s commitment to improving quality of care through setting of standards, whereas she actually wanted to deflect public attention away from her. The political changes that occurred in the country in 2008 removed Minister Tshabalala-Msimang from the further development of the

National Core Standards for Health Establishments. The two Ministers who actually drove the development of the latter policy were Minister Motsoaledi and Deputy Minister Sefularo.

This study has also found that the successful framing of a policy issue is not a permanent achievement, but is time-bound. This is particularly the case if it is influenced by insufficient knowledge among some of the actors participating in these processes. As it was the case with the PMTCT policy, the development of the National Core Standards confirms the dominance of powerful political actors in health policy development, albeit during different eras in South Africa, and under different political administrations. However, both case studies also reflect that powerful political actors and their framing of policy issues do not last permanently. In the case of the PMTCT policy, evidence of the efficacy of a nevirapine-based PMTCT programme triumphed over the scepticism that had been created. When credible evidence is consistently provided to and constantly consumed by policy-makers, it leads to enhanced knowledge. As Figure 8.4 suggests, as the knowledge levels of stakeholders in the policy processes improve, they are more likely to develop their own policy positions and challenge the dominant frame if it is not aligned. Knowledge becomes an important source of power for these stakeholders and a root cause of contestation between them and the previous leaders of policy processes.

In the case of the PMTCT policy, the Minister of Health was initially successful in her framing and portrayal of the need for “more evidence” as the solution to the problem of high rates of transmission of HIV (Shiffman & Smith, 2007). However, as more evidence emerged, some of the Health MECs used it to advocate for the national roll-out of PMTCT. The Minister’s delaying tactic of clamouring for yet more evidence, while ignoring existing evidence, was not sustainable. The increasing levels of knowledge about the efficacy of a nevirapine-based PMTCT programme among Health MECs in ANC-governed provinces, starting with Gauteng and KwaZulu-Natal, led them to challenge the policy positions of the national Minister of Health. This knowledge then strengthened the confidence and assertiveness of other provincial Health MECs and became a source of power for them. This is consistent with the policy analysis literature that portrays the policy environment as continuously shifting and transforming relations between groups and between organisations (Walt & Gilson, 1994). By 2002, Health MECs in two provinces had developed an opposing policy frame, based on their enhanced knowledge, which supported the development of the PMTCT policy and programme. They became decisive and emboldened to challenge the positions adopted by the national Health Minister. In this manner, knowledge became an important catalyst for the use of evidence in health policy formulation.

In the case of the National Core Standards policy, the original notion that the Office of Standards Compliance should be located within the National DoH and ultimately report to the Ministry of Health proved untenable over time. An independent and fully-fledged Office of Health Standards Compliance was eventually created several years later and located outside the National DoH, as a juristic person, in terms of the National Health Amendment Act of 2013. In addition, the knowledge levels of Minister Motsoaledi and Deputy Minister Sefularo helped them to champion the development of the National Core Standards. The two Ministers used their knowledge to provide political support for the development of this policy, and strongly promoted the use of

evidence in health policy-making. They supported a team of technocrats from the National DoH to undertake visits to several countries, amassing knowledge and evidence on how to develop these core standards.

Third, the two policy process cases also illustrate that as levels of knowledge improve and enhance the power and confidence of one group of stakeholders, it simultaneously reduces the power and influence of those who were previously powerful in a health policy-making process. Even the use of framing as a tactic for portraying issues in a particular way favourable to the dominant policy leaders is not a permanent strategy. The court judgement of 2002 sealed the fate of any political leaders opposed to the national roll-out of PMTCT. Similarly, the removal of the Minister from office in September 2008, by her own political party, enabled a faster pace of development of the National Core Standards for Health Establishments policy, and also attested to the fact that power is time-bound. This was because the two Ministers who replaced her, Barbara Hogan and Aaron Motsoaledi, both of whom were deputised by Molefe Sefularo, rapidly advanced the development of the National Core Standards for Health Establishments policy.

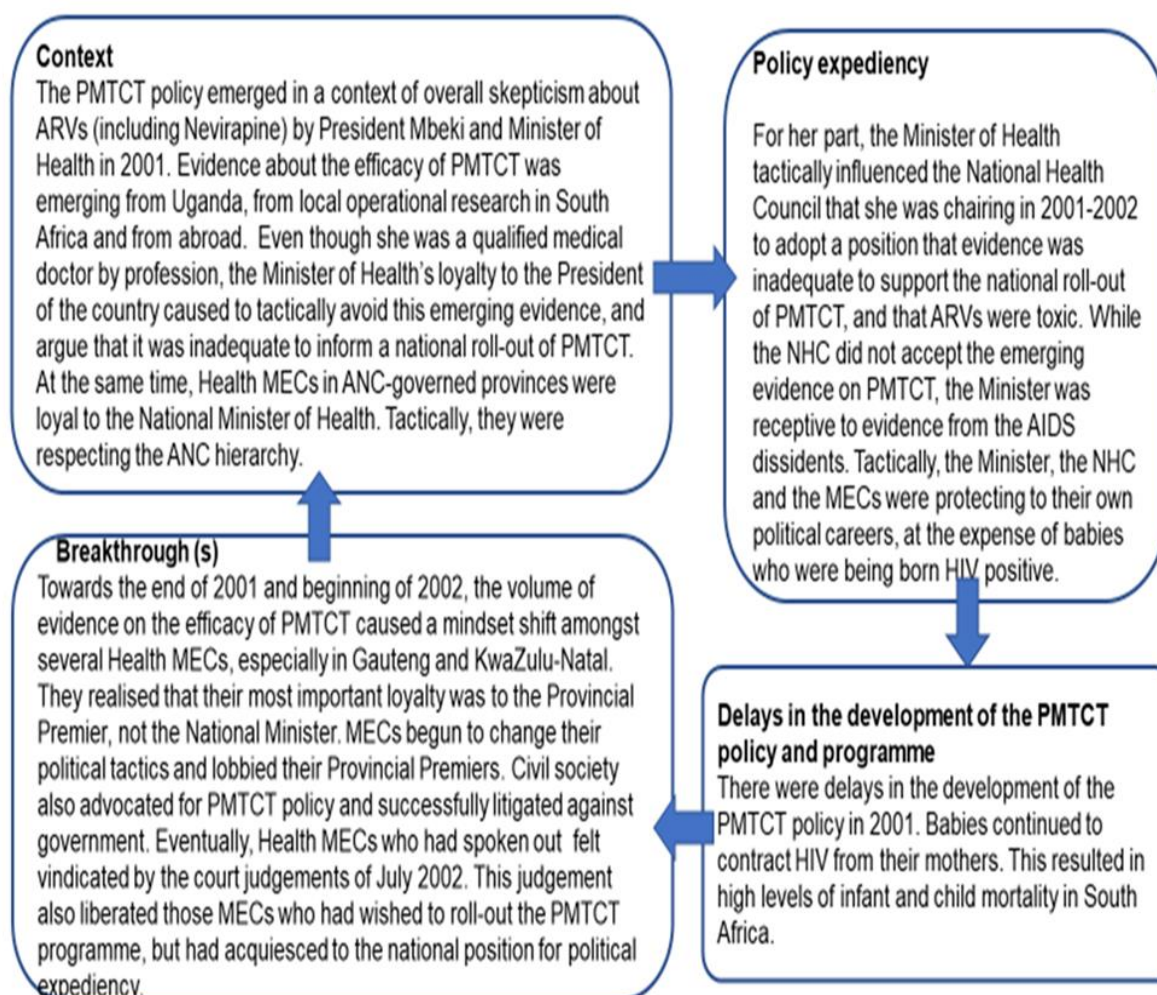
Finally, the two policy process cases examined here illustrate **how** evidence is used in health policy formulation. The study consistently found that evidence was used tactically to achieve political goals. Framing is tactical. This study adopts a straightforward Collins English Dictionary definition of a *tactic* as “the methods that you choose to use in order to achieve what you want in a particular situation” (Collins Dictionary, n.d. b).

Tactical use of evidence in this study simply refers to the use of evidence to achieve the political goals of powerful political actors, even when the evidence does not directly justify such goals. As reflected in **Figure 8.5 below**, evidence was used tactically in the early development of the PMTCT policy to obtain MEC acquiescence, supported by, as discussed above, political and institutional factors.

Evidence was also used tactically in the development of the National Core Standards policy. The development of this policy was a top-down process and was less controversial than the PMTCT policy. However, as reflected in **Figure 8.5 below**, the Ministers first supported all the evidence-gathering efforts of the technical policy elites in the national sphere of government in 2010 and 2011, including funding their international visits to gather evidence. However, after the evidence had been amassed, these political leaders tactically selected pieces of evidence that would be applied in the policy-making processes, and pieces that would be jettisoned, taking account of political considerations. Based on international experience, technocrats in the national sphere of government argued that one measure of success of these standards should be improvement in health outcome indicators. However, the political leaders realised that linking core standards directly to improved health complex was ambitious and politically risky, and separated the two issues. The National Core Standards would focus on improving the quality of services provided in both the public and private sectors, and on improving patients’ experience of care. Improving health outcomes would be a linked but separate matter, which, politicians argued, required much more than just the core standards. The partial or selective use of existing evidence in the formulation of the National Core Standards policy was therefore again the tactical use of evidence. This is reflected in **Figure 8.6 below**. As Parkhurst (2017)

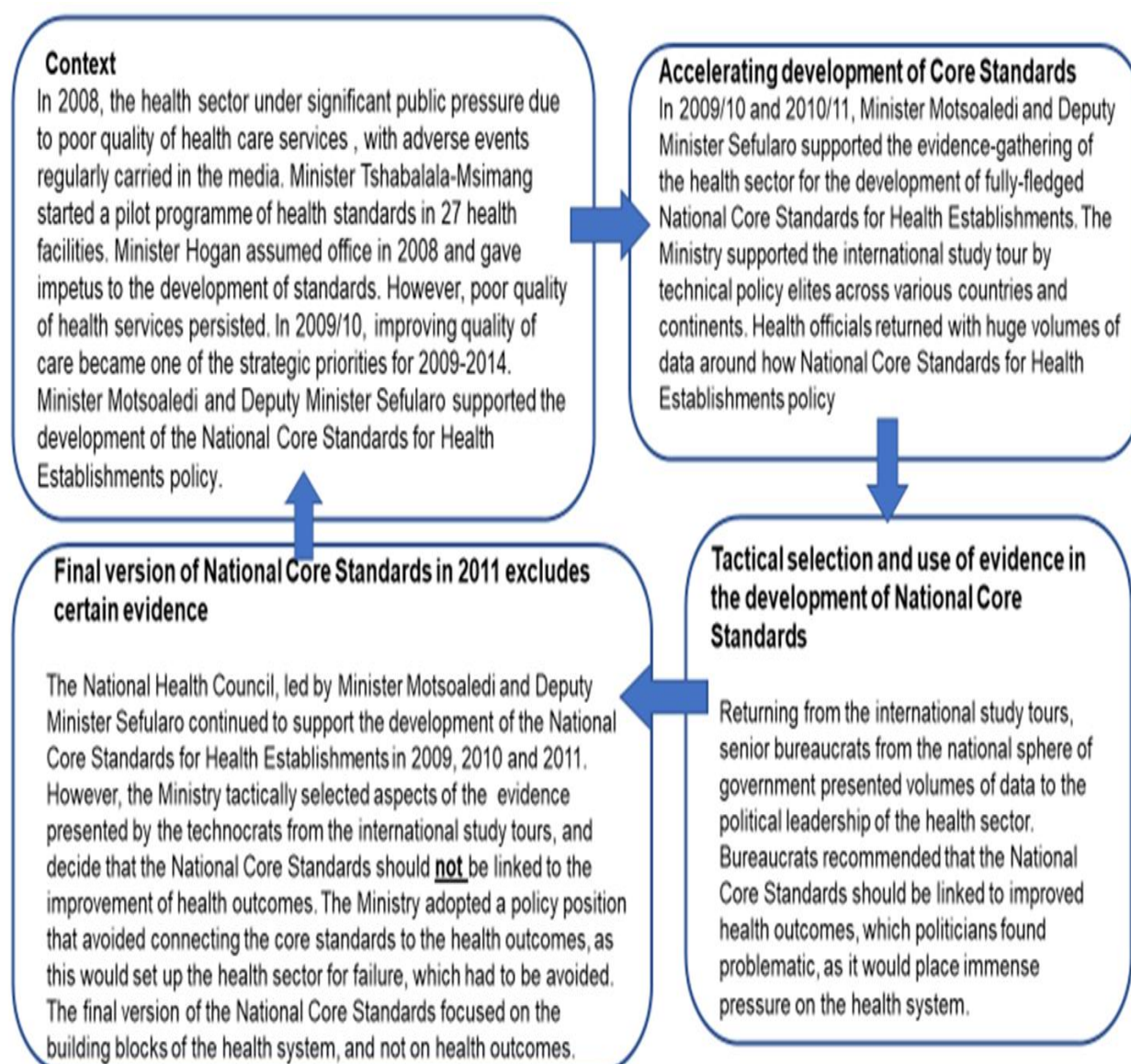
contends, evidence is **not** apolitical, but can in fact be decidedly political by promoting a *de facto* choice among competing values.

Figure 8.5: Tactical use of evidence in the development of the PMTCT policy



Source: Designed by myself based on findings of this study, and reviewed by the thesis supervisor

Figure 8.6: Tactical use of evidence in the development of the National Core Standards for Health Establishments policy



Source: Designed by myself based on findings of this study and reviewed by the thesis supervisor

8.4.4. Theme 3: The nature of a policy issue determines why and how evidence will be used in health policy-making

The two policy cases were selected for closer examination with the assumption that because one is a programmatic, clinical health policy and the other a health systems policy, their development processes would be different. As indicated in the methodology chapter, the most important rationale for the selection of the two policies was that they provide contrasting variables that existing literature indicates are likely to influence evidence use in policy change. These include: (a) different actor networks involved, (b) different processes of policy development, (c) different types of evidence applied, and (d) different levels of confidence by policy-makers in the evidence available to inform policy.

Table 8.2 summarises key similarities and differences between the policy cases, using the Walt and Gilson (1994) Health Policy Analysis triangle framework. It demonstrates that the key actors in the development of the two policies were senior politicians and health policy-makers in different historical eras. However, the wider actor network was quite different, with greater civil society engagement in PMTCT than the National Core Standards (see also force field analyses in Chapters 6 and 7). Contestation of the PMTCT policy was, thus, a more public process than that of the National Core Standards. Indeed, the two cases also differed considerably in terms of their policy process: PMTCT ultimately entailed bottom-up policy change, engaging a wide range of actors, whereas the National Core Standards were developed in a strongly top-down manner, primarily engaging public officials.

These differences in themselves reflect the nature of these two policies – with PMTCT being more of a high politics issue and National Core Standards a low politics issue. Grindle and Thomas (1989) note that high politics issues focus on “problems pressed on decision makers by interests outside government, in which small groups of high level decision-makers are closely involved, and there is a sense of urgency to act”. In a high politics issue, policy elites are concerned about “macro-political issues such as legitimacy, social stability, and the costs and benefits of such a policy [which] accrue major national interests, for the duration of the regime in power” (Grindle & Thomas, 1989). Although political leaders did not initially demonstrate an urgency to act, it did become a policy area that threatened political legitimacy. When this policy was developed in 2001 and 2002, South Africa was a pariah state in the world owing to the widely publicised AIDS denialism of the then President and Minister of Health.

By contrast, low politics issues are of low political stakes and are focused on a problem selected by decision-makers, entail incremental change in policy, and reflect little sense of urgency (Grindle & Thomas, 1989). Although political leaders did feel an urgency to act on the National Core Standards, the concerns that were contested were those common to such issues – bureaucratic issues such as “budget, compliance, responsiveness of implementers and incentives to modify bureaucratic behavior, and micro political issues such as narrow coalition building” (Grindle & Thomas, 1989). Whereas users of health services were vocal in the development of the PMTCT policy, the patient voice was silent in the development of the National Core Standards policy. Overall, then, these findings are consistent with the assertion by Grindle and Thomas (1989) that “the characteristics of particular reforms

determine the type of conflict and opposition that surround their implementation...characteristics of a policy have a powerful influence on whether it will be implemented as intended or whether the outcome will be significantly different” (p. 216).

Finally, the policy process case studies examined demonstrate that the nature of a policy issue determines why and how evidence will be used in health policy-making. A key difference between these two cases was the availability and nature of evidence to inform policy development.

The development of the PMTCT policy and programme had already occurred in several countries before 2001, including African countries such as Uganda, and the South African government did not have to start from the outset in crafting the PMTCT policy. Most importantly, evidence to inform this process was also available from research studies and clinical guidelines from UN agencies, such as the WHO and UNAIDS, which could be followed. This is characteristic of programmatic policies. Despite the initial contestation, over time, policy actors came to accept that this evidence indicated that South Africa should roll out PMTCT using the best available drugs, and the policy guidance was adapted in line with this evidence. Although the Minister disputed the evidence, the wider array of policy actors had, for the most part, confidence in this evidence.

In contrast, there were no globally adopted guidelines for the National Core Standards, and experience from other countries had, inevitably, to be adapted to the specific context of South Africa. This is characteristic of health system policies. The evidence-gathering process for the core standards, therefore, included research and benchmarking against other countries, but not the wholesale importation of policy ideas from these countries. The nature of the evidence available and the need to adapt it to context allowed, moreover, for contestation, as was demonstrated.

Table 8.2: Summary of the policy characteristics of the PMTCT Policy and National Core Standard Policy

Criteria for comparison	PMTCT Policy	National Core Standards Policy
Policy content	• Clinical or service delivery-oriented policy, focusing on two specific programmes, HIV/AIDS and Maternal and Child Health	• Health systems policy, seeking to improve quality of care in all 3880 health facilities in South Africa, across ALL health programmes
Key Actors in Policy Development	• National Minister of Health • Provincial Health MECs • Senior National DoH administrators • Provincial MECs of Health • Senior Provincial DoH administrators	• National Minister of Health • Provincial Health MECs • Senior National DoH administrators • Provincial MECs of Health • Senior Provincial DoH administrators • Invisible civil society involvement, not as well organised through established civil society structures
	• Very active civil society participation, through formal organisations; civil society litigated against government on PMTCT	• Numerous complaints about quality of care in the media, but no formal civil society organisations formed

Criteria for comparison	PMTCT Policy	National Core Standards Policy
Policy process	• Bottom-up agenda setting inspired by activists and clinicians, advocating and lobbying for the roll-out of PMTCT; policy was born of struggle • Home-grown policy but based on international guidelines, which were adapted to South Africa • Societal focus	• Top-down agenda setting, driven by Deputy Minister Sefularo, in response to concerns about quality of care in the public health sector • Home-grown policy • Inward government focus
National policy context	• National Minister of Health was reluctant to allow space for the development of this policy	• Full political support for the policy development process • National Minister and Deputy Minister of Health supported the development of the new policy
International context	• South Africa was a pariah state in the world in 2001 and 2002 due to the widely publicised belief by the then President and the then Minister of Health that HIV does not cause AIDS. • The political climate in which the PMTCT policy was developed was hostile. • The two leaders were sceptical of the emerging evidence that PMTCT based on nevirapine could save babies born of HIV-positive mothers. • South African scientists, researchers, and academics accepted the emerging evidence on the efficacy of nevirapine-based PMTCT.	• South Africa was a well-respected member state of the WHO in 2010 and 2011. • The Minister and the Deputy Minister of Health were deeply concerned about the perceptions and reality of poor quality of care in public health sector facilities. • The political climate in which the National Core Standards policy was developed was favourable and supportive. • The media played a key role in exposing deficiencies in public health sector facilities.
Evidence issues	• Emerging evidence internationally, supporting the efficacy of PMTCT, globally and in Africa (Uganda) • Contestations about “adequacy” of evidence from Minister	• Emerging evidence in different countries, mostly in Europe, supporting the need for Core Standards for Quality Care • Ministers embraced evidence • Contestations from provinces about “relevance” of the evidence, since it was derived from Europe, and about the affordability of the national norms and standards

8.5. Towards a Conceptual Evidence-to-Policy Framework for the South African Health Sector

As indicated previously, the fourth objective of this study was to propose a new conceptual framework for understanding the complexities of the evidence-to-policy context, and to promote consensus about policy-relevant research and evidence-based policy in South Africa. As Kuchenmueller et al. (2022) state, “while calls for institutionalisation of evidence-informed policy-making (EIP) have become stronger in recent years, there is a paucity of methods that governments and organisational knowledge brokers can use to sustain and integrate EIP as part of mainstream health

policy-making” (p. 1). Kuchenmueller et al. (2022) also acknowledge the inherently political nature of the process of developing an evidence-to-policy framework, when they cogently assert that “fostering the use of evidence in policy is, however, a complex, multifaceted and inherently political process [13] where a diversity of factors influence the way evidence can shape policy, requiring interactive and systemic approaches” (p. 2). While it is beyond the scope of this study to develop a fully-fledged evidence-to-policy framework for the country, as this is a complex process, it does, however, proffer some contributions to the development of an evidence-to-policy framework in South Africa.

This study found that there is commitment to EIP on the part of the political leadership of the health sector. Envisioning a collaborative role of policy-makers and producers of evidence, one of the most senior political leaders interviewed in the study stated:

“What is important is we are not far from moving in that direction of understanding that research just for its own sake without any relevance to solving social problems of society will not be very valuable. That is the fundamental point of departure and therefore we need a signage wherein policy-makers, both managerial and political, have to accept also the fact that in developing policies which are meant to assist and solve challenges of the improvement of quality of life of people, this should not be by gut feeling or just by whims of a political will” (senior political leader, national sphere of government).

Turning to the role of policy-makers, the senior political leader asserted:

“If we are going to be, as policy-makers and as political managerial leaders, if we are going to be effective we must value the inputs of evidence from credible research which must inform policy. Whether we are dealing with how to improve access, whether it’s about universal health coverage, whether it’s about the provision of pharmaceutical and diagnostics and overall broadening access to health services, whether it’s about tackling specific outbreaks, whether it be communicable or non-communicable diseases and all that. We will only be effective if at every step we look at what evidence is available on the basis of where information is available and where it is not available we can’t find credible evidence as to how best to improve a particular service, how best then to commission so that when we commit to taking particular steps those steps are informed by credible evidence” (senior political leader, national sphere of government).

This statement is a powerful commitment and vision for the future, articulated by a senior political leader. It is a vision that both policy-makers and members of the research community should certainly embrace.

Various legal and policy frameworks already exist for the creation of a formal evidence-to-policy framework or concept in the South African health sector. As reflected in **Table 8.3**, these include relevant health policies, legislation, and governance structures for evidence, and represent another essential building block of

EIP in South Africa. The documents listed below reflect that South Africa does have an established and solid health policy and legislative framework, which can serve as useful building blocks for the creation of a formal evidence-to-policy pathway. These foundations can contribute towards institutionalising the use of evidence in health policy development.

Table 8.3: Current building blocks for a formal evidence-to-policy framework for the South African Health Sector

Relevant Policy		Key Provisions of the Policy
1	White Paper on the Transformation of the Health System, 1997	• White Paper of 1997 makes an explicit commitment to an inclusive process of developing a new research agenda for the country, in collaboration with all key role players. • White Paper of 1997 binds the health sector to two important goals: (a) including the research community in setting the research agenda, as equal partners, and (b) using evidence for information-based decision-making.
2	National Health Act, No. 61 of 2003	• Provides for the establishment of a National Health Research Committee (NHRC), the functions of which are to advise the national Minister on health research priorities. The NHRC is a Ministerial Advisory Committee. • The NHRC must (among others) ensure that health research agendas and research resources focus on priority health problems. • Provides for the creation of a National Health Research Ethics Council (NHREC), the objectives of which are, among others, to: determine guidelines for the functioning of health research ethics committees; set norms and standards for conducting research on humans and animals, including norms and standards for conducting clinical trials; and advise the national department and provincial departments on any ethical issues concerning research. The NHREC is also a Ministerial Advisory Committee.
3	National Health Research Database (NHRD) established in 2013	• The NHRD serves as a repository of health-related research which has been and is currently being conducted in South Africa. • The NHRD provides researchers and research committees with a snapshot of current and past research priorities. • It facilitates equitable and relevant allocation of resources for research.

	Relevant Policy	Key Provisions of the Policy
4	2018 National Health Research Summit	• Convened by the National DoH in September 2018 to consult with stakeholders on research for health to address the social determinants of health. • Summit made six recommendations, namely: (a) prioritisation of the social determinants of health, (b) building capacity of health human resources, (c) improving health research funding, (d) creating a national system of implementing health research, (e) creating an evidence-based system of health research information management, and (f) improving the provision of health research infrastructure⁵.
5	National Health Research Strategy: Research Priorities for 2021-2024	• Provides high level research priorities that can be filtered down to specific research questions by the research community • Is informed by consultations at the National Health Research Summit held in September 2018 and proposals from stakeholders • Identifies broad challenges in four areas, namely: (a) Burden of Disease, (b) Health systems strengthening, (c) Universal Health Coverage, and (d) Digital Health⁶

In terms of the policy framework, the 1997 *White Paper on the Transformation of the Health System* commits the health sector to include the research community as equal partners in setting the research agenda, and to use evidence for information-based decision-making. The National Health Act, No. 61 of 2003, provides an enabling and overarching legal framework to support the evolution of EIP in the South African health sector. This is because this legislation provides for the establishment of the National Health Research Committee (NHRC), the functions of which are to advise the national Minister on health research priorities. By extension, it can be argued that the results of these research studies must inform health policy. The Act also provides for the creation of a National Health Research Ethics Council (NHREC), the objectives of which include determining guidelines for the functioning of health research ethics committees, and setting norms and standards for conducting research on humans and animals. Third, the National Health Research Database (NHRD) established in 2013 serves as a repository of health-related research which has been and is currently being conducted in South Africa. Fourth, in 2019, the Presidency entered into a Health Compact with more than 178 stakeholder organisations to improve the functioning of the South African health system. The Presidential Health Compact 2019 commits the health sector to, among others, develop Annual Health Research Priorities to continuously generate knowledge and new products for promoting, restoring, and maintaining health. As illustrated above, the building blocks for the institutionalisation of the use of evidence exist in South Africa in the form of relevant health policies, legislation, and governance structures for evidence.

⁵ DoH (2018)

⁶ DoH (2021)

This study has also found, however, that the functioning of these different legislative and policy building blocks can be optimised and enhanced to maximise the implementation of EIP in South Africa. A set of principles can be derived from the policy and legislative documents to drive an Evidence-Informed Policy (EIP) framework in the South African health sector, as reflected in **Table 8.4** below.

Table 8.4: Proposed principles for strengthening the building blocks for the development of the Evidence-Informed Policy (EIP) Framework in the South African health sector

Relevant Policy		Proposed principles
1	White Paper on the Transformation of the Health System, 1997	<u>Health Sector should be a learning organisation:</u> • White Paper of 1997 commits the health sector to evidence-based policy-making and transforming the national sphere of the health system into a learning organisation. • A learning organisation uses evidence in an iterative manner in health policy formulation. • The health sector should be guided by the letter and spirit of the White Paper of 1997 in developing all health policies.
2	National Health Act, No. 61 of 2003	Public visibility of the functions of the Ministerial Advisory Committees • Advisories provided by the NHRC and NHREC to the Ministry of Health should be made public, even in summarised forms, to ensure public scrutiny. Practically, the Government Gazette published to announce new policies should have annexures reflecting the evidence base that informed the policy. • Health policies that are developed on the basis of these advisories (and of course other factors) should also be made public. • Government and non-governmental stakeholders should work together to enhance collaboration around the health policy development processes in South Africa, including the transparent use of evidence in health policy formulation.
3	National Health Research Database (NHRD) established in 2013	• The NHRD is a useful facility and repository for health research. • Its utility should be enhanced by regular updates on new studies incorporated, as well as a section on the new health policies developed on the basis of data drawn from the NHRD. In this manner, the NHRD will contribute to the development of the evidence-to-policy pathway in the South African health sector.

Relevant Policy		Proposed principles
4	2018 National Health Research Summit	• The six priority focus areas (recommendations) adopted at the 2018 National Health Research Summit were important and remain pertinent today. • However, the summit missed an opportunity to define or design the “national system of implementing health research”. No details were provided on its functioning. • The summit also focused exclusively on health research and ignored other forms of evidence, which this study has found to be extremely important. • The health sector must adopt a broader definition of evidence.
5	National Health Research Strategy: Research Priorities for 2021-2024	• In addition to the five broad areas of challenges, the Strategy presents 12 Specific Priority Areas and almost 50 Key Focus Areas for Research. An elaborate list of priorities ceases to be a set of key priorities. The key principle here is that the health sector must produce a concise and well thought through list of priorities. When key focus areas reach a total of 50, they cease to be priority areas, but a wish list. Furthermore, like the summit on which it is based, the National Health Research Strategy: Research Priorities for 2021-2024 missed an opportunity to define or design South Africa’s evidence-to-policy pathway.

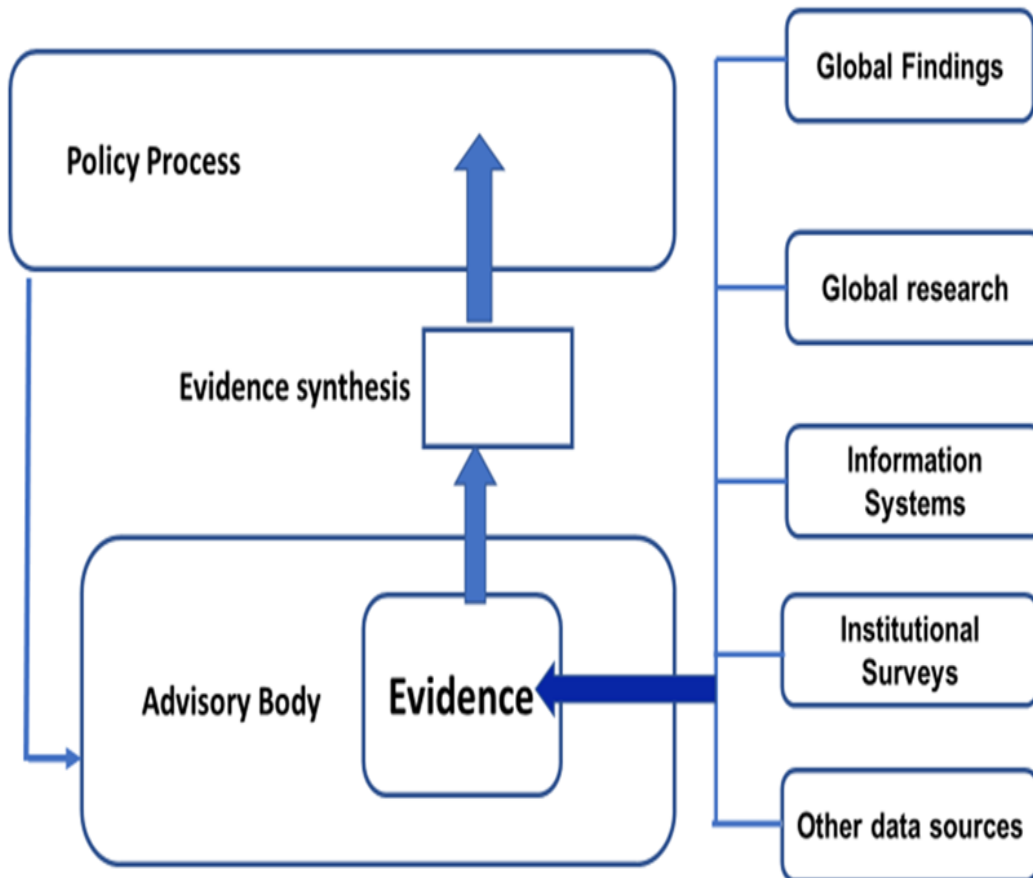
First, as reflected in the **White Paper of 1997**, the health sector should be a learning organisation that uses evidence in an iterative manner in health policy formulation. Drawing from the **National Health Act, No. 61 of 2003**, the advisories provided by the NHRC and NHREC to the Ministry of Health should be made public, even in summarised forms, to ensure public scrutiny. Furthermore, health policies that draw on these advisories should also be made public. The **National Health Research Database (NHRD)** allows for transparency about all health-related research conducted in South Africa. The NHRD should serve as an important starting point for all policy-makers in the national and provincial spheres of the health system, through which they ascertain the evidence base for any health policy that is anticipated. Finally, drawing from the **Presidential Health Compact 2019**, there must be a participatory development of South Africa’s Health Research Priorities, and the annual revision of the Annual Health Priorities list should be as inclusive as possible, comprising the entire research community inclusive of clinical and health systems and policy researchers. This would ensure that both policy-makers and producers of evidence contribute meaningfully to the setting of health priorities and to nurturing EIP in South Africa.

One mechanism through which the entire research community, inclusive of clinical and health systems and policy researchers, can meaningfully participate in health policy formulation is by examining the evidence base that informs the Government Gazettes, which communicate proposed national policies. These gazettes are published for public comment. However, the evidence base that informs these policies is not reflected in these gazettes. The process that is followed to sift through the volumes of evidence that inform health policy is also **not** outlined, and therefore

the specific process of evidence selection is **not** made public. A transparent and inclusive process of evidence selection and evidence use in the policy formulation process is required, which will involve a wider multidisciplinary team of researchers, rather than just the NHRC and NHREC working in isolation to produce recommendations to the Ministry of Health. The NHRC and NHREC should also issue media statements after each of their meetings and meetings with the Ministry of Health, to inform the public of deliberations behind the scenes. This proposal can be expanded further to suggest that together with the various Government Gazettes published to announce the arrival of different policies, there must be annexures that reflect the evidence base that informed the policy development. Sound evidence can be ignored and bypassed in policy-making processes if it is seen as inconsistent with the desired policy goals and outcomes; however, transparency is an important ingredient of any evidence-to-policy framework. In fact, Young et al. (2018) include transparency in the definition of such a framework when they state that “evidence-informed health policy (EIHP) is characterised by systematic and transparent approaches to access, appraise and use evidence as inputs to decision-making processes” (p. 1).

As discussed previously, this study illustrates the role of political institutions in facilitating the evidence-to-policy interface, as has been more widely discussed (Parkhurst, 2017; Ettelt, Hawkins & Parkhurst, 2018; Kuchenmueller et al., 2022). Consistent with this, Liverani, Chheng and Parkhurst (2018) evaluated two fundamental aspects of the evidence-to-policy transition, namely “domestic capacities to generate health policy-relevant evidence and institutional mechanisms to monitor, evaluate and incorporate evidence into the policy process” (p. 1). Based on their work in Cambodia, Liverani, Chheng and Parkhurst (2018) concluded that even though increasing availability of data might contribute towards an evidence advisory role in the health sector, the unavailability of clear guidelines and weak domestic capabilities might impact negatively on the efforts to enhance evidence for decision-making and policy formulation. Liverani, Chheng and Parkhurst (2018) assert that “no one discipline or researcher could possibly have the skills or knowledge to answer all [research] questions and therefore interdisciplinary teams are required, although difficult to assemble” (p. 9). These authors therefore propose what they refer to as an “Independent Advisory Body” that can “serve as central knowledge repository, review/integrate the diverse forms of evidence on particular health issues and produce evidence synthesis to inform the health policy process” (Liverani, Chheng & Parkhurst, 2018, p. 9). Their proposals are reflected in **Figure 8.7** below.

Figure 8.7: Function and Value of an independent advisory body that serves as central knowledge repository



Source: Liverani, Chheng and Parkhurst (2018)

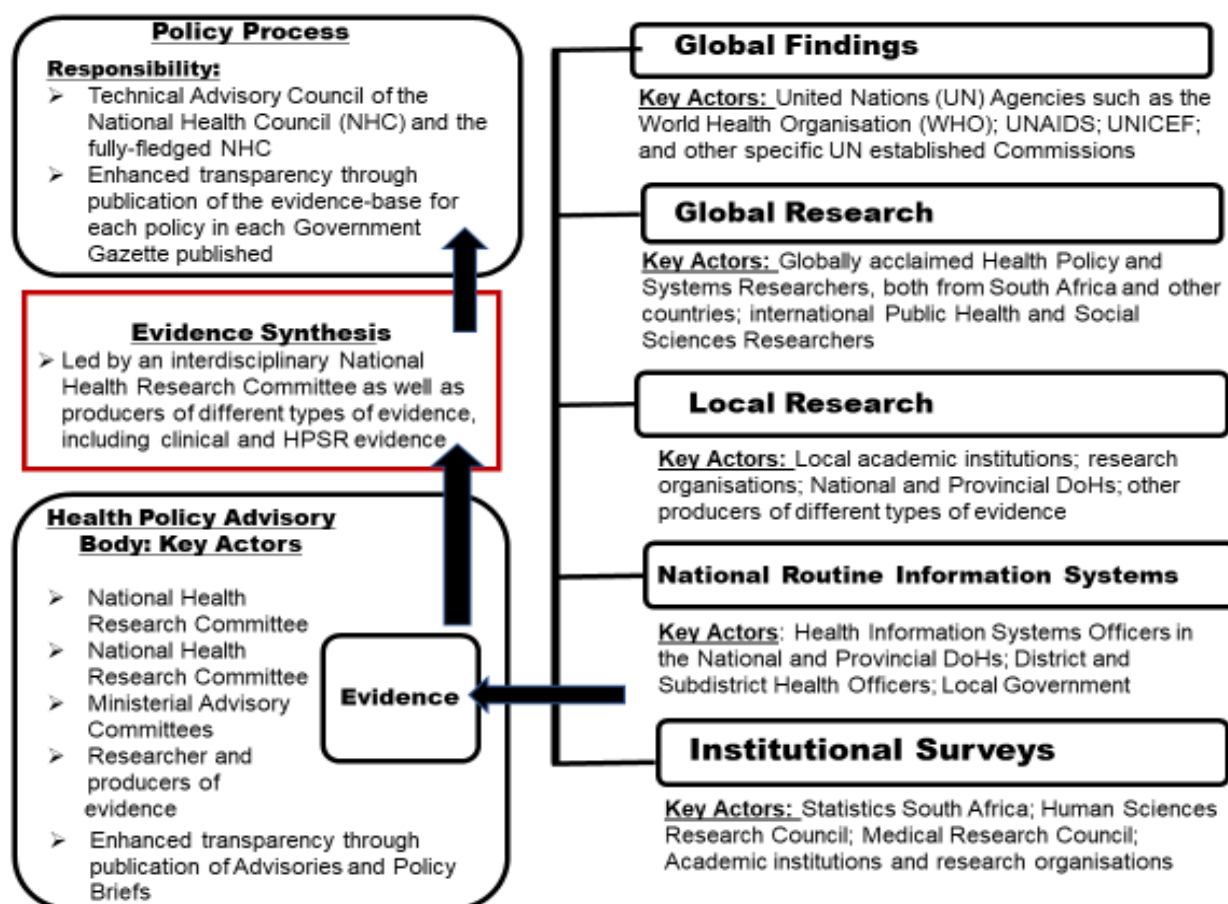
In South Africa, all the steps that Liverani, Chheng and Parkhurst (2018) propose are, in essence, already in place and are largely followed, as suggested in Table 8.4 above. The NHRC has played an important role in advising the Ministry of Health in determining health research priorities. For instance, under the leadership of the late Prof. Bongani Mayosi from UCT, the NHRC convened a National Health Research Summit in 2011 where over 300 researchers participated and identified key priority areas to be strengthened. This was an important process that laid the foundation for an open process of setting research priorities. Following on this best practice, a subsequent summit was convened by the health sector in September 2018, which, among other tasks, reviewed progress towards the recommendations of the 2011 Summit. Although some areas of progress were noted, concerns remained that South Africa's expenditure on research was still modest, at 0,8% in 2016 against a recommended target of 1%, and there was a lack of a national research financing strategy (Blecher & Gordon, 2018). The challenges identified at the 2018 National Health Research Summit are mostly identical to those identified by the NHRC in 2011, including the following: (a) shortage of human resources for health research in South

Africa, especially black South Africans and women, with a far lower associated research production than the world average for a middle-income country, (b) virtual absence of national planning, coordination, and translation of research into health innovations, policy, programmes, and practice, and (c) inadequate alignment of the funding programme of the MRC to achieve the health outcomes of the country (Mayosi et al., 2011). At the 2018 Summit, the Human Sciences Research Council (HSRC) called for the development of a “translation research model for social sciences” (Reddy, 2018). In summary, seven years after the first summit, the picture was still largely the same, and the health sector still lacked a documented evidence-to-policy framework or documented pathway. This study asserts that this framework is needed now.

An adjusted representation of the proposal by Liverani, Chheng and Parkhurst (2018) is reflected in **Figure 8.8 below**. This diagram takes into cognizance the building blocks reflected in **Table 8.3** and the principles proposed in **Table 8.4**.

The proposals made in the foregoing section and in **Figure 8.8** seek to address the limitation that once the policy formulation processes commence, these are not open and visible to the public. The evidence base used during these policy processes is also not made public, hence the call for greater transparency even while recognising that policy-making is inherently political. At a technical level, which is the level at which evidence is amassed, analysed, and packaged before it is submitted to the policy elites (political leaders), transparency can be achieved, as evidence has to be valid and replicable in similar settings. This transparency is needed now in South Africa.

Figure 8.8: South African adaptation of Liverani, Chheng and Parkhurst's (2018) Function and Value of an independent advisory body that serves as central knowledge repository



Source: Adapted by myself from Liverani, Chheng and Parkhurst (2018)

Figure 8.8 builds on the existing building blocks of an evidence-to-policy framework in South Africa, and considers the NHRC and the NHREC, which are advisory committees to the Minister of Health, to be the evidence-brokers. In advising the Minister on research priorities and research ethics, these committees have to consider a wide array of evidence from diverse sources. These include formal sources such as research evidence and routine information systems, but also both expert and anecdotal evidence. The evidence gathered by these committees should take into cognizance not only their own evidence or evidence produced by their own institutions, but also the work of other researchers and producers of evidence broadly. The NHRC and NHREC should produce research synthesis, having taken into account interdisciplinary research evidence, including both clinical and HPSR evidence. This synthesis should be the melting pot of these various forms of evidence. As reflected in Figure 8.8, this synthesis should inform the formal policy processes by the Technical Advisory Council of the National Health Council and the NHC itself. Most importantly, the evidence base that informs each health policy must be published with each Government Gazette to promote transparency.

Furthermore, research councils and institutions such as the Medical Research Council (MRC) could play a greater role in strengthening the evidence-to-policy interface, as it is the case with the Oswaldo Cruz Foundation in Brazil. The MRC could be more entrepreneurial and expand its mandate beyond research, knowledge production and dissemination, to promoting knowledge uptake and creating fora for researchers to come forward and engage with policy makers. In this manner, it could play a pivotal role in the production of the research syntheses.

8.6. The Socio-Economic Impact Assessment System (SEIAS) and other measures to improve the use of evidence in government's policy-making processes

Other initiatives are currently seeking to improve the use of evidence in policy formulation in South Africa. First, to support government-wide evidence-informed policy formulation, the Department of Planning, Monitoring and Evaluation (DPME) designed and implemented the Socio-Economic Impact Assessment System (SEIAS) (DPME, 2021) in 2017. This is a system for assessing the impact of policy initiatives, laws, and regulations in South Africa (DPME, 2021), which was developed to address concerns expressed about policy impact and implementation failures. It aims to reduce “unintended consequences, unanticipated outcomes and unnecessary costs from policy initiatives, regulations and legislation” (DPME, 2021, p. 2). As reflected in the SEIAS founding document, “the Executive Authority will not consider new policy proposals by any department that has not implemented the SEIAS. The system provides public officials with a powerful analytical tool to ensure that proposals are rigorously reviewed and evidence informed” (DPME, 2021, p. 2).

The SEIAS approach emphasises appropriate evidence management in policy formulation, including the need for “skills in the collation, storage, and curation of a body of different evidence types, as well as stakeholder engagements to ensure inclusive voices” (DPME, 2021, p. 4). SEIAS accentuates the need for building evidence management capacity before and after SEIAS is conducted. It is anchored on an evidence-synthesis methodology, which entails a set of seven steps, namely:

- (a) Define the policy narrative/statement including the key interventions and expected outcomes;
- (b) Agree on the which types of evidence to include in the SEIAS (drawing from the SEIAS policy cycle and related evidence needs);
- (c) Undertake a systematic search for evidence internal and external to the department;
- (d) Organise the evidence according to the SEIAS steps, keeping track of all the full texts;
- (e) Extract data, information, and evidence to answer the SEIAS questions posed;
- (f) Use external and other scientific evidence to validate and triangulate for rigour. Critically appraising the evidence will ensure reliability as well as legitimacy in reporting;
- (g) Update and maintain the evidence base to defend the SEIAS options and referencing.

It is encouraging that the South African government has initiated systematic processes of implementing an evidence-informed approach to policy development. However, the SEIAS approach is still taking root in South Africa, and its actual impact will only be felt in the next few years. Another current limitation of SEIAS is that government departments still have a tendency to request exemption from the Presidency from conducting a SEIAS process. Stated differently, when under pressure to produce certain policies within limited time frames, government departments still take the shorter route of not subjecting the proposed policies to a SEIAS process, which implies that they evade a rigorous assessment of the evidence that informs the new policies. This study and other similar studies in future, can reinforce the SEIAS process by consistently advocating for a formal, transparent, and evidence-informed policy-making process in South Africa, including in the health sector.

Another fairly recent development in the local South African context are attempts to improve policy formulation processes, led by authors within government. A literature review by Lane et al. (2020) has proposed a total of five stages and 34 steps by which policy development and management processes can be improved in LMICs, including South Africa (Lane et al., 2020). As reflected in **Table 8.5** below, these steps sequentially entail agenda setting, policy formulation, decision-making, implementation, and evaluation. These steps suggest an underlying understanding of policy-making as a linear, ordered process without any contestations or rugged terrain. This does not adequately address the tensions involved in policy-making processes, in which policy-makers debate and consider different types of evidence, and select the most relevant and appropriate evidence. As Bertscher, London and Orgill (2018) state, “although the South African Government has recently made efforts to develop guidelines for developing evidence-based policy, international literature suggests that the use of guidelines is **not** a panacea to ensure good quality evidence, as policy-making is an inherently political process that involves bargaining, priority setting, and policy alternatives” (p. 795). Without transparency about evidence-selection and evidence use, these guidelines will likely remain only on the shelves of policy elites, both technocrats and elected political leaders.

Table 8.5: Potential best practices for policy development and management practices

Stages	Potential best practices
Stage 1: Agenda Setting	• Conduct robust situational analysis • Facilitate ideas and feedback from key stakeholders to policy-makers • Develop clearly defined problem statements • Facilitate policy-maker access to resources with current evidence • Conduct stakeholder analyses
Stage 2: Policy Formulation	• Brainstorm possible interventions to address problem statement • Analyse potential interventions using expressly defined criteria • Develop stakeholder engagement plan to ensure input from all relevant stakeholders • Model implementation to identify potential implementation barriers • Consider impact of staff turnover on policy implementation • Conduct a policy conflict analysis

Stages	Potential best practices
	• Conduct a costing analysis that estimates resource needs over time • Identify sources of funding • Policies should be clear and areas of flexibility should be expressly acknowledged • Clearly define targets, objectives, goals, and indicators • Include clear implementation targets with timelines • Establish a consistent framework for M&E plans • Identify and coordinate M&E system(s)/data sources
Stage 3: Decision-Making	• Standardise definitions for different types of policies • Establish consistent requirements for review and approval of different types of policies
Stage 4: Implementation	• Disseminate policies through push and pull mechanisms to all relevant stakeholders • Provide sufficient role-specific training on policy details • Educate key stakeholders on policy components • Verify knowledge of policy details by key stakeholders • Empower managers to provide guidance and support to front line implementers • Empower frontline implementers to engage in policy development and implementation processes • Designate champions/leaders responsible for implementation at each level • Ensure strong financial management throughout implementation
Stage 5: Evaluation	• Engage in regular implementation monitoring • Monitor availability of inputs/supplies/medicines for policy compliance • Conduct evaluation when required by policy • Ensure evaluation is transparent and verifiable • Use results of policy evaluation to inform policy-making processes

According to Lane et. al (2020), these 34 potential best practices constitute a “framework for governments, especially in LMICs, to review their existing processes with an eye toward greater standardization and improved management” (p. 6). These stages and best practices are operational, and useful for the technocrats involved in technical policy-making processes. The approach proposed by Liverani, Chheng and Parkhurst (2018), that is, for a functional and independent advisory body that serves as central knowledge repository, becomes more useful in the South African context.

8.7. Conclusion

This chapter has presented a discussion of the findings of this study, considering both Phase 1 and Phase 2. The study has investigated the use of evidence in health policy formulation in the South African health system, focusing on the seven steps of policy development that are located between agenda setting and policy implementation, which Berlan et al. (2014) refer to as ‘the bit in the middle’. The study used the PMTCT policy developed in 2002 and National Core Standards for Health Establishments policy of 2011 as policy process cases. The first take home message from these two policies is that powerful political actors derive their power not from one source, but

from a diversity of sources or standings within society, including political office, proximity to higher levels of power, genealogical pedigree and inheritance, academic qualification and previous track records, proximity to the President of the country, and personal attributes such as intellectual ability and kinship lineages. This power is then used to influence the development of national policy.

The second lesson is that both political power and framing are **not** permanent features of the policy process, but are instead fluid and transient. Events occur which lead to changes in the political landscape, which changes the balance of power and the influence of powerful political actors. At the same time, as key stakeholders gain more insight and knowledge, they gain confidence, contesting the dominant policy frames used by key actors and producing their own alternative frames.

Looking ahead, the findings of this study suggest that opportunities exist for strengthening the evidence-to-policy interface in the South African health sector. Building on the existing legislation, regulations, and policies, it is proposed that the framework first developed by Liverani, Cheng and Parkhurst (2018) can be applied to enhance the manner in which the NHRC and the NHREC provide policy advice to government. A key enhancement of this process is transparency (Oliver & Pearce, 2017). It is important that when national policies are published for public comment through Government Gazettes, the evidence base that informs these proposed policies is also published for public and academic scrutiny. Oliver and Pearce (2017) assert that being transparent amounts to power sharing. Indeed, being in a position of advising government on health policy is a powerful place. This source of power can be shared through transparency and bringing other role players into the space of examining the evidence base that informs national health policy.

CHAPTER 9: CONCLUSIONS, REFLECTIONS AND RECOMMENDATIONS

9.1. Introduction

This chapter presents conclusions from and reflections on this PhD research. The chapter is divided into three sections.

The first section outlines the contribution of the study to the existing body of South African literature on policy analysis broadly, and specifically on the literature focusing on health policy formulation, as well as the use of evidence in policy development. It also discusses the contributions of this study to the global literature from both LMICs and HICs.

This chapter then presents the limitations on the judgements that can be drawn from this study and how these were addressed, and recapitulates the proposed framework for enhancing the evidence-to-policy pathway in South Africa that was discussed in detail in Chapter 8. The final section presents my personal reflections on this study, followed by the conclusion of the chapter.

9.2. Contribution of the study to the expansion of South African literature

9.2.1. Health policy analysis and policy formulation

A common theme in the South African literature on health policy analysis and the use of evidence in policy development is the paucity of published articles in this field of study. In his treatise on evidence-based policy analysis in South Africa, Cloete (2009), writing from the University of Johannesburg, noted that evidence-based policy analysis was “an increasingly popular paradigm for public policy analysis” in the country, but hastened to add that this field was in an “emerging state” in the country (p. 293). Almost a decade and half later, in 2023, this study has observed some modicum of growth in the field of health policy analysis, but this expansion remains very limited, when compared to global literature. This study therefore contributes to the existing body of literature in this area.

This study addresses, moreover, a peculiar limitation of the existing South African and global policy analysis literature, which is its bias towards researchers’ perspectives and limited exposition of policy-makers’ perspectives. This study exposed the views of the senior most health policy-makers, both bureaucrats and politicians, who Grindle and Thomas (1989) refer to as technical policy elites and policy elites, respectively. It supplements existing empirical and scholarly efforts to address this imbalance in the country. Published literature includes work on the Policy BUDDIES Project undertaken in Western Cape province, which was a “programme of formalised dialogue between researchers and provincial health policymakers in South Africa” (Young et al., 2018). In the evaluation of this programme, Young et al. (2018) found that “researchers knew little about policymaking or needs of

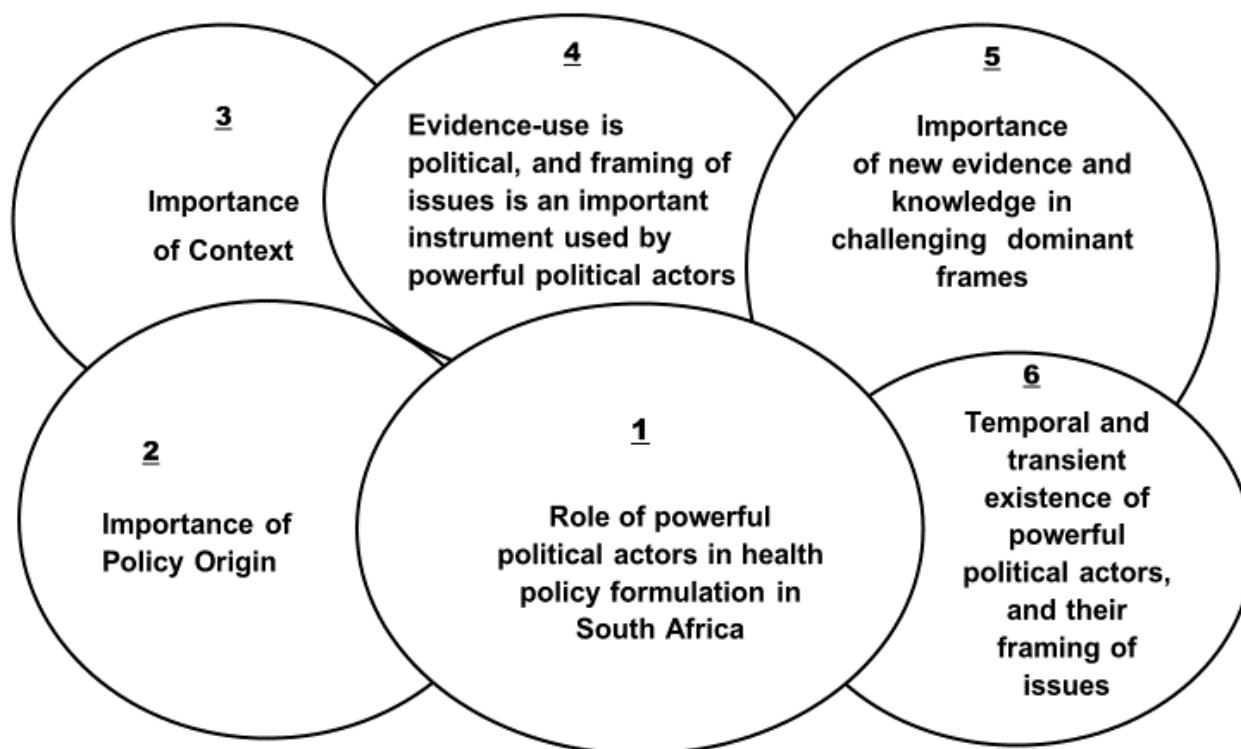
policymakers. Policymakers respected the contact with researchers, respected researchers' objectivity and appreciated the formalised approach. Having policymaker champions facilitated the dialogue" (p. 1). Studies by Young et al. (2018) and the Western Cape HPSR Journal Club Team (2020) also demonstrated how partnerships between academic institutions, researchers, and policy-makers can jointly produce knowledge, and that this approach improves the trust placed in this knowledge and increases the opportunities that it will be considered in health policy formulation.

Bertscher London and Orgill (2018) also sought to expose the views of diverse stakeholders by interviewing both stakeholders who were supportive of the Draft Control of Marketing of Alcoholic Beverages Bill, although they were mainly from the private sector (alcohol industry), and five senior government representatives from the Departments of Health and Social Development.

Turning to the specific field of health policy formulation, the study contributes to the empirical literature on health policy formulation in South Africa specifically by unearthing the views and experiences not only of policy-makers who occupied offices during the period of the study, but also of previous incumbents of those positions. In this manner, the study benefitted from the wealth of experience and expertise that former senior government officials possess, and which they contributed during key informant interviews. This was made possible by being, very unusually, an insider led research study. The study has clarified and presented material about formal policy-making in the South African sector which was not in the public domain including, for instance, the formal policy-making process presented in Chapter 5.

This study has revealed six sets of findings about the complexity of health policy formulation processes, which are reflected in **Figure 9.1**. These are: (a) the role of powerful political actors in health policy formulation in South Africa, (b) the importance of policy origin, (c) the importance of context, (d) evidence use is political and the framing of issues is an important instrument used by powerful political actors, (e) the importance of new evidence and knowledge in challenging dominant frames, and (f) the temporal and transient existence of powerful political figures and their framing of issues.

Figure 9.1: Areas of value-addition of this study to the existing literature on the use of evidence in policy-making in the South African Health Sector



Source: Designed by the researcher and reviewed by the thesis supervisor

Turning to the first of the six abovementioned points, the two policy process cases examined in this study reflect that **powerful political actors** are probably the most important variable in policy formulation, and lie at the centre of policy development, as previously illuminated in global conceptual literature (e.g. Walt & Gilson, 1994). This study further exposes their role in influencing the use of evidence in policy formulation, despite the fact that this is normally regarded as the role of technocrats. The study has also illustrated that powerful political actors draw their power and influence from existing political institutions, and from other sources. Through the two policy process cases, this study adds to the existing literature on the importance of political institutions that distribute political power among political parties and among government actors that enable them to dictate policy processes. However, the study has also shown the importance of other sources of power, such as the academic qualifications of powerful political actors, their previous track record, and personal attributes such as their lineage and proximity to the President. One of the relatively recent South African studies akin to this study is the work of Bertscher, London and Orgill (2018) who examined the formulation of the national Draft Control of Marketing of Alcoholic Beverages Bill (developed between March 2011 and 2017) considering the seven steps of policy formulation, known collectively as the 'bit in the middle'. These seven steps were discussed in detail in Chapters 4, 5, and 8 of this thesis. However, whereas Bertscher, London and Orgill (2018) focused on one piece of legislation, this study examined two policy process cases, the PMTCT and National Core Standards for Health Establishments policies. Bertscher, London and Orgill

(2018) found that in South Africa, “networks of powerful actors, including non-state actors with commercial and financial interests, can use diverse strategies to influence health policy formulation processes in a low- and middle-income country context” (p. 787). Similarly, this study has illustrated how political actors influenced (and almost derailed) the development of the PMTCT policy, by contesting the evidence base that existed in 2001 and 2002, and how political actors supported (and fast-tracked) the development of the National Core Standards for Health Establishments policy in 2009/10 and 2010/11. It confirms that health policy-making in South Africa is a political process, located in the hands of powerful policy actors. As reflected later in this chapter, authors such as Votruba et al. (2018) have asserted that this is a common feature of policy-making processes in LMICs.

The second area of value-addition of this study is that it demonstrates how **policy origin** influences the complexities associated with policy-making and the controversies that emerge about whether evidence will be used in policy processes. As reflected in Chapters 6, 7, and 8, the PMTCT policy originated in a bottom-up manner, prompted by civil society and academic institutions, which resulted in the use of evidence in this policy process case not being fully supported by policy-makers in the national sphere of government. The latter also experimented with evidence from the AIDS dissidents. By contrast, the National Core Standards policy originated in a top-down manner, driven by the political policy elites in the national sphere of government and enjoyed much more enthusiastic use of evidence than the PMTCT policy, even if it was selective use. The two policies experienced contrasting levels of support from the policy-makers, based on their diverse origin.

The third value-addition of this study is its findings around the importance of the **political context** in which a policy emerges. This finding is consistent with the work of South African scholars such as Schneider et al. (2006), Simelela and Venter (2014), and Schneider et al. (2010), who have written extensively about the history of HIV/AIDS in South Africa, particularly the role of civil society in advocating for the national scale-up of the PMTCT policy and programme. These authors celebrate the important role of civil society in campaigning for access to ART in the country, and in successfully mobilising different sectors of society, and ultimately, the judiciary, in support of PMTCT and ART. Linked to the foregoing narrative on context, this study adds to the existing literature by surfacing the concept of people’s power, which civil society formations and academic and research organisations demonstrated with their successful advocacy for PMTCT and ART.

Another important institution in the South African context is the independent judiciary, which exists in a democratic political system, and which can therefore make rational judgements that are not politically biased. Key informants in this study articulated how, in the case of the PMTCT policy, the court judgements of 2002 liberated Health MECs who had always wanted to expand access to the PMTCT programme in the ANC-governed provinces. As reflected in Chapter 6, in 2001 and 2002, some Provincial Health MECs in ANC-governed provinces actually agreed with civil society organisations, but could **not** articulate these views publicly, in light of the diametrically opposed policy position of the national sphere of government. What is not published, however, and which was discovered in this study, is that these MECs were relieved by the breakthrough that occurred in 2002, when the Constitutional Court ruled in favour of civil society. In this way, this study validates the work of Simelela and Venter

(2014) and Schneider et al. (2010) about the importance of an independent judiciary in a democratic country in health policy formulation.

The fourth area of contribution of this study to the South African literature on health policy formulation is its concrete illustration that **the use of evidence is political**. Powerful political actors influence the selection and use of evidence in policy formulation, using the tactic of *framing*. As reflected in Chapters 6, 7, and 8, this study contributes to the literature that shows how framing enables powerful political actors to influence the use of evidence in policy-making in a manner that suits their political objectives. In particular, this study demonstrates that, in both policy cases examined, once the key evidence required for policy formulation was amassed by technical experts, inclusive of the research community, technical expert committees, and health information officers who produce routine data, the most important determining factor as to whether such evidence will be used in health policy-making is the powerful political actors who hold office at any given historical period. Bertscher, London and Orgill (2018) refer to this as “the battle for evidence”, a concept that highlights the contestations about “correct evidence” to support policy processes (p. 795). In their study, Bertscher, London and Orgill (2018) found that this battle occurred between policy-makers in government and external stakeholders in the private sector. Similarly, in the development of the PMTCT policy, the contestations around evidence occurred between policy-makers on the one hand and a lobby group comprising academics, research institutions, and civil society on the other. In the case of the National Core Standards, the technical policy elites were disappointed with the selective use of evidence by the policy elites, or powerful political actors. This phenomenon was not unique to South Africa. In their systematic review of 48 studies, Baker et al. (2018) found that the studies reviewed concluded that evidence-based policy was gathering support “...as an attempt to ‘de-politicise’ the policy-making process” (p. 106). However, these studies also found a phenomenon of selective uptake of public health evidence “to fit the political priorities of governments in power” (p. 106).

The fifth contribution of this study is the finding around the importance of new evidence and knowledge in challenging dominant frames. As discussed in detail in Chapter 6, the year 2002 was important in propelling the evolution of the PMTCT policy in that Health MECs embraced new evidence and knowledge and together with the Western Cape province challenged the position adopted by the Ministry of Health, which argued that there was insufficient evidence to inform the development of this policy.

The sixth area of value-addition of the study is that it focuses on the temporal and transient existence of powerful political actors and their framing of issues, illustrated by the court judgement of 2002, which ushered in the accelerated development of the PMTCT policy and the removal from office of the then President and the Minister of Health in 2008, which ameliorated the pervasive AIDS denialism in South Africa. In this regard, the findings of the study further contribute to the South African literature that illuminates other important characteristics of the policy-making processes. For example, Gilson and McIntyre (2008) assert that the policy-making process in the country is driven by accidents of timing, chance, and personalities, while Balane et al. (2020) assert that “sources of power should also be treated as context dependent and time bound as the power of stakeholders may shift over time and may only be

applicable in certain contexts” (p. 10). The findings of this study provide evidence showing that powerful political actors and their framing of issues are transient and not permanent. Accidents of timing, chance, and personalities include the acquisition of evidence, knowledge, and confidence by Health MECs during the development of the PMTCT policy in 2002, which resulted in the development of alternative frames that enabled them to contest the dominant views from the powerful actors in the national sphere of government. Other ‘accidents’ included the recall of President Mbeki from office in 2008, prior to the end of his term of office, and the subsequent removal from office of Minister Tshabalala-Msimang from the Health Portfolio, which enabled the National Core Standards policy to prosper. These events enabled the new Minister Aaron Motsoaledi and Deputy Minister Sefularo to accelerate the pace of development of the National Core Standards policy.

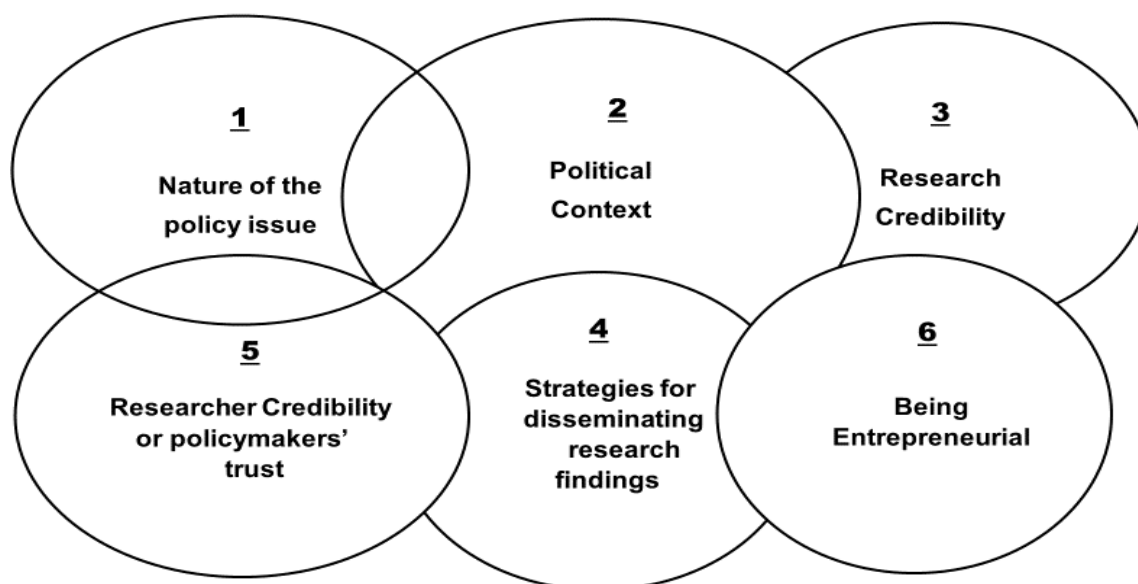
These findings are consistent with the South African policy analysis literature. For instance, Cloete (2009) asserts that “policy systems can be regarded as complex adaptive systems in society, because they are open systems with many variables subject to external environmental influences that interact in non-linear ways that defy full understanding. These systems tend to operate *on the edge of chaos* and they have inherent self-regulatory attributes ensuring their adaptation to changing circumstances, eventually ensuring their survival, even against huge odds” (p. 307). The results of this study expand this knowledge by illustrating, through the use of two policy process cases, a set of contextual influences that impact on health policy formulation in South Africa.

The foregoing exposition illustrates that in the South African health sector, linear mechanisms for pushing research evidence into the policy space will not be useful if they do not consider the six factors outlined above, and in **Figure 9.1** above.

9.2.2. The evidence-to-policy interface in South Africa

A second set of issues highlighted by this study focuses on the factors influencing the evidence-to-policy interface specifically. This present study corroborates the work of two health systems and policy research groups – the Centre for Health Policy (CHP) attached to the University of the Witwatersrand (Wits) and the Health Economics Unit (HEU) located at UCT (Doherty, Gilson & McIntyre, 2002; Rispel & Doherty, 2011) – undertaken in the first decade of democracy (Gilson & McIntyre, 2008). Six key factors play an important role in generating insights into how evidence can be brought to the attention of policy-makers, and how it can influence policy formulation processes. These are: the nature of the policy issue, the political context, research credibility, researcher credibility or policy-makers’ trust, strategies for disseminating research findings, and being entrepreneurial. These are reflected in **Figure 9.2** below.

Figure 9.2: Six factors that facilitate the evidence-to-policy interface in the South African context (Gilson & McIntyre, 2008) to which this study adds further empirical evidence



Source: Designed by the researcher based on the work of Gilson and McIntyre (2002) and Rispel and Doherty (2011), and reviewed by the thesis supervisor

First, there is the **nature of the policy issue**, as the influence of research differs between policy issues (Gilson & McIntyre, 2008). This study has illustrated this point by showing the differences between the PMTCT and National Core Standards policies, with the former being a bottom-up, high stakes, and high politics issue, and the latter being a top-down, low stakes, and low politics issues (Grindle & Thomas, 1989).

Second, the findings of this study add to the scholarly work of the CHP and the HEU which posits that **political context** always exerts an important influence over the research/policy interface, providing or constraining opportunities for engagement (Gilson & McIntyre, 2008). This study has demonstrated this factor by illustrating the hostile political environment in which the PMTCT policy emerged, compared to the relatively peaceful context in which the National Core Standards for Health Establishments was developed. This has been covered in the foregoing sections.

Third, this study dovetails with and supplements the scholarly work of Gilson and McIntyre (2008) about the importance of **research credibility** in the eyes of research users. The perceived validity, openness, and relevance of research to policy-makers may contribute to its acceptance and partial use. This study has shown that in the origin of the PMTCT policy in 2001, the government of the day attached credibility to the work of the AIDS dissidents, the disciples of Professor Duesberg. By contrast, the work of AIDS dissidents was not regarded as credible by the rest of the HIV/AIDS research community, globally and locally. The South African government disregarded

rational empirical evidence that emerged from Uganda, South Africa, and global research. However, by 2002, the latter evidence, including the results of the evaluation of 18 PMTCT pilot sites in South Africa by the Health Systems Trust (HST), swayed the policy position of several Health MECs and eventually convinced the Constitutional Court that it was credible and rational. In the case of the National Core Standards, the credibility of research evidence, although drawn largely from international sources, also enabled it to inform policy formulation.

It is important to point out that credibility is **not** only about scientific credibility, but also about acceptability of evidence to those who would use it for policy development. Credibility is also political and context specific. In the case of the evidence used for the development of the National Core Standards policy, Provincial DoHs were originally sceptical about the fact that the evidence applied by the National DoH in the development of the standards emanated from European countries. Provinces asserted that there were no two countries with identical health systems. In the final analysis, however, consensus was reached about the credibility of this evidence, which enabled the finalisation of the policy.

Fourth, this study also contributes to the existing literature that posits that **researcher credibility or policy-makers' trust** in the researchers involved in any study may contribute more towards encouraging the use of research findings than valid research activities or effective dissemination strategies. The current study found that the Schools of Public Health and Family Medicine as well as Departments of Obstetrics Gynaecology and Paediatrics at the Universities of Cape Town, KwaZulu-Natal, and Wits produced volumes of evidence on the efficacy of PMTCT (former senior bureaucrat, national sphere of the health system, 2020). These were eminent and globally respected institutions (key informant interview, Medical Research Council, 2017). While their evidence might **not** have convinced the National DoH in 2001, it earned the trust of the judiciary, which ruled in 2002 that the PMTCT programme must be rolled out nationally. The credibility of the researchers was affirmed not by policy-makers, but by the judiciary. This also implies that evidence must be disseminated widely and not just to formal policy elites.

Fifth, the current study also contributes to the existing literature that demonstrates that the strategies adopted in **disseminating research findings** are critical for influencing the potential of research to impact on policy issues (Gilson & McIntyre, 2008). In the case of the PMTCT policy, there was scepticism and lack of political support for the policy in 2001 and 2002. Furthermore, the AIDS dissidents also maintained close proximity to the incumbent Minister of Health and the President in 2001 and 2002, and were included in the Advisory Panel of Experts established by President Mbeki. This actually became an ideological battle rather than contestation about evidence. However, technical policy elites in the National DoH, supported by external HIV/AIDS experts, sustained the dissemination strategies. They revised their presentations and delivered them unflinchingly to the NHC and TECH-NHC. Local HIV conferences were also held in South Africa, such as the 2000 version, which was attended by President Mandela, wherein he called for an end to debates and the start of actual work. In the case of the National Core Standards, this role was performed by the Ministerial Advisory Committee established for this purpose, which included academics, researchers, NGOs, and technocrats, and which was described in detail in Chapter 7.

Sixth, this study dovetails with the literature that illustrates that a **researcher's credibility** is also rooted in how entrepreneurial she and her organisation are with respect both to specific projects and their broader programme (Gilson & McIntyre, 2008). In generating the evidence that ultimately led to the national roll-out of the PMTCT policy, as well as the National Core Standards, the researchers and the Ministerial Advisory Committee (MAC) who were proponents and protagonists of both policies, were entrepreneurial in their approach, as suggested by Gilson and McIntyre (2008). The MAC secured regular engagements with the Minister and particularly the Deputy Minister of Health in which they presented evidence to inform policy formulation, built a healthy relationship with the Ministry of Health, and convened colloquia on the National Core Standards. The findings of this study also accentuate that the AIDS dissidents were also entrepreneurial in peddling their evidence and influenced the policy positions adopted by both President Mbeki and Minister Tshabalala-Msimang in 2001 and 2002. However, they lost the PMTCT policy debates due to their flawed science, which was unsustainable in the long run. The MAC on the National Core Standards were handpicked by the Ministry in 2010, and, by virtue of this, enjoyed the support of the policy-makers.

9.2.3. Health policy formulation and contestation in quasi-federal systems

Yet another value-addition of this study is that it exposes the contestations about health policy in a democratic country with a quasi-federal governance system such as South Africa. Such contestations are inevitable, and can be beneficial for policy processes, in that they expose alternative perspectives on issues, and propel the policy development forward. These contestations will continue for as long as the governance system and political institutions in South Africa are structured so that a paradox exists between the powers allocated by the Constitution to the national and provincial spheres of government, and the powers allocated by the National Health Act, No. 61 of 2003. Constitutionally, health care is an area of concurrent competence between the national and provincial spheres of government. However, the National Health Act allocates to the national sphere of government the powers to develop legislation, policy, norms and standards, and monitoring of equity. These are the political institutions that exist in the country. One province that has taken its Constitutional powers very seriously is the Western Cape, which has openly and overtly challenged national policies when these were not suitable to the province. However, this study has found that even in provinces governed by the ruling ANC, there is disquiet and concern about the 'excessive' powers of the national sphere, and how these are exercised, with specific reference to policy development. However, these are silent concerns which are not overtly or openly expressed in the TECH-NHC and NHC.

Furthermore, given that, constitutionally, health is a concurrent function in South Africa, contestations must always be expected in health policy development. Despite the fact that the National Health Act, No. 61 of 2003, creates a cascade of powers and assigns the policy formulation function to the national sphere of the health sector and policy implementation to the provincial sphere, provinces still believe that the constitution assigns equal powers to both spheres. Furthermore, the Western Cape

province also has its own Provincial Constitution. Lessons from the development of the two tracer policies, the PMTCT policy and the National Core Standards for Health Establishments, are that in the absence of evidence, or in a context of lack of incontrovertible evidence, what happens is contestation. Contestation also happens around the range and acceptability of evidence required to craft sound policy. In the case of the PMTCT policy, questions were raised around the adequacy of the existing evidence that led to contestations. The Western Cape province used its constitutional leverage and commenced with the PMTCT programme in defiance of the national policy position. By contrast, in the case of the National Core Standards, contestations occurred for reasons beyond evidence, created by the unfunded mandates in particular. The provincial sphere of the health sector expressed concern that legally one sphere of government could not impose functions on another sphere without providing the necessary resources.

The findings of this study contribute, then, to the discourse about centralised versus decentralised policy-making processes. Linked to the governance issues outlined above, the study has found that the provincial sphere of government believes that the national sphere of government is responsible for policy-making, and therefore responsible for using evidence in policy development. This is despite the fact that all nine Provincial DoHs and the South African Local Government Association (SALGA) are part of the TECH-NHC and Policy Committee of the NHC, which consists of MECs of Health. These findings are not unique, but are consistent with the empirical work of Haq et al. (2017) in Pakistan, where they concluded that “an interesting finding from this study was that despite their role in policy, some participants perceived ‘others’ as policymakers and not themselves. They maintained the traditional top-down viewpoint according to which policy formulation is seen as a function of the Cabinet and ministers while its implementation is an administrative or managerial process, disconnected from formulation” (p. 1455). In the South African context, the findings of this study suggest that the provincial sphere of the health sector experiences the national sphere as dominant and domineering.

Contestations within the health sector are likely to continue into the foreseeable future. The government of South Africa has chosen National Health Insurance (NHI) as the pathway to the achievement of universal health coverage. Section 32(2) of the NHI Bill 2019, approved by the National Assembly in June 2023, states that:

- (2) Subject to the transitional provisions provided for in section 57, the Minister may introduce in Parliament proposed amendments to the National Health Act for the purpose of centralising the funding of health care services as required by this Act, and in such cases the Minister may—
 - (a) delegate to provinces as management agents, for the purposes of provision of health care services, and in those cases the Fund must contract with sections within the province such as provincial tertiary, regional and emergency medical services;
 - (b) designate provincial tertiary and regional hospitals or groups of hospitals as autonomous legal entities accountable to the Minister through regulation; and
 - (3) Without derogating from the Constitution or any other law, the functions of a Provincial Department must be amended to comply with the purpose and provisions of this Act, subject to the provisions of section 57.

It is highly unlikely that all nine Provincial Legislatures will accept the curtailing of their powers to provide health services to their residents as proposed in the NHI Bill 2019, without contestation.

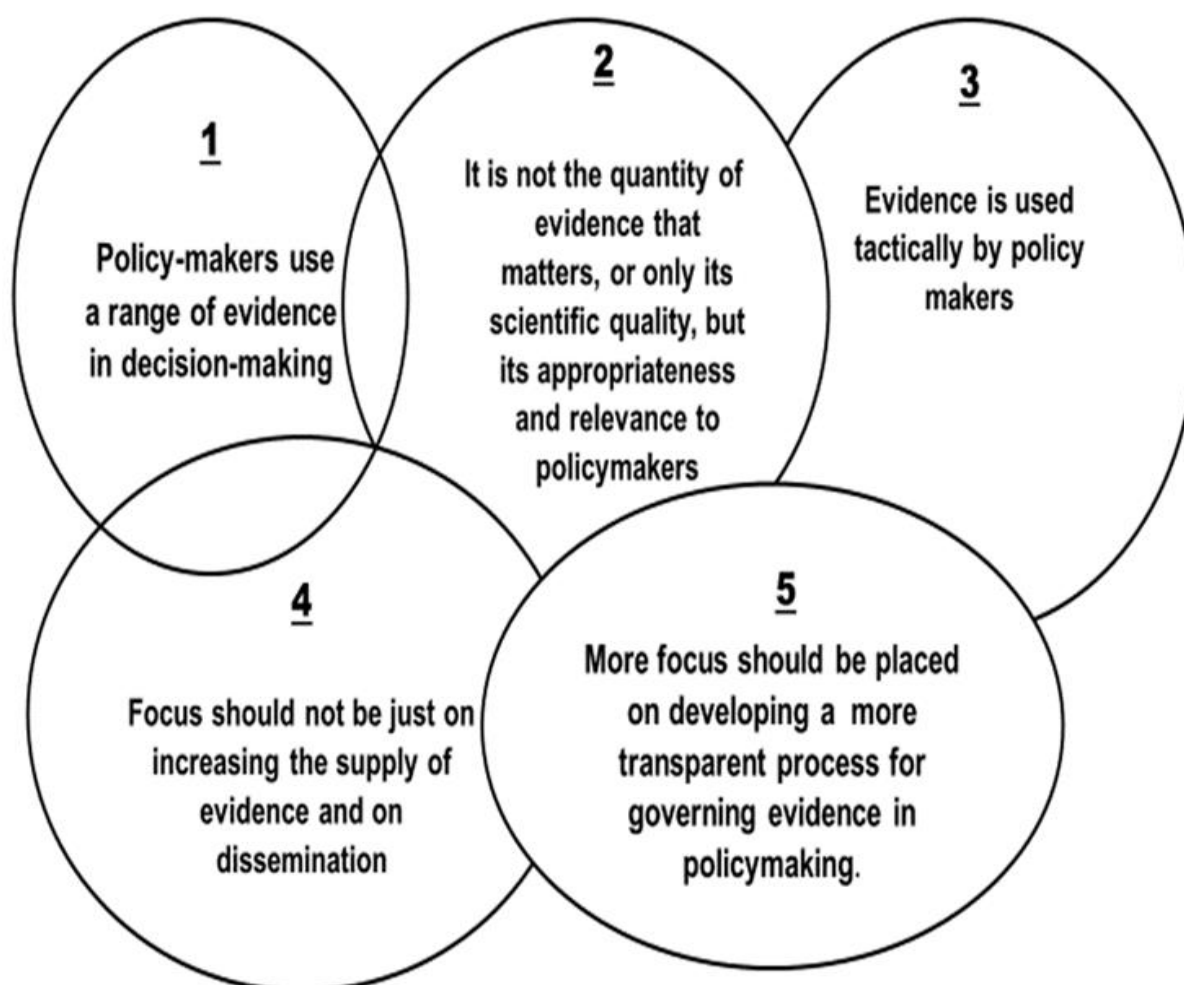
9.3. Specific contributions of this study to global literature from both Low- and Middle-Income Countries (LMICs) and High-Income Countries (HICs)

The findings of this study also contribute to both the conceptual and empirical global literature on policy analysis and the evidence-to-policy interface. In their systematic review of the use of evidence in LMICs and HICs, Votruba et al. (2018) assert that in the field of health, “evidence-based policy-making is generally seen as the gold standard, and both policy-makers and researchers widely claim to aim for evidence-based health policy-making. Nevertheless, the realisation of this goal is limited by their political and academic realities” (p. 2). Votruba et al. (2018) specifically assert that “overall, policy-making is subject to numerous influences from interest groups, issue networks, social elites or ‘state level bureaucrats’” (p. 3). This is consistent with the caveat issued by Walt and Gilson (1994) almost two decades ago, cautioning that policy analysis should not focus excessively on the content, to the neglect of processes contingent on developing and implementing the required change and the context within which policy is developed. This study demonstrates the political realities cited by Votruba et al. (2018), as well as the significance attached by Walt and Gilson (1994) to the political nature of policy-making, and the importance of both policy processes and policy context in determining policy outcomes. In the two policy process cases, this study has shown how successive Ministers of Health and the NHC exerted political influence on policy processes and outcomes.

Yet another contribution of this study to the international literature is the finding that the use of evidence is determined by powerful political actors, including in LMICs such as South Africa. This study has illustrated how powerful political actors in the health policy-making space influenced the selection and use of evidence in health policy formulation. From this perspective, this study adds to the work of authors such as Votruba et al. (2018), who assert that “evidence–policy interrelationships in LMIC settings differ from those in high income countries. Frequently, political contexts are troubled, policy-making processes are chaotic and obscure, research capacity is low, partnerships with policy are lacking, and donors and other policy elites, as well as an emerging civil society, are externally influencing the research-to-policy process” (p. 2-3). Onono et al. (2019) state that regardless of the setting where it takes place, “priority setting is often value-laden and political” (p. 2).

The specific value-addition of this study to the global literature consists of five key findings, namely: (a) policy-makers use a range of evidence in decision-making, (b) it is not the quantity of evidence that matters, or only its scientific quality, but its appropriateness and relevance to policy-makers, (c) evidence is used tactically by policy-makers, (d) focus should not be just on increasing the supply of evidence and on dissemination, and (e) focus should be on developing a more transparent process for governing evidence in policy-making. These issues are reflected succinctly in **Figure 9.3** and discussed in detail below.

Figure 9.3: Specific contributions of this study to global literature from both Low- and Middle-Income Countries (LMICs) and High-Income Countries (HICs)



Source: Designed by the researcher and reviewed by the thesis supervisor

The first contribution of this study to the global literature is that its findings emphasise that policy-makers use a **range of evidence**. Globally, policy-makers have been found to use the following data sources: local data, joint needs assessments, practice guidelines, public health surveillance data, qualitative research studies, health impact assessments, systematic reviews, and experimental or trial data (Burchett et al., 2015; Oliver, Lorenc & Innvaer, 2014; Oliver et al., 2015; Oliver & de Vocht, 2017). Similarly, in the South African context, during the formulation of both the PMTCT and National Core Standards policies, the sources of evidence used by policy-makers included published literature, research evidence, research synthesis, and global evidence (which feeds into the guidelines released by UN agencies). In this regard, the findings of the current study reflect yet another value-addition to the literature produced by scholars from LMICs and HICs. In South Africa, the key theme from this study, which dovetails with global literature, is that policy-makers do not use only published

literature, but also a range of other sources of data. These include data from routine information systems, survey data, expert evidence, and anecdotal evidence.

Secondly, the study has also found that the use of evidence in policy formulation processes is **not** necessarily determined by the **quantity of evidence**. The key barrier to the use of evidence in policy-making processes is **not** the limited availability of evidence. Scholars such as Cairney and Oliver (2017), having conducted systematic reviews of studies relevant to evidence-based policy-making in HICs, concluded that some evidence-based policy studies have erroneously identified a key barrier to evidence use as limited supply of evidence to policy-makers, and have subsequently developed strategies to improve dissemination. As Cairney and Oliver (2017) state, the incorrect solution developed is that “better dissemination will prompt policymakers to think, like scientists, that the scientific evidence alone is persuasive or self-evident” (p. 2). The findings of this study support this assertion by Cairney and Oliver (2017).

Third, as reflected in Chapter 8, both the policy process cases, the PMTCT and the National Core Standards policies, demonstrate that **evidence is used tactically** by powerful policy elites to achieve political goals. The findings of this study contribute to the existing literature in this area by illustrating that, in the case of the PMTCT policy, the tactical approach entailed framing existing evidence as limited or inadequate to avoid upsetting a sitting President who believed that there was no causal link between HIV and AIDS. In the case of the National Core Standards, the political leadership selectively used the evidence gathered by bureaucrats to actively address the challenge of poor quality of health care services.

The findings of this study are consistent with the conceptual work of Lavis, Ross, and Hurley (2002), who postulated three different uses of evidence, which are referred to as indirect use, direct use, and tactical use of research evidence. *Indirect use* of research (also known as conceptual use or enlightenment) refers to the changes in knowledge, awareness, or attitude, for instance, when research has informed political debate, or audiences have adopted the ideas, concepts or language of the research to inform decision-making and assist problem-solving (Lavis, Ross, & Hurley, 2002). *Direct use* of research (also known as instrumental, structural, or problem-solving use) refers to changes in behaviour, such as observed or self-reported changes in policies, procedures, and programmes (Lavis, Ross, & Hurley, 2002). Third, research evidence may be used symbolically to justify positions or actions that policy-makers have already adopted or to achieve specific goals (Lavis, Ross, & Hurley, 2002). When commissioning the HST to evaluate the 18 PMTCT sites in 2002, Minister Tshabalala-Msimang only wanted to illustrate her commitment to evidence-based policy-making by demanding more evidence, which she therefore never acted upon when it was presented to her. Similarly, when commissioning the 27 pilot sites for the National Core Standards in 2007, Minister Tshabalala-Msimang only wanted to justify or illustrate her commitment to the implementation of standards, and she was therefore not committed to implementing these on a full scale as they would have exposed weaknesses in the health system at the time.

Fourth, the foregoing summary of findings therefore suggest that the focus of researchers and scholars should not be on increasing the supply of evidence. Rather,

their efforts should be geared towards understanding the suitability (or relevance) of existing evidence to the needs and requirements of policy-makers.

This is linked to the fifth contribution of this study to the global literature, which emphasises that **more focus should be placed on developing a more transparent process for governing evidence in policy-making**. This includes understanding the imperative to provide policy-makers with relevant evidence, that is, evidence pertinent not only to policy processes, but also to their political objectives. From this perspective, the findings of the study are aligned with the work of Abeysinghe and Parkhurst (2013), who assert that it is imperative to examine evidence through the lens of ‘appropriateness’. Consistent with this view, Waddell et al. (2007) argue that “...researchers must balance academic rigour and policy relevance to make meaningful contributions to policy” (p. 181). Stated differently, unless it is relevant, it cannot be excellent.

The additional contribution of this study to the literature on PMTCT lies partly in some closer examination of the dynamics around evidence use and, more importantly, the comparison with another policy process case. In this study, a comparative analysis of PMTCT and the National Core Standards for Health Establishments Policy is presented – generating specific insights around evidence use in policy formulation. Previously the PMTCT case study has been primarily documented as an historical experience of power and contestation, without a primary focus on how evidence use was part of and influenced those dynamics. The use of various theoretical lenses in this thesis (eg Shiffman and Smith, 2007; Lavis et al, 2002; Parkhurst 2016; 2017; 2018 and 2020) also enriches this analysis and distinguishes it from other literature.

9.4. Recommendations for Policy and Practice

The study has found that senior technical policy elites who were key informants argued that the use of evidence must be mandatory throughout government and that National Treasury must implement this policy for all budget bids from Departments (i.e. requests by government departments for funding from the national fiscus). This is one of the pragmatic ways in which the use of evidence in policy-making can be institutionalised in the routine policy-making avenues in the South African health sector.

Another recommendation for policy and practice emerging from this study is that the key informants in this study asserted that because public sector officials were accustomed to completing templates, the formats for Cabinet memoranda and budget bids to Treasury must include the provision of incontrovertible evidence on the subject matter. This finding is consistent with the assertion by Haq et al. (2017) that “health advocates need to understand the policy process and the actors involved if they are to identify points of impact where their interaction with policy brings the maximum leverage” (p. 1449). In this study, key informants identified National Treasury and National Cabinet as some of the essential critical points of impact for enhancing the use of evidence in health policy development, even if it is by compulsion, at least at the technical (bureaucratic) level. In the same vein, Parkhurst et al. (2020) assert that

“it would be naïve to assume that government officials are principally motivated to improve or maximise their use of scientific evidence. Rather, officials can be seen to use evidence in ways that help them achieve their organisational goals” (p. 17). In future support for a more efficient evidence-to-policy pathway, key informants from the HPSR community asserted that the public sector must improve and strengthen its communication with research organisations and academic institutions about policy-related research questions, so that researchers can assist the public sector in addressing these questions.

To achieve these noble goals articulated by both policy-makers and researchers as producers of evidence, the current processes through which evidence is conveyed to policy-makers need to be improved. As indicated in Chapter 8, all the steps that Liverani, Chheng and Parkhurst (2018) propose are in place and largely followed in South Africa, and are implemented through the National Health Research Committee (NHRC) and the National Health Research Ethics Committee (NHREC). However, as also indicated in Chapter 8, the working of the NHRC focuses only on the identification of research priorities, but does not extend further to define a mechanism or process by which research findings will find expression in policy processes. The National Health Research Strategy: Research Priorities for South Africa 2021-2024 presents a catalogue of research priorities or areas in which research must be undertaken. However, it stops here and falls short of defining how studies undertaken in the various areas will influence policy processes. Oliver and Pearce (2017) accentuate the need to establish clear and transparent processes and structures through which research will inform decision-making. This study emphasises that it is essential that the NHRC and NHREC advance their work further and develop a comprehensive framework with levers through which evidence, in all its forms (not only research evidence), will inform health policy-making in South Africa. This must be done in a transparent and consultative manner, inclusive of both policy-makers, the research community and the public at large. Policy briefs provided by the NHRC and the NHREC must be accessible to the public.

Secondly, government always publishes its proposed policies in Government Gazettes, for public comment, and always extends the period allowed for the submission of comments, where necessary. However, the evidence base that ultimately informs these policies is not reflected in them. The process through which massive volumes of evidence are sifted and assessed is also not outlined. So, the specific process of evidence selection is not made public. A transparent and inclusive process of evidence selection and evidence use in policy formulation processes is required. It must involve a multidisciplinary team of researchers, rather than just the NHRC and NHREC working in isolation to produce recommendations to the Ministry of Health. The evidence base that informs the recommendations should also be made available to the rest of the research community. The NHRC and NHREC should also issue media statements after each of their meetings and meetings with the Ministry of Health, to inform the public of deliberations behind the scenes. This proposal can be expanded further to suggest that together with the various Government Gazettes published to announce the arrival of different policies, there must be annexures that reflect the evidence base that informed policy-development. However, this requires a significant paradigm shift due to the fact that evidence is used to achieve political goals. This was demonstrated by the PMTCT and National Core Standards policies.

9.5. Limitations of the study and recommendations for future research

The first limitation of this study was that as an insider-researcher, I could have brought into the analysis my own biases about the development of the two tracer policies, especially having worked in the public health sector previously. As stated in the methodology chapter, Thomas, Chataway and Wuyts (1998) assert that case study work can be criticised for “simply finding evidence to fit with your preconceived ideas”. In this study, I used two main approaches to minimise my personal bias. The first was the triangulation of my perspectives with other data sources, including anchor interviews with key senior technical policy elites who were had ample knowledge of the public health sector, as well as the two policy process cases, the PMTCT and National Core Standards policies. This is explained in detail in the methodology chapter. The second and most important approach was the continuous conversation with my thesis supervisor, who read my interview transcripts, tested my analytic judgements, and provided me with invaluable feedback, which was incorporated into the study. To ensure rigour in data collection and analysis in this study, and to overcome the limitations outlined above, I jointly reviewed, together with my thesis supervisor, the interview transcripts for quality assurance and to eliminate bias in the line of questioning. As described in detail in Chapter 3, I also used the methods outlined by Gilson (2012) in the Methodology Reader of the Alliance for Health Policy and Systems Research to achieve rigour in this study. These included: (a) triangulation, (b) negative case analysis, (c) peer debriefing and support, (d) respondent validation (member checking), and (e) clear report of methods of data collection and analysis (audit trail). A few approaches were of particular value in this study. One of these is peer debriefing and support, which Gilson (2012) describes as a “review of findings and reports by other researchers” or “members of the research team” (p. 57). Because I was the sole researcher in this study, as already noted, my thesis supervisor effectively played the role of debriefing and support. This was done through reviewing my preliminary case study reports and providing me with constant feedback and support. This was a major contribution towards sustaining rigour in this study.

In the light of these potential limitations, future studies of a similar nature should be undertaken, to further investigate the use of evidence in health policy development processes in South Africa. These should be undertaken collaboratively by the HPSR community and government officials, to ensure co-production of additional knowledge. Results from such studies will strengthen the evidence-to-policy interface in the South African health sector, in a transparent manner.

9.6. Personal reflections on the PhD

This study took place over a seven-year project that commenced after the UCT Ethics Committee approved the first research protocol on 3 November 2016.

The original inspiration for this study, which has now been satisfied, occurred when I worked as the Chief Director for Strategic Planning in the National DoH, and I learnt about the work of the Oswaldo Cruz Foundation, a scientific institution for research

and development in Brazil, and how researchers at this institution were producing evidence that informed health policy formulation in Brazil. My presence at the Oswaldo Cruz Foundation was as part of the Ministerial Study Visit to Brazil in May 2010, which was led by former Minister of Health, Dr. Aaron Motsoaledi. This study visit also involved Health MECs from eight provinces in South Africa, with the exception of the Western Cape. The objective of the visit was to learn about progress towards Universal Health Coverage in four Latin American Countries, namely Brazil, Colombia, Mexico, and Chile. While in Brazil, I wondered if the same collaboration between researchers and policy-makers could be achieved in South Africa. As indicated in previous sections, the study has enlightened me about the factors that have to be taken into serious cognizance if South Africa is to institutionalise a coherent evidence-to-policy interface, which is not oblivious of key political factors that are attendant to such processes.

Another motivation for this study arose from the proceedings of the National Health Research Summit convened by the National DoH and the National Health Research Committee in 2011, in which over 300 researchers participated. I was at the time the Chief Director for Health Information Management, Monitoring, Evaluation and Research (HIMMER) in the National DoH. As reflected in Chapter 1, the research community expressed concern about the “absence of an organised pathway to translate new evidence into policy, programmes, and practice” (Abdool Karim, 2011, in Mayosi et al., 2011, p. 3). Compared to the lessons learnt during the Brazil study tour, the concern from the researchers stuck with me. Through this study, I therefore sought to contribute to a broader understanding of how and why evidence is used in health policy formulation in our country.

What also inspired me to undertake the PhD journey was my perception that South Africa has experienced a steady increase in research institutions that focus on Knowledge Translation, which is a field of study that endeavours to shed light on how research-based knowledge can inform health policy formulation (Edwards, Zweigenthal & Olivier, 2019). Stellenbosch University houses the Centre for Evidence-based Healthcare, while UCT’s Lung Institute has the Knowledge Translation Unit. The South African Medical Research Council (MRC) has also stabilised its Cochrane African Network (Edwards, Zweigenthal & Olivier, 2019). This network was established in 2007 as one of the intramural units of the MRC to “promote evidence-informed healthcare decision making by producing high-quality, relevant, accessible Cochrane reviews and other synthesised research evidence” (MRC, n.d.).

I also took notice of the existence of the Africa Centre for Evidence at the University of Johannesburg (Tannous, 2019). According to Tannous (2019), the centre now incorporates a network of over 3,000 researchers interested in the generation and use of evidence for poverty reduction in Africa (Tannous, 2019). Notwithstanding this steady increase I discerned, there was also a personal observation that there was a limited number of studies written by South African authors on how and why evidence is used in health policy development. I was also inspired by Orgill et al. (2013), who asserted that further work was required to entrench the knowledge-translation field in the country. I regarded it as my duty and service to my country to generate more insights into the evidence-to-policy interface, particularly with all the insider-knowledge that I possess having served the government for 18 consecutive years.

This study therefore sought to contribute to the existing body of knowledge on how research and other forms of evidence are used for policy development in the South African public health sector, and why certain types of evidence are used – from the perspectives of both researchers and policy-makers, but with particular concern for policy-makers. By conducting key informant interviews with both policy-makers and health policy and systems researchers, and independently analysing their perspectives, this study sought to contribute to the existing body of knowledge.

This study is, moreover, an insider-led study or “work-based research”, which Costley, Elliot and Gibbs (2010) define as a study conducted within the researchers’ own work practice. Chapter 4 of the study outlines in more detail the benefits of insider-led research. Critically, my insider-researcher position enabled great access to key informants, particularly senior bureaucrats, the highest-ranking administrators in the public sector, given the rapport that existed between myself and these key informants. This rapport was itself based on the nine years I worked in the health sector, during which period I attended both the TECH-NHC and the fully-fledged NHC, and my continued engagement with them over the almost 10-year period that I have worked in the DPME in the Presidency (2013-2023). I also had easy access to the senior HPSR researchers interviewed in the study, because I have worked with almost all of them in different capacities, including my membership of committees established by Schools of Public Health at different South African universities. Despite my heavy work schedule in the DPME and Presidency, I have always honoured invitations to speak at seminars or conferences organised by these academic institutions, thereby building good relations and strong partnerships with them. I was therefore well placed to conduct this type of insider research.

In addition to gaining access to the key informants mentioned above, this study adds to the existing body of knowledge about the evidence-to-policy interface by virtue of the frankness and honesty with which key informants, especially the senior management of the public service, articulated their views. The dominant culture in government is to be secretive and protective of information. However, these senior bureaucrats were very comfortable with me as a researcher and as their government colleague, and freely expressed their views. I was pleasantly surprised by the openness of these key informants across several interviews. For example, some of the honest views expressed by the senior bureaucrats from the provincial sphere of the health sector in this study, about the leadership practices of the national leadership of the health sector, were issues that they had not raised before in the TECH-NHC and NHC itself. A case in point was that some key informants from the provincial sphere raised concerns about the non-use or insufficient use of evidence in the development of national policy. A related concern was that the national sphere was dominant and domineering, and imposed policies on Provincial DoHs without providing the resources for policy implementation, and these became unfunded mandates. This study unearthed the real positions of the key informants about the health policy development processes in South Africa, which were more explicit than the socially acceptable views they normally express in the TECH-NHC and NHC.

Yet another value-addition of this study was that it was able to trace and interview former senior bureaucrats of the health sector, who were no longer in their positions but who possessed institutional memory. These former technical policy elites were

able to provide insights into policy-making processes in the health sector, as well as the motives of the powerful political actors at the time and the dynamics at play in policy-making, including the use or non-use of available evidence. These insights had not been published in formal literature because they were sensitive at the time. The former senior bureaucrats also revealed their positions on policy issues, particularly about the development of the two policy process cases, the PMTCT and National Core Standards for Health Establishments policies. My data collection for a PhD thesis in 2017-2023 was less threatening to them than the policy processes of 2002 and 2011.

Finally, the PhD journey has had its own frustrations, arising mainly from the challenge of doing a PhD degree on a part-time basis, while juggling other important work from the highest office in the country, The Presidency, and from the DPME. Watching my fellow students at UCT and UWC complete their PhD theses, having started at the same time as me, had two opposite effects on me. First, it inspired me to work harder, with a belief that a PhD degree can be attained. I was happy for my colleagues and for their achievements. However, their success within reasonable time frames also lowered my self-confidence, which in turn also sank my conceptual abilities. However, each time I slipped into this melancholy, my PhD supervisor was able to lift me up with motivation and inspiration, and I continued with this PhD project.

9.7. Conclusions

This study sought to understand why and how different forms of evidence are used in health policy-making in South Africa. The conceptual work of Parkhurst has been very useful in shaping my thinking about the factors that influenced the use (and non-use) of evidence in both policy cases. Indeed, evidence was only one of the many factors considered during these processes – and politics also matters.

Powerful actors dictate if and how evidence will be used for health policy-making in South Africa. In fact, Parkhurst argues that the assertion that political leaders should **not** be involved in influencing the evidence-to-policy interface actually aims to depoliticise the inherently political process known as ‘policy-making’. This perspective is consistent with the views of Weiss (1979), who would have placed only one condition on this debate, which was that for as long as the evidence is **not** distorted, tactical use of research findings by politicians is legitimate. Yet this study has also found that good quality and comprehensive evidence does present a strong case for itself, and can have influence, as was the case with the PMTCT policy in 2002.

The research community also needs to produce policy-relevant evidence, which effectively informs health policy-making processes in the country. It should be aware of the range of sources of evidence used by policy-makers, including routine health information systems, expert committees, and, as shown in this study, the famous ‘lamppost’. On the other hand, policy-makers should also be alert to and receptive of ground-breaking evidence of different types, as defined broadly in this study, which shift the frontiers of current knowledge when it is produced and presented to them. The generation of evidence should not only serve to justify already existing policy positions, but should, in keeping with Weiss’ (1979) enlightenment model, also be

granted an opportunity to fundamentally change existing positions, where this is required.

An encouraging finding from this study was that the degree of mistrust between policy-makers and the research community in South Africa is dissipating. This is buttressed by the fact that Expert Committees (i.e. Ministerial Advisory Committees on different health priority areas) are reported by policy committees as being a “trusted” source of evidence for policies developed by the health sector. In addition, both researchers and policy-makers indicated that they were moving much closer to one another. South African policy-makers, researchers, and other producers of evidence will ultimately find an agreed process of strengthening the use of evidence in policy processes.

Ultimately, Fafard and Hoffman (2018) assert that, “simply put, policymaking is an inherently political process that cannot be reduced to maximising the take-up of relevant research evidence” (p. 9). Concurring with Parkhurst (2016), these authors also contend that, “ultimately, what is required is the ‘good governance of evidence that might well include a system of public and transparent evidence synthesis, and systematic efforts to ensure that the relevant evidence is available to all members of the policy network but especially to decision-makers” (p. 8).

As reflected in Chapter 8, the study has generated initial ideas about ensuring greater transparency in how evidence is used in policy-making processes in the South African health system – even while recognising that policy development is inherently a political process. A summary of the evidence base that informs the development of each national health policy should be published when each policy is published in the national government gazette, together with the SEIAS Report, and when such policy is released for public comment.

Finally, I fully agree with Parkhurst (2017), who asserts that the process of policy-making must **not** be depoliticised; indeed it cannot be. Nonetheless, recognising that it can never be an entirely scientific process based on evidence, it is important that there is increased transparency in policy-making in order to improve the governance of evidence and enhance its use for health policy formulation.

REFERENCES

- Abeyasinghe, S. and Parkhurst, J. (2013). 'Good' evidence for improved policy making: from hierarchies to appropriateness, Working Paper # 2, *Getting Research into Health Policy and Practice*, London School of Hygiene and Tropical Medicine. Available from: <http://researchonline.lshtm.ac.uk/3220946/> [accessed 08 October 2015].
- African National Congress (ANC). (1994). *The Reconstruction and Development Programme (RDP)*, 1 March 1994. Available from: <https://www.anc1912.org.za/policy-documents-1994-the-reconstruction-and-development-programme-implementing-the-rdp/> [accessed 16 October 2020].
- African National Congress (ANC). (1999). National Elections Manifesto. ANC, 1 May 1999. Available from: <https://www.anc1912.org.za/anc-manifesto-1999>
- African National Congress (ANC). (2012). The ANC's 1994 election manifesto. *Politicsweb*, 19 February 2012. Available from: <https://www.politicsweb.co.za/documents/the-ancs-1994-election-manifesto>
- African National Congress (ANC). (n.d. a). *Deployment to Committees* [online]. Available from: <https://anc1912.org.za/deployment-committees> [accessed 20 March 2023]
- African National Congress (ANC). (n.d. b). *NEC: Powers of the NEC* [online]. Available from: <https://www.anc1912.org.za/nec/> [accessed 20 March 2023]
- Alliance for Health Policy and Systems Research (Alliance HPSR). (2007). *Briefing Note 1, June 2007*. WHO. Available from: www.who.int/entity/alliance-hpsr/resources/AllBriefNote1_5.pdf [accessed 08 October 2017]
- Almeida, C. and Bascolo, E. (2006). Use of research results in policy decision-making, formulation, and implementation: A review of the literature. *Cad. Saúde Pública, Rio de Janeiro*, 22(Sup:S7-S33).
- Baker, P., Friel, S., Kay, A., Baum, F., Strazdins, L. and Mackean, T. (2018). What Enables and Constrains the Inclusion of the Social Determinants of Health Inequities in Government Policy Agendas? A Narrative Review. *International Journal of Health Policy and Management*, 7(2), 101–111. doi: 10.15171/ijhpm.2017.130
- Balane, M.A., Palafox, B., Palileo-Villanueva, L.M., McKee, M. and Balabanova, D. (2020). Enhancing the use of stakeholder analysis for policy implementation research: Towards a novel framing and operationalised measures. *BMJ Global Health* 2020(5), Article e002661. doi: 10.1136/bmjgh-2020-002661

Barron, P., Pillay, Y., Doherty, T., Sherman, G., Jackson, D., Bhardwaj, S., Robinson, P. and Goga, A. (2013). Eliminating mother-to-child HIV transmission in South Africa. *Bulletin of the World Health Organization*, 2013(91), 70-74. doi:10.2471/BLT.12.106807

Basdeo, M. (2012). The Impact and Dilemma of Unfunded Mandates Confronting Local Government South Africa: A Comparative Analysis. *Africa's Public Service Delivery & Performance Review*, 1(2), Article 30. <https://doi.org/10.4102/apspdpr.v1i2.30>

Bateman, C. (2005). HIV/AIDS Pandemic – A Legacy of Conquest and Mistrust. *South African Medical Journal*, 95(7), Izindaba: Aids Conference Special. Available from: <http://www.samj.org.za/index.php/samj/article/view/1744/1069>

Bennett, S., Agyepong, I.A., Sheikh, K., Hanson, K., Ssengooba, F. and Gilson, L. (2011). Building the Field of Health Policy and Systems Research: An Agenda for Action. *PLoS Med* 8(8), e1001081. doi:10.1371/journal.pmed.1001081

Berlan, D., Buse, K., Shiffman, J. and Tanaka, S. (2014). The bit in the middle: A synthesis of global health literature on policy formulation and adoption. *Health Policy and Planning*, 29(3), iii23–iii34. <https://doi.org/10.1093/heapol/czu060>

Beresford, D. (2010). Manto Tshabalala-Msimang obituary: South African minister of health notorious for her stance on Aids. *The Guardian* [online], 7 January 2010. <https://www.theguardian.com/world/2010/jan/07/manto-tshabalala-msimang-obituary>

Bertscher, A., London, L. and Orgill, M. (2018). Unpacking policy formulation and industry influence: The case of the draft control of marketing of alcoholic beverages bill in South Africa. *Health Policy and Planning*, 33(7), 786–800, doi: 10.1093/heapol/czy049

Blecher, M. and Gordon, R. (2018). Funding flows for health research. In: DoH, *2018 National Health Research Summit Report* [online]. Available from: https://www.health.gov.za/wp-content/uploads/2020/11/national-health-research-summit-report_compressed.pdf

Bowen, S. and Zwi, A.B. (2005). Pathways to “Evidence-Informed” Policy and Practice: A Framework for Action, *PLoS Medicine*, 2(7), e166. <https://doi.org/10.1371/journal.pmed.0020166>

Burchett, H.E.D., Mayhew, S., Lavis, J.N. and Dobrow, M.J. (2015). The usefulness of different types of health research: Perspectives from a low-income country. *Evidence & Policy*, 11(1), 19-33. <http://doi.org/10.1332/174426514X13990430410723>

Burris, H., Parkhurst, J., Adu-Sarkodie, Y. and Mayaud, P. (2011). Getting research into policy - Herpes simplex virus type-2 (HSV-2) treatment and HIV infection:

international guidelines formulation and the case of Ghana. *Health Research Policy and Systems*, 9(1), Article S5. doi:10.1186/1478-4505-9-S1-S5

Buse, K., Dickinson, C., Gilson, L. and Murray, S.F. (2007). *How can the analysis of power and process in policy-making improve health outcomes?* Briefing Paper 25. Overseas Development Institute [accessed 14 March 2017].

Buse, K., Mays, M. and Walt, G. (2012). *Making Health Policy: Understanding Public Health*. 2nd ed. Berkshire, England: Open University Press, McGraw-Hill Education. Available from: <https://mhebooklibrary.com/doi/book/10.1036/9780335246359> [accessed 14 March 2017].

Butler, A. (2005). South Africa's HIV/AIDS policy, 1994–2004: How can it be explained? *African Affairs*, 104(417), 591-614. <https://doi.org/10.1093/afraf/adi036>.

Cairney, P. and Oliver, K. (2017). Evidence-based policymaking is not like evidence-based medicine, so how far should you go to bridge the divide between evidence and policy? *Health Research Policy and Systems*, 15, Article 35. <https://doi.org/10.1186/s12961-017-0192-x>

Cairney, P. and Oliver, K. (2018). How Should Academics Engage in Policymaking to Achieve Impact? *Political Studies Review*, 18(2), 228–244. <https://doi.org/10.1177/1478929918807714>

Cloete, F. (2009). Evidence-based policy analysis in South Africa: Critical assessment of the emerging government-wide monitoring and evaluation system. *Journal of Public Administration*, 44(2). <https://hdl.handle.net/10520/EJC51711> [accessed 14 March 2017].

Collins Dictionary. (n.d. a). *Definition of 'people power'*. Available from: <https://www.collinsdictionary.com/dictionary/english/people-power>

Collins Dictionary. (n.d. b). *Definition of 'tactic'*. Available from: <https://www.collinsdictionary.com/dictionary/english/tactic>

Costley, C., Elliot, G. and Gibbs, P. (2010). *Doing Work Based Research: Approaches to Enquiry for Insider Researchers*. London: SAGE. <https://doi.org/10.4135/9781446287880>

Davies, P. (2008). *Making Policy Evidence-Based: The UK Experience*. World Bank Middle East and North Africa Region, Regional Impact Evaluation Workshop, Cairo, Egypt, 13-17 January 2008. Washington, DC and Oxford England: American Institutes for Research. Available from: <http://pubdocs.worldbank.org/en/775081526315037998/English-EvidenceBasedPolicy-Davies-Cairo.pdf>

Department of Health (DoH). (1997). White Paper for the Transformation of the Health System in South Africa. Government Printers. http://www.doh.gov.za/docs/policy/white_paper/healthsys9701.html [accessed 10 November 2017].

Department of Health (DoH). (2008). *Annual Report for 2007/08*. Pretoria: DoH.

Department of Health (DoH). (2009). *Annual Report for 2008/09*. Pretoria: DoH.

Department of Health (DoH). (2010a). *Annual Report for 2009/10*. Pretoria: DoH.

Department of Health (DoH). (2010b). *National Department of Health Strategic Plan 2010/11-2012/13*. DoH.

Department of Health (DoH). (2010c). *Report on the Ministerial Traveling Seminar to Brazil, 26 May to 03 June 2010*. 21 June 2010

Department of Health (DoH). (2011). *“Towards Quality Care for Patients”: National Core Standards for Health Establishments in South Africa*. Tshwane: DoH.

Department of Health (DoH). (2015). Procedural Regulations Pertaining to the functioning of the Office of Health Standards Compliance and Its Board. *Government Gazette*, No. 38486, 18 February 2015 [accessed 20 May 2018].

Department of Health (DoH). (2018). *2018 National Health Research Summit Report*. Available from: https://www.health.gov.za/wp-content/uploads/2020/11/national-health-research-summit-report_compressed.pdf

Department of Health (DoH). (2019). *Annual Report for 2018/19*. Pretoria: DoH.

Department of Health (DoH). (2021). *National Health Research Strategy: Research Priorities for South Africa 2021-2024*. Available from: <https://www.health.gov.za/wp-content/uploads/2021/04/national-health-research-strategy-2021-2024.pdf>

Department of Justice and Constitutional Development (DoJ). (2022). Courts in South Africa. DoJ, amended 8 August 2022. Available from: <https://www.justice.gov.za/about/sa-courts.html> [accessed 20 October 2020]

Department of Planning, Monitoring and Evaluation (DPME). (2021). *Evidence management for an effective and efficient Socio-economic Impact Assessment System (SEIAS): An organizational guide on using evidence when implementing SEIAS*. Pretoria, South Africa: DPME.

Doherty, J., Gilson, L., and McIntyre, D. (2002). Getting Research into Practice: The Experience of the ‘SAZA’ Project: An opinion piece. *Establishing and Reinforcing Links between EC-financed Health Systems Research and Technical Assistance/Development Projects 24–26 June*, Department of Tropical Hygiene and

Public Health, University of Heidelberg, Germany.
www.healthpolicysa.files.wordpress.com/2011/02/heidelberg-document.doc
[accessed 06 May 2014]

Donald, A. (2002). Evidence-Based Medicine: Key Concepts. *MedGenMed*, 4(2) [formerly published in *Medscape Psychiatry & Mental Health eJournal*, 7(2), 2002].
<http://www.medscape.com/viewarticle/430709> [accessed 23 October 2014].

D'Souza, B. and Parkhurst, J.O. (2018). When "Good Evidence" Is Not Enough: A Case of Global Malaria Policy Development. *Global Challenges*, 2(9), 1700077.
<https://doi.org/10.1002/qch2.201700077>

Duesberg, P.H. (1991). AIDS epidemiology: Inconsistencies with human immunodeficiency virus and with infectious disease. *Proceedings of the National Academy of Sciences of the United States of America*, 88(4), 1575-1579.
<https://doi.org/10.1073/pnas.88.4.1575>

Edwards, A., Zweigenthal, V. and Olivier, J. (2019). Evidence map of knowledge translation strategies, outcomes, facilitators and barriers in African health systems. *Health Research Policy and Systems*, 17(16). <https://doi.org/10.1186/s12961-019-0419-0>

Ettelt, S., Hawkins, B. and Parkhurst, J. (2018). Preface. In: Parkhurst, J., Ettelt, S. and Hawkins, B., eds. *Evidence Use in Policy Making: An International Public Policy Perspective*. Springer Nature.

Fafard, P. and Hoffman, S. J. (2018). Rethinking knowledge translation for public health policy. *Evidence & Policy*, 16(1), 165-175.
<https://doi.org/10.1332/174426418X15212871808802>

Fiocruz. (n.d.). *The foundation*. Fiocruz: The Oswaldo Cruz Foundation. Available from: <https://portal.fiocruz.br/en/foundation> [accessed 20 June 2019]

Government Communication and Information Services (GCIS). (2002a). Statement on Cabinet meeting of 17 April 2002. *GCIS*, 17 April 2002. Available from: <https://www.gcis.gov.za/content/newsroom/media-releases/cabinet-statements/statement-cabinet-meeting-17-april-2002-1>

Government Communication and Information Services (GCIS). (2002b). Statement on Cabinet meeting of 09 October 2002. *GCIS*, 9 October 2002.
<https://www.gcis.gov.za/content/newsroom/media-releases/cabinet-statements/statement-cabinet-meeting-9-october-2002-1>

Gilson, L., Doherty, J., Lake, S., McIntyre, D., Mwikisa, C. and Thomas, S. (2003). The SAZA study: implementing health financing reform in South Africa and Zambia. *Health Policy and Planning*, 18(1), 31-46. doi:10.1093/heapol/18.1.31

Gilson, L. and McIntyre, D. (2008). The interface between research and policy: Experience from South Africa. *Social Science & Medicine*, 67(5), 748-759. <https://doi.org/10.1016/j.socscimed.2008.02.005>

Gilson, L. (ed). (2012). *Health Policy and Systems Research: A Methodology Reader*. Alliance for Health Policy and Systems Research, World Health Organisation. <https://apps.who.int/iris/handle/10665/44803>

Gilson, L., Erasmus, E., Borghi, J., Macha, J., Kamuzora, P. and Mtei, G. (2012). Using stakeholder analysis to support moves towards universal coverage: Lessons from the SHIELD project. *Health Policy and Planning*, 27(1), i64–i76. <https://doi.org/10.1093/heapol/czs007>

Goga A.E., Dinh T.H. and Jackson D.J. for the SAPMTCTE study group. (2012). *Evaluation of the Effectiveness of the National Prevention of Mother-to-Child Transmission (PMTCT) Programme Measured at Six Weeks Postpartum in South Africa, 2010*. South African Medical Research Council, National Department of Health of South Africa and PEPFAR/US Centers for Disease Control and Prevention.

Goga A.E., Dinh T.H. and Jackson D.J. for the SAPMTCTE study group. (2013). *Early (4-8 weeks post-delivery) Population-level Effectiveness of WHO PMTCT Option A, South Africa, 2011*. South African Medical Research Council, National Department of Health of South Africa and PEPFAR/US Centers for Disease Control and Prevention.

Green, J. and Thorogood, N. (2004). *Qualitative Methods for Health Research*. London: SAGE.

Green, J. and Thorogood, N. (2004). *Qualitative Methods for Health Research*. Fourth ed. London: SAGE.

Greenhalgh, T., Thorne, S. and Malterud, K. (2018). Time to challenge the spurious hierarchy of systematic over narrative reviews? *European Journal of Clinical investigation*, 48(6), e12931. <https://doi.org/10.1111/eci.12931>.

Grindle, S. and Thomas, J.W. (1989). Policy Makers, Policy Choices, and Policy Outcomes: The Political Economy of Reform in Developing Countries. *Policy Sciences*, 22(3/4), 213–248. <http://www.jstor.org/stable/4532171>.

Guay, L.A., Musoke, P., Fleming, T., [Bagenda](#), D., Allen, M., Nakabiito, C., Sherman, J., Bakaki, P., Ducar, C., Deseyve, M., Emel, L., Mirochnick, M., Fowler, M.G., Mofenson, L., Miotti, P., Dransfield, K., Bray, D., Mmiro, F. and Jackson, J.B. (1999). Intrapartum and Neonatal Single-Dose Nevirapine Compared With Zidovudine For Prevention Of Mother-To-Child Transmission Of HIV-1 In Kampala, Uganda: HIVNET 012 Randomised Trial. *The Lancet*, 354. Available from: <https://nru.uncst.go.ug/xmlui/bitstream/handle/123456789/1654/Intrapartum%20And%20Neonatal%20Single->

[Dose%20Nevirapine%20Compared%20With.pdf?sequence=1](#) [accessed 10 July 2017]

Haq, Z., Hafeez, A., Zafar, S. and Ghaffar, A. (2017). Dynamics of evidence-informed health policymaking in Pakistan. *Health Policy and Planning*, 32(10), 1449–1456. <https://doi.org/10.1093/heapol/czx128>

Hawkins, B. and Parkhurst, J. (2016). The ‘good governance’ of evidence in health policy. *Evidence & Policy*, 12(4), 575-592. <https://doi.org/10.1332/174426415X14430058455412>

Hoffrage, U. and Reimer, T. (2004). Models of Bounded Rationality: The Approach of Fast and Frugal Heuristics. *Management Revue*, 15(4), 437-459. doi: 10.5771/0935-9915-2004-4-437

Ile, C.O (2021). The State of Health Workforce Planning in South Africa: A Health Policy Analysis. *African Journal of Public Affairs*, 12(3). Available from: https://hdl.handle.net/10520/ejc-ajpa_v12_n3_a2 [accessed 10 November 2022]

Innvaer, S., Vist, G., Trommald, M. and Oxman, A. (2002). Health policy-makers' perceptions of their use of evidence: A systematic review. *Journal of Health Services Research & Policy*, 7(4), 239-44. doi: 10.1258/135581902320432778

Kaiser Family Foundation. (2010). *Political Leadership in Health Roundtable Meeting on National Health Insurance: The Foundation for Universal Access, Affordability and Quality Summary Report*. Rio de Janeiro, May 28-30, 2010

KFF Health News. (2002). Morning Briefing: South Africa's ANC-Controlled Gauteng Province to Provide Nevirapine to HIV-Positive Pregnant Women in Defiance of National Policy, Other Provinces. *KFF Health News*, 19 February 2002. Available from: <https://khn.org/morning-breakout/dr00009544/>

Koon, A.D., Hawkins, B. and Mayhew, S.H. (2016). Framing and the health process: A scoping review. *Health Policy and Planning*, 31(6), 801-816. <https://doi.org/10.1093/heapol/czv128>

Koon, A.D., Windmeyer, L., Bigdeli, M., Charles, J., Jardali, F.E., Uneke, J. and Bennett, S. (2020). A scoping review of the uses and institutionalisation of knowledge for health policy in low- and middle-income countries. *Health Research Policy and Systems*, 18(7). <https://doi.org/10.1186/s12961-019-0522-2>

Kuchenmueller, T., Boeira, L., Oliver, S., Moat, K., El-Jardali, F., Barreto, J. and Lavis, J. (2022). Domains and processes for institutionalizing evidence-informed health policy-making: a critical interpretive synthesis. *Health Research Policy and Systems*, 20, Article 27. <https://doi.org/10.1186/s12961-022-00820-7>

Lane, J., Andrews, G., Orange, E., Brezak, A., Tanna, G., Lebesse, L., Carter T., Naidoo, E., Levendal, E. and Katz, A. (2020). Strengthening Health Policy Development and Management Systems in Low- and Middle- Income Countries: South Africa's Approach. *Health Policy Open*, 1, 100010. <https://doi.org/10.1016/j.hpopen.2020.100010>

Lavis, J. N., Ross, S. E., & Hurley, J. E. (2002). Examining the role of health services research in public policymaking. *The Milbank Quarterly*, 80(1), 125-154. <https://doi.org/10.1111/1468-0009.00005>

Lavis, J. N., Robertson, D., Woodside, J. M., McLeod, C. B., Abelson, J. and Knowledge Transfer Study Group. (2003). How can research organizations more effectively transfer research knowledge to decision makers? *Milbank Quarterly*, 81(2), 221–172. <https://doi.org/10.1111/1468-0009.t01-1-00052>

Lavis, J.N., Oxman, A.D., Moynihan, R. and Paulsen, E.J. (2008). Evidence-informed health policy 1 – Synthesis of findings from a multi-method study of organizations that support the use of research evidence. *Implementation Science*, 3, 53. <https://doi.org/10.1186/1748-5908-3-53>

Liverani, M., Hawkins, B. and Parkhurst, J. (2013). Political and Institutional Influences on the Use of Evidence in Public Health Policy: A Systematic Review. *PLOS ONE*, 8(10), e77404. <https://doi.org/10.1371/journal.pone.0077404>

Liverani, M., Chheng, K. and Parkhurst, J. (2018). The making of evidence-informed health policy in Cambodia: Knowledge, institutions and processes. *BMJ Global Health*, 3(3), e000652. doi:10.1136/bmjgh-2017-000652

London School of Economics and Political Science (LSE, n.d.). Dr Justin Parkhurst [online]. Available from: <https://www.lse.ac.uk/health-policy/people/dr-justin-parkhurst> [accessed 10 August 2020].

Mail & Guardian. (2001). ANC condemns Aids court action. *Mail & Guardian*, 3 December 2001. Available from: <https://mg.co.za/article/2001-12-03-anc-condemns-aids-court-action/>

Maluleke, R. (2022). *Mid-year population estimates, 2022*. StatsSA. Available from: <https://www.statssa.gov.za/publications/P0302/MidYear2022.pdf>

Marrian, N. (2009). New health watchdog to be introduced next year. *Mail & Guardian*, 24 November 2009. Available from: <https://mg.co.za/article/2009-11-24-new-health-watchdog-to-be-introduced-next-year/>

Marshall, C. and Jitsing, A. (2013). *Regulating the Quality of Health Services: Benchmarking of Approaches, Institutions and Systems: Towards the establishment of an Office of Health Standards Compliance (OHSC)* [online]. National Department of Health.

Mayosi, B.M., Mekwa, N.J., Blackburn, J., Coovadia, H., Friedman, I.B., Jeenah, M., Madela-Mntla, E.N., Magwaza, A.S., Makatini, Z., Mkize, D.L., Mokgatle-Makwakwa, C., Mokwena, K., Nevhutalu, K. and Paruk, F. (2011). *Strengthening research for health, innovation and development in South Africa*. Proceedings and recommendations of the 2011 National Health Research Summit, 26-27 July 2011, OR Tambo Conference Centre, Birchwood Hotel, Ekurhuleni, Gauteng, South Africa.

McCoy, D., Besser, M., Visser, R. and Doherty, T. (2002). *Interim Findings on the National PMTCT Pilot Sites: Lessons and Recommendations*. Health Systems Trust, https://www.hst.org.za/publications/HST%20Publications/PMTCT_Interim.pdf [accessed 30 May 2017]

Medical Research Council (MRC). (n.d.). *Cochrane African Network (CAN)*. Available from: <https://www.samrc.ac.za/intramural-research-units/Cochrane-CAN> [accessed 20 July 2023]

Mhazo, A.T. and Maponga, C.C. (2021). Agenda setting for essential medicines policy in sub-Saharan Africa: A retrospective policy analysis using Kingdon's multiple streams model. *Health Research and Policy Systems*, 19, 72. <https://doi.org/10.1186/s12961-021-00724-y>

Mitton, C., Adair, C.E., McKenzie, E., Patten, S.B., and Perry, B.W. (2007). Knowledge transfer and exchange: Review and synthesis of the literature. *The Milbank Quarterly*, 85(4), 729–768. <http://doi.org/10.1111%2Fj.1468-0009.2007.00506.x>

Mondal, S., Van Belle, S., Bhojani, U., Law, S. and Maioni, A. (2022). Policy Processes in Multisectoral Tobacco Control in India: The Role of Institutional Architecture, Political Engagement and Legal Interventions. *International Journal of Health Policy and Management*, 11(9), 1703-1714. doi: 10.34172/ijhpm.2021.66

Morestin, F. (2017). *The advisors of policy makers: Who are they, how do they handle scientific knowledge and what can we learn about how to share such knowledge with them? Knowledge sharing and public policy series*. Montréal and Québec, Canada: National Collaborating Centre for Healthy Public Policy.

National Health Act 61 of 2003. Government Gazette, Vol. 469, No. 26595, South Africa, 23 July 2004 [accessed 08 October 2017].

National Health Amendment Act 12 of 2017. Government Gazette, Vol. 469, No. 26595, South Africa, 23 July 2004 [accessed 08 October 2017].

National Health Insurance Bill 2019 ((As amended by the Portfolio Committee on Health (National Assembly), [B 11B—2019], Republic of South Africa

Nattrass, N. (2008). AIDS and the Scientific Governance of Medicine in Post-Apartheid South Africa. *African Affairs*, 107(427), 157–176. <https://doi.org/10.1093/afraf/adm087>

Naude, C.E., Zani, B., Ongolo-Zogo, P., Wiysonge, C.S., Dudley, L., Kreda, T., Garner, P. and Young, T. (2015). Research evidence and policy: Qualitative study in selected provinces in South Africa and Cameroon. *Implementation Science*, 10, Article 126, <https://doi.org/10.1186/s13012-015-0315-0>

News24. (2002). KZN approves 3 month Aids plan. News24, 30 January 2002. Available from: <https://www.news24.com/news24/xarchive/archive/kzn-approves-3-month-aids-plan-20020130>

Ntsabo, M. (2019). Zuma explains role of ANC deployment committee. *Eyewitness News (EWN)* [online], 17 July 2019. Available from: <https://ewn.co.za/2019/07/17/zuma-explains-role-of-anc-deployment-committee> [accessed 16 October 2020]

Nutley, S., Walter, I. and Davies, H.T.O. (2003). From Knowing to Doing: A Framework for Understanding the Evidence-Into-Practice Agenda. *Evaluation*, 9(2), 125–148. <https://doi.org/10.1177/1356389003009002002>

Office of Health Standards Compliance (OHSC). (2018). Annual Inspection Report of the Office of Health Standards Compliance: A summary of national and provincial performance – 2016/17. *OHSC: Portfolio Committee on Health*, 5 June 2018. Available from: <https://static.pmg.org.za/180605OHSC.pdf>

Office of Health Standards Compliance (OHSC) (2022). *Bi-Annual Report April-September 2022: Certification of Health Establishments*. Available from: <https://ohsc.org.za/wp-content/uploads/Bi-Annual-Report-C-n-E-April-September-2022-1.pdf> [accessed March 2023].

Okeyo, I., Lehmann, U. and Schneider, H. (2020). Policy Adoption and the Implementation Woes of the Intersectoral First 1000 Days of Childhood Initiative, In the Western Cape Province of South Africa. *International Journal of Health Policy and Management*, 10, 364-375. doi: 10.34172/ijhpm.2020.173

Oliver, K., Innvar, S., Lorenc, T., Woodman, J. and Thomas, J. (2014). A systematic review of barriers to and facilitators of the use of evidence by policymakers. *BMC Health Services Research*, 14, Article 2. <https://doi.org/10.1186/1472-6963-14-2>

Oliver, K., Lorenc, T. and Innvaer, S. (2014). New directions in Evidence-Based Policy Research: A critical analysis of the literature. *Health Research Policy and Systems*, 12, 34. <https://doi.org/10.1186/1478-4505-12-34>

Oliver, K.A., de Vocht, F., Money, A., Everett, M. (2015). Identifying public health policymakers' sources of information: Comparing survey and network analyses. *European Journal of Public Health*, 27(2), 118–123. <https://doi.org/10.1093/eurpub/ckv083>

Oliver, K.A. and de Vocht, F. (2017). Defining 'evidence' in public health: a survey of policymakers' uses and preferences. *European Journal of Public Health*, 27(2), 112–117. <https://doi.org/10.1093/eurpub/ckv082>

Oliver, K. and Pearce, W. (2017). Three lessons from evidence-based medicine and policy: increase transparency, balance inputs and understand power. *Palgrave Communications*, 3, 43, <https://doi.org/10.1057/s41599-017-0045-9>

Oliver, K. and Boaz, A. (2019). Transforming evidence for policy and practice: Creating space for new conversations. *Palgrave Communications*, 5, 60. <https://doi.org/10.1057/s41599-019-0266-1>

Oliver, K. and Cairney, P. (2019). The dos and don'ts of influencing policy: A systematic review of advice to academics. *Palgrave Communications*, 5, 21. <https://doi.org/10.1057/s41599-019-0232-y>

Oliver, K., Hopkins, A., Boaz, A., Guillot-Wright, S. and Cairney, P. (2022). What works to promote research-policy engagement? *Evidence & Policy*, 18(4), 691–713. <https://doi.org/10.1332/174426421X16420918447616>

Onoka, C.A., Hanson, K. and Hanefeld, J. (2015). Towards universal coverage: a policy analysis of the development of the National Health Insurance Scheme in Nigeria. *Health Policy and Planning*, 30(9), 1105–1117. <https://doi.org/10.1093/heapol/czu116>

Onono, M.A., Brindis, C.D., White, J.S., Goosby, E., Okoro, D.O., Bukusi, E.A. and Rutherford G.W. (2019). Challenges to generating political prioritization for adolescent sexual and reproductive health in Kenya: A qualitative study. *PLOS ONE*, 14(12), e0226426. <https://doi.org/10.1371/journal.pone.0226426>

Orgill, M., Nxumalo, N., Amde, W., Erasmus, E., Lehmann, U., Goudge, J. and Gilson, L. (2013). Health Policy and Systems Research: Needs, challenges and opportunities in South Africa – a university perspective. In: Padarath, A. and English, R., eds. *South African Health Review 2012/13*. Durban: Health Systems Trust. <http://www.hst.org.za/publications/south-african-health-review-2012/13> [Accessed 20 December 2017]

Oxford English Dictionary (OED). (n.d.). *People power*. Available from: <https://www.oed.com/search/dictionary/?scope=Entries&q=people%20power>

Reddy, P. (2018). Setting priorities for health research. In: DoH, *2018 National Health Research Summit Report* [online]. Available from: https://www.health.gov.za/wp-content/uploads/2020/11/national-health-research-summit-report_compressed.pdf

Oxman, A.D., Lavis, J.N., Fretheim, A. and Lewin, S. (2009a). SUPPORT Tools for evidence-informed health Policymaking (STP) 16: Using research evidence in balancing the pros and cons of policies. *Health Research Policy and Systems*, 7(Suppl 1), Article S16. <https://doi.org/10.1186/1478-4505-7-S1-S16>.

Oxman, A.D., Lavis, J.N., Fretheim, A. and Lewin, S. (2009b). SUPPORT Tools for evidence-informed health Policymaking (STP) 17: Dealing with insufficient research evidence. *Health Research Policy and Systems*, 7(Suppl 1), Article S17. <https://doi.org/10.1186/1478-4505-7-S1-S17>

Parashar, R., Gawde, N. and Gilson, L. (2021). Application of “Actor Interface Analysis” to Examine Practices of Power in Health Policy Implementation: An Interpretive Synthesis and Guiding Steps. *International Journal of Health Policy Management*, 10(7), 430-442. doi: 10.34172/ijhpm.2020.191

Parkhurst, J. (2016). Appeals to evidence for the resolution of wicked problems: the origins and mechanisms of evidentiary bias. *Policy Sciences*, 49, 373–393. <https://doi.org/10.1007/s11077-016-9263-z>

Parkhurst, J. (2017). *The politics of evidence: from evidence-based policy to the good governance of policy*. Routledge Studies in Governance and Public Policy. Abingdon, Oxon, UK: Routledge.

Parkhurst, J., Ettelt, S. and Hawkins, B. (eds). (2018). *Evidence use in Health Policy Making: An International Public Policy Perspective*. International Series on Public Policy. Palgrave Macmillan. <https://doi.org/10.1007/978-3-319-93467-9>

Parkhurst, J., Ghilardi, L., Webster, J., Hoyt, J., Hill, J. and Lynch, C.A. (2020). Understanding evidence use from a programmatic perspective: Conceptual development and empirical insights from national malaria control programmes. *Evidence & Policy*, 17(3), 447–466. <https://doi.org/10.1332/174426420X15967828803210>

Reardon, R., Lavis, J. & Gibson, J. (2006). *From Research to Practice: A Knowledge Transfer Planning Guide*. Institute for Work and Health. Available from: <https://www.iwh.on.ca/tools-and-guides/from-research-to-practice-kte-planning-guide> [accessed on 27 July 2017]

Rispel, L. and Doherty, J. (2011). Research in support of health systems transformation in South Africa: The experience of the Centre for Health Policy. *Journal of Public Health Policy*, 32(Suppl 1), S10–S29. <https://doi.org/10.1057/jphp.2011.33>

Ritchie, J. and Spencer, L. (1994). Qualitative data analysis for applied policy research. In: Bryman, A. and Burgess, R.G., eds. *Analyzing Qualitative Data*. London: Routledge, pp.173-194. https://doi.org/10.4324/9780203413081_chapter_9

Schneider, H., Gilson, L., Ogden, J., Lush, L. and Walt, G. (2006). Health Systems and the Implementation of Disease Programmes: Case Studies from South Africa. *Global Public Health*, 1(1), 49-64. <https://doi.org/10.1080/17441690500361083>

Schneider, H., Coetzee, D., Van Rensburg, D. and Gilson, L. (2010). Differences in antiretroviral scale up in three South African provinces: the role of implementation management. *BMC Health Services Research*, 10(Suppl 1), S4. <https://doi.org/10.1186/1472-6963-10-S1-S4>

Sefularo, M. (2009). Address by the Deputy Minister of Health, Dr Molefi Sefularo, to the Medical Students' Conference at the University of the Witwatersrand (WITS), Johannesburg. *South African Government*, 25 September 2009. Available from: <https://www.gov.za/address-deputy-minister-health-dr-molefi-sefularo-medical-students-conference-university>

Shiffman, J. and Smith, S. (2007). Generation of political priority for global health initiatives: A framework and case study of maternal mortality. *The Lancet*, 370(9595), 1370-1379. [https://doi.org/10.1016/S0140-6736\(07\)61579-7](https://doi.org/10.1016/S0140-6736(07)61579-7)

Sidley, P. (2006). South Africa blames deaths of 22 infants on the legacy of apartheid. *British Medical Journal*, 333(7559), 115. PMID: PMC1502165. Available from: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1502165/> [accessed 16 June 2022]

Simelela, N.P. and Venter, W.D.F. (2014). A brief history of South Africa's response to AIDS. *South African Medical Journal*, 104(3 Suppl 1), 249–251. <https://doi.org/10.7196/samj.7700>

Smith, D. (2009). South Africa's ANC wins big election victory, final results show. *The Guardian*, 25 April 2009. Available from: <https://www.theguardian.com/world/2009/apr/25/south-africa-election-anc-result>

South African History Online (SAHO). (2017). The 52nd ANC National Conference – Polokwane 2007. *SAHO*, 13 December 2017. Available from: <https://www.sahistory.org.za/article/52nd-anc-national-conference-polokwane-2007>

South African Press Association (SAPA). (2002). South Africa: Gauteng Announces Nevirapine Roll-Out Programme. *SAPA*, 18 February 2002.

StatsSA. (2022). *General Household Survey 2021*. Available from: <https://www.statssa.gov.za/publications/P0318/P03182021.pdf>

Stewart, R., Dayal, H., Laurenz, L. and Van Rooyen, C. (2019). The evidence ecosystem in South Africa: growing resilience and institutionalisation of evidence use. *Palgrave Communications*, 5, 90. <https://doi.org/10.1057/s41599-019-0303-0>

Sutcliffe, S. and Court, J. (2005). Evidence-based Policymaking: What is it? How does it work? What relevance for developing countries? London: Overseas Development Institute. Available from: <https://odi.org/en/publications/evidence-based-policymaking-what-is-it-how-does-it-work-what-relevance-for-developing-countries/> [accessed 21 July 2017]

Tannous, N. (2019). *ACE Prof rates amongst South Africa's best*. Africa Centre for Evidence. Available from: <https://africacentreforevidence.org./learning-to-ace-it-2/> [accessed 15 September 2020]

Tendengu, T.P. (2021). The Applicability of Agenda Setting Policy Implementation Theory on COVID-19 Lockdown Policy in Southern African Countries. *Open Journal of Political Science*, 11(03), 549-559. doi:[10.4236/ojps.2021.113035](https://doi.org/10.4236/ojps.2021.113035)

The Conversation. (n.d.). *Ruth Stewart*. Available from: <https://theconversation.com/profiles/ruth-stewart-268037> [accessed 24 November 2021]

The Presidency. (2009). Questions and answers on the release of the Green Paper on Performance, Monitoring and Evaluation. *South African Government*, 4 September 2009. Available from: <https://www.gov.za/questions-and-answers-release-green-paper-performance-monitoring-and-evaluation>

Thomas, A., Chataway, J., & Wuyts, M. (Eds.) (1998). *Finding out Fast: Investigative Skills for Policy and Development*. London: The Open University SAGE Publications Ltd. Available from: <https://www.scirp.org/reference/ReferencesPapers.aspx?ReferenceID=2068862> [accessed 20 June 2017]

Thow, A., Greenberg, S., Hara, M., Friel, S., duToit, A. and Sanders, D. (2018). Improving policy coherence for food security and nutrition in South Africa: a qualitative policy analysis. *Food Security*, 10, 1105–1130. <https://doi.org/10.1007/s12571-018-0813-4>

Tshabalala-Msimang, M. (2008). *Foreword to the policy and guidelines for the implementation of the PMTCT programme*. National Department of Health. Available from: https://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_125633.pdf [accessed 15 June 2017]

Vecchione, E. and Parkhurst, J. (2016). *Evidence Advisory System Briefing Notes: Ethiopia*. London School of Hygiene and Tropical Medicine GRIP-Health Programme. Available from: <https://researchonline.lshtm.ac.uk/id/eprint/3213919/>

Verboom, B. and Baumann, A. (2020). Mapping the Qualitative Evidence Base on the Use of Research Evidence in Health Policy-Making: A Systematic Review.

International Journal of Health Policy and Management, 11(7), 883–898.
<https://doi.org/10.34172/ijhpm.2020.201>

Votruba, N., Ziemann, A., Grant, J. and Thornicroft, G. (2018). A systematic review of frameworks for the interrelationships of mental health evidence and policy in low- and middle-income countries. *Health Research Policy and Systems*, 16, 85.
<https://doi.org/10.1186/s12961-018-0357-2>

Waddell, C., Shepherd, C.A., Lavis, J.N., Lomas, J., Abelson, J. and Bird-Gayson, T. (2007). Balancing Rigour and Relevance: Researchers' Contributions to Children's Mental Health Policy in Canada. *Evidence & Policy*, 3(2), 181-195.
<https://doi.org/10.1332/174426407781172180>

Walt, G. and Gilson, L. (1994). Reforming the health sector in developing countries: the central role of policy analysis. *Health Policy and Planning*, 9(4), 353-370.
<https://doi.org/10.1093/heapol/9.4.353>

Walt, G. and Gilson, L. (2014). Can frameworks inform knowledge about health policy processes? Reviewing health policy papers on agenda setting and testing them against a specific priority-setting framework. *Health Policy and Planning*, 29(Suppl 3), iii6–iii22. <https://doi.org/10.1093/heapol/czu081>

Walt, G., Shiffman, J., Schneider, H., Murray, S.F., Brugha, R. and Gilson, L. (2008). 'Doing' health policy analysis: methodological and conceptual reflections and challenges. *Health Policy and Planning*, 23(5), 308-317.
<https://doi.org/10.1093/heapol/czn024>

Weiss, C.H. (1979). The Many Meanings of Research Utilization. *Public Administration Review*, 39(5), 426-431. <https://doi.org/10.2307/3109916>

Western Cape HPSR Journal Club Team. (2020). "Not Just a Journal Club – It's Where the Magic Happens": Knowledge Mobilization through Co-Production for Health System Development in the Western Cape Province, South Africa. *International Journal of Health Policy and Management*, 11(3), 323-333. doi: 10.34172/ijhpm.2020.128

Wikipedia. (2022). *Law of persons in South Africa*. Available from:
https://en.wikipedia.org/wiki/Law_of_persons_in_South_Africa

Wikipedia. (2023). *Duesberg Hypothesis*. Available from:
https://en.wikipedia.org/wiki/Duesberg_hypothesis

World Health Organization (WHO). (2018). *Health policy*. Available from:
http://www.who.int/topics/health_policy/en/

World Health Organization (WHO). (2021). *Evidence, policy, impact: WHO Guide for evidence-informed decision-making*. Geneva: World Health Organization. Available

from: <https://www.who.int/publications-detail-redirect/9789240039872> [accessed 20 January 2023]

Yamey, G. and Feachem, R. (2011). Evidence-based policymaking in global health – the payoffs and pitfalls. *Evidence-Based Medicine*, 16(4), 97–99. <https://doi.org/10.1136/ebm.2011.100060>

Yin, R. K. (1994). *Case Study Research: Design and Methods*. Second ed. Thousand Oaks, CA: SAGE Publications.

Young, T., Shearer, J.C., Naude, C., Kredo, T., Wiysonge, C.S. and Garner, P. (2018). Researcher and policymaker dialogue: the Policy BUDDIES Project in Western Cape Province, South Africa. *BMJ Global Health*, 3(6). Available from: <https://gh.bmj.com/content/3/6/e001130> [accessed 10 July 2022]

Zida, A., Lavis, J.N., Sewankambo, N.K., Kouyate, B. and Ouedraogo, S. (2018). Evaluating the Process and Extent of Institutionalization: A Case Study of a Rapid Response Unit for Health Policy in Burkina Faso. *International Journal of Health Policy and Management*, 7(1), 15–26. <https://doi.org/10.15171/ijhpm.2017.39>

GREY LITERATURE

1. Various sets of minutes of the Technical Advisory Council of the National Health Council (unquotable)
2. Various sets of minutes of the National Health Council (Political Committee) (unquotable)

ANNEXURES

ANNEXURE 1: ETHICS APPROVAL FROM THE UCT FACULTY OF HEALTH SCIENCES HUMAN ETHICS RESEARCH COMMITTEE – 25 OCTOBER 2017



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E53-46 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [0211 406 6626
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

3 November 2016

HREC REF: 710/2016

Prof L Gilson
Public Health & Family Medicine
Falmouth Building

Dear Prof Gilson

PROJECT TITLE: HOW AND WHY ARE DIFFERENT FORMS OF EVIDENCE USED IN POLICYMAKING IN THE SOUTH AFRICAN HEALTH SECTOR? A CASE STUDY OF THE NATIONAL CORE STANDARDS FOR HEALTH ESTABLISHMENTS AND THE PREVENTION-OF-MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT) POLICY FOR SOUTH AFRICA (PHD CANDIDATE - MR T C MASILELA)

Thank you for your letter to the Faculty of Health Sciences Human Research Ethics Committee dated 28 October 2016.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th November 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period. (Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal Investigator.

Please note that for all studies approved by the HREC, the principal Investigator **must** obtain appropriate institutional approval before the research may occur.

The HREC acknowledge that the student Thulanl Clifford Masilela will also be involved in this study.

Yours sincerely

T. Burgess

pp **PROFESSOR M BLOCKMAN**
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE
Federal Wide Assurance Number: FWA00001637.

HREC 710/2016

ANNEXURE 2: APPROVAL LETTER FROM THE NATIONAL DEPARTMENT OF HEALTH



**DIRECTOR GENERAL
HEALTH
REPUBLIC OF SOUTH AFRICA**

PRETORIA
Private Bag X828, PRETORIA, 0001. 27th Floor, Room 2710, Civitas Building, Cnr Thabo Sehume & Struben Street, PRETORIA, 0001 Tel: 012 395 8000, Fax: 012 395 8422
CAPE TOWN
P.O. Box 3875, CAPE TOWN, 8000. 6th Floor, Room 617, 103 Parliament Towers, Plain Street, CAPE TOWN, 8000 Tel: 021 461 2040, Fax: 021 461 6864

Mr TC Masilela
Department of Planning, Monitoring and Evaluation
Private Bag X944
PRETORIA
0001

Dear Mr Masilela

PERMISSION TO CONDUCT A STUDY ON HOW AND WHY ARE DIFFERENT FORMS OF EVIDENCE USED IN POLICY-MAKING IN THE SOUTH AFRICAN HEALTH SECTOR

The National Department of Health (NDoH) acknowledges receipt of a request for approval to conduct a study on "How and Why are Different Forms of Evidence Used in Policy-making in the South African Health Sector" dated 5 July 2016.

In response to your request to interview the Leadership and the Executive Management of the NDoH, permission is provisionally granted. Approval is granted on conditions that:

- The Research Ethics Committee approval/ Research Ethics Clearance Certificate is submitted to the NDoH before the commencement of the study;
- The permission to present or publish findings of the study is sought with the NDoH first.

Submission and presentation of the final report with recommendations to the NDoH will also be required.

Yours sincerely

MS MP MATSOSO
DIRECTOR-GENERAL: HEALTH
DATE: 16/8/2016

ANNEXURE 3: APPROVAL LETTER FROM THE NORTH WEST PROVINCIAL DEPARTMENT OF HEALTH



POLICY, PLANNING, RESEARCH, MONITORING AND EVALUATION

Name of researcher : Mr. T. Masilela
University of Cape Town

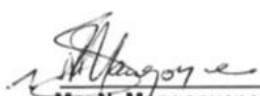
Physical Address
(Work/ Institution) _____

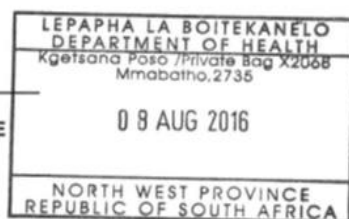
Subject : Request to interview the Head of Department: How and Why are different forms of evidence used in Policy-Making in the South African Health Sector? A case study of the National Core Standards for Health establishments and the Prevention of Mother-to-Child Transmission (PMTCT) of HIV Policy for South Africa.

This letter serves to inform the Researcher that permission to interview the Head of Department has been granted. The Researcher is expected to arrange in advance with the Acting Director (Office of the HOD): Mr. K. Dibodu
Contact Details : 018 391 4185
E-mail : kdibodu@nwpg.gov.za
and issue this letter as proof that permission has been granted.

This letter should be signed and a copy returned to the Department. By signing, the Researcher agrees, binds him/herself and undertakes to furnish the Department with an electronic copy of the final research report. Alternatively, the Researcher can also provide the Department with electronic summary highlighting recommendations that will assist the department in its planning to improve some of its services where possible. Through this the Researcher will not only contribute to the academic body of knowledge but also contributes towards the bettering of health care services and thus the overall health of citizens in the North West Province.

Kindest regards


Ms. N. Mangonyane
Acting Director: PPRM&E



08/08/2016
Date

Researcher _____

Date _____


Healthy Living for All

ANNEXURE 4: APPROVAL LETTER FROM THE WESTERN CAPE DEPARTMENT OF HEALTH



Chief Directorate: Health Strategy and Support
Reference: Support for Research
Enquiries: Ms Charlene Roderick
Ph: 021-483 9341

Mr CT Masilela
Private Bag X944
Pretoria
0001

Project Title: How and Why are Different Forms of Evidence Used Policy-Making in the South African Health Sector

Dear Mr Masilela

The Western Cape Government Department of Health hereby indicates in-principle support for the study you are proposing titled How and Why are Different Forms of Evidence Used Policy-Making in the South African Health Sector. We recognise that the study has the potential to address an important health challenge facing our population.

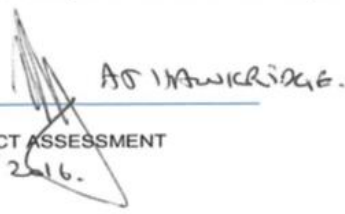
In giving our in-principle support, we indicate that our support is based on the understanding that

- (i) If and when you receive your grant for the study, you will provide us with your grant number, ethics approval reference number (by locally accredited committee) and proof of scientific review of your research proposal.
- (ii) You will submit the proposal to the health research sub-directorate as per the normal routes for permission (www.capegateway.gov.za/eng/pubs/public_info/H/213781) so that the implementation of the study does not inconvenience the day to day functioning of our facilities.

We look forward to a good working relationship with you as you conduct your project.

I appreciate the time that you have taken to enquire and solicit our support.

Sincerely,


Dr Anthony Hawkrige
Director: HEALTH IMPACT ASSESSMENT
DATE: 29/7/2016.

5th Floor, 8 Riebeeck Street, Cape Town, 8001
PO Box 2060, Cape Town, 8000
tel: +27 21 483 9341 fax: +27 21 483 6058 www.capegateway.gov.za

ANNEXURE 5: INFORMATION SHEET AND CONSENT FORM FOR STUDY PARTICIPANTS: PHASE 1 AND PHASE 2 OF THE STUDY

PART 1: INFORMATION BROCHURE

INFORMATION SHEET: KEY INFORMANT INTERVIEW

How and Why Are Different Forms of Evidence used in Policy-Making in the South African Health Sector?

A Case Study of the National Core Standards for Health Establishments and the Prevention-Of-Mother-To-Child Transmission of HIV (PMTCT) Policy for South Africa

Dear Sir/Madam,

My name is Thulani Clifford Masilela, I am student at the University of Cape Town (UCT), studying for the degree of Doctor of Philosophy (PhD) in Public Health. I am also a government official working for the Department of Planning, Monitoring and Evaluation (DPME). As part of my studies, I am conducting a research study entitled: **How and Why Are Different Forms of Evidence used in Policy-Making in the South African Health Sector?**

This research study seeks to find out how and why are different forms of evidence used in policy-making in the South African Health Sector. I will be using two tracer policies from the public health sector namely, the National Core Standards and the Prevention-of-Mother-To-Child Transmission of HIV (PMTCT) Policy for South Africa.

I wish to kindly request you to participate in this study, by granting me an opportunity to interview you. This will take between **40 and 50 minutes**.

A. The main objectives of this research study are as follows:

1. To describe the routine avenues of national health policy making in the South African public health sector;
2. To explore the nature of research evidence (and other forms of evidence) that is viewed as important and used for policy making processes in the public health sector in South Africa - focusing on two tracer policies, the National Core Standards and the Prevention of Mother-to-Child Transmission of HIV (PMTCT) Policy for South Africa

3. To explain the factors that facilitate and those that inhibit the use of different types of evidence in policy making – from the perspectives of both policy-makers and researchers;
4. To explore mechanisms of fortifying the research-to-policy interface in South Africa

B. The procedures for this part of the study?

The study involves:

1. A series of in-depth 'elite' interviews with key stakeholders with insights on health policy development in the public health sector in South Africa
2. Interviews with health policy researchers who have investigated health policy processes and the use of evidence in South Africa
3. Literature Review to order to better understand and support the perspectives gathered through the interviews

C. Your participation?

You have been asked to participate in this study because you have been identified as a key stakeholder who should be able to provide valuable information on health policy development in the South African public health sector. This might include knowledge about historical health policies and current policies of government. The focus on this study is on the National Core Standards and the Prevention of Mother-to-Child Transmission of HIV (PMTCT) Policy for South Africa.

However, you may use your experiences in the development of other policies to illustrate your points. You may be retired or currently based within the public health system – or you may have been identified as third party observer with important perspectives on health systems change in South Africa. This study seeks to explore how and why evidence is used. There are therefore no right or wrong answers to the questions that we will ask, your views are all of interest.

D. What are the processes and procedures during and after the interviews?

1. I anticipate expect that completing the interview will take between **40 and 50 minutes**.
2. I will guide the interview in a semi-structured way, asking you questions about how the health system has changed over time.
3. The interviews will take place in a venue of your choice, in a quiet location where no interruptions are likely to occur. If it is **inconvenient** for you to meet with me personally, an electronic interview (by telephone or web-based tele-conference)

would be arranged – although this is a secondary option to an in-person interview.

4. Should you agree, the interview will be audio recorded to ensure for accuracy of later transcriptions. You may refuse to be recorded without any consequence and I will take handwritten notes, or you may select only to have the recording used for accuracy.
5. If you have provided contact information, and if you so prefer, I will contact you within four months of the interview, and provide you with feedback in the form of a summary of the interview.
6. You will be sent the main research reports prior to publication (should you choose), and have the opportunity to comment or clarify any questions you may have. This feedback will be through email.
7. All documents and recordings will be kept in files on a computer that are password protected. Interview sheets and documents will be kept in files that will be stored safely in a locked cupboard.

E. Your right to participate, not participate, or withdraw from this study?

1. Your participation in this study is entirely voluntary.
2. Complete answers are most helpful for the research, but if you decide to participate, you may refuse to answer any question and you are free to stop at any time.
3. You will be given the option to make your responses anonymous (to be marked on the consent form prior to the interview begins). Should you choose this option, your confidentiality will be protected – that is, your name would not be used in any reporting.
4. You have the right to ask questions at any point before or after the interview.

F. What are the expected risks or benefits to you or to others for participating in

This research study?

1. This is considered a minimal risk study. There is some risk that shared reflection and publication on these matters reflect opinions that policy makers across levels of the health system have about each other's work and influences, as well as opinions that researchers and policy makers have about each other's work. This can lead to individuals feeling some reputational risk. All efforts will be made by the researchers to mitigate such risk.
2. You will not be paid for participating in this study and there will be no direct benefits to you as a participant.
3. The results of this research study will be used to improve health policy making in South Africa and contribute evidence to policy-makers and academics engaged in the field of health policy and systems research.

G. Who is carrying out this study?

This research is being carried out by:
Thulani C. Masilela,
Outcome Facilitator for Health
Department of Planning, Monitoring and Evaluation (DPME)
Office No 254, East Wing, Union Buildings,
Tel: 012 312 0107
Email: thulani.masilela@dpme.gov.za

H. Ethical clearance?

This study has been approved by the University of Cape Town (UCT) Faculty of Health Sciences (FHS) Human Research Ethics Committee (HREC). The contact details are: Human Research Ethics Committee of the Health Sciences Faculty, University of Cape Town, The Faculty of Health Sciences, Human Research Ethics Committee; E 52, Room 24, Old Main Building, Groote Schuur Hospital, Observatory, 7925, South Africa; Telephone: +27 21 406 6492. Fax: +27 21 406 641

H. Clearance by the DPME

This study has been reviewed and approved by the Department of Planning, Monitoring and Evaluation (DPME)

Contact details:

Mr. Tshediso Matona
Secretary for Planning and Acting Director-General
Office No 254, East Wing, Union Buildings,
Tel: 012 312 0234 (Personal Assistant: Ms. Ellen Mabunda)
Email: Tshediso@presidency-dpme.gov.za
Tel: 079 495 4692

If you agree to participate, please sign the attached consent form.

Should you not agree to participate, we thank you for letting us tell you about the research study.

This information sheet is your copy to keep for your records. Before departing, please ensure that the interviewer has your correct contact details (email or telephone address) so that you can be contacted with following information.

PART 2: CONSENT FORM

INFORMED CONSENT FORM: KEY INFORMANT INTERVIEW

How And Why Are Different Forms of Evidence used in Policy-Making in the South African Health Sector?

A Case Study of the National Core Standards for Health Establishments and the Prevention-Of-Mother-To-Child Transmission of HIV (PMTCT) Policy for South Africa

By signing below, I confirm that I have been informed about the research on the **use of evidence in Policy-Making in the South African Health Sector**, and that I agree to the following:

(By initialling the appropriate blocks you agree to)

Participation

To participate in this in-depth interview	
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Anonymity

I do <u>not</u> require my responses to be made anonymous	
I am willing for researchers to utilise my name in reporting, but only if I have been given the opportunity to review materials prior to publication	
I require this interview to be completely anonymous and confidential (no personal identifiers to be used in reporting)	

Audio-recording

To have the interview audio-recorded for accuracy purposes only (to ensure transcripts are more accurate)	
<u>Not</u> to have the interview audio-recorded	

Follow-up

I have provided the Researcher with my contact information, and choose the following follow-up options:

To be sent a summary of the interview within four months of the interview (by email)	
To be contacted by the researcher by email, with questions of clarification	
To be contacted by the researcher in order to set up another in-depth interview, should this be deemed necessary	
To be sent a draft version of the initial research report for comment	
To share further forms of evidence (archival, documentary, data etc.) with the Researcher by email or post	

Interviewer	Participant (Interviewee)
I certify that the participant has been given ample time to read and learn about the study. All questions and clarifications raised by the participant have been addressed.	I certify that I voluntarily agree to answer the interview questions, that the interview has been explained to me. All my questions have been answered satisfactorily. I understand I am free to discontinue participation at any time if I so choose.
Printed name:	Printed name:
Signature:	Signature:
Date of interview:	Date of interview:
Location of interview:	Location of interview:

ANNEXURE 6: INTERVIEW GUIDE FOR PHASE 1 OF THE STUDY

INTERVIEW GUIDE FOR A PhD RESEARCH STUDY ENTITLED:

HOW AND WHY ARE DIFFERENT FORMS OF EVIDENCE USED IN POLICY-MAKING IN THE SOUTH AFRICAN HEALTH SECTOR? A CASE STUDY OF THE NATIONAL CORE STANDARDS AND THE PREVENTION-OF-MOTHER-TO-CHILD TRANSMISSION (PMTCT) OF HIV POLICY FOR SOUTH AFRICA

POLICY MAKERS AND RESEARCHERS – PHASE 1

Many national health policies have been developed in South Africa over the 22 years of democracy, aimed at creating an accessible, acceptable and equitable health system. However, there is limited published literature on the processes of health policy development in the country, as well as factors that influence these process. The set of questions that I will be asking seek to enhance my insights into this area.

1. Please can you share with me, in your own view, who are the **key actors** in the development of national health policy in South Africa?
2. Can you give me some examples of how these actors have played a role in particular policy processes, or the types of roles they have played across these processes?
3. What roles do external stakeholders such as researchers, NGOs or CBOs play in the policy development process?
4. Are there **contestations about policy priorities** that occur between the National and Provincial spheres of government- given that health is a concurrent function Constitutionally? How are these handled? Can you give me some examples?
5. Once an issue has been identified as a policy priority for the public health sector, how is consensus reached about the **content of the policy**?
6. Can you identify the critical steps in the development of any health policy in SA? Which steps do you think are most important, and why? Please give concrete examples.
7. In your view, does **evidence** play a major part in the development of national health policy?
8. To what extent is research evidence or other forms of evidence, used in the policy-making process? Can you give me some examples?

9. In your view, which sources of evidence are mostly used by government? What are the characteristics or quality of these sources
10. How can the **use of evidence** in policy-making be strengthened in South Africa?
11. Are there any **additional comments** you would like to make?

ANNEXURE 7: INTERVIEW GUIDE FOR PHASE 2 OF THE STUDY



INTERVIEW GUIDE FOR A PhD RESEARCH STUDY ENTITLED:

HOW AND WHY ARE DIFFERENT FORMS OF EVIDENCE USED IN POLICY-MAKING IN THE SOUTH AFRICAN HEALTH SECTOR? A CASE STUDY OF THE NATIONAL CORE STANDARDS AND THE PREVENTION-OF-MOTHER-TO-CHILD TRANSMISSION (PMTCT) OF HIV POLICY FOR SOUTH AFRICA

POLICY MAKERS AND RESEARCHERS – PHASE 2

Many national health policies have been developed in South Africa over the 22 years of democracy, aimed at creating an accessible, acceptable and equitable health system.

This study seeks to establish the extent to which different forms of evidence are used in policy-making. The study aims to generate a better understanding of: (a) the pathways for infusing research evidence into the policy-making process; (b) stages of policy-making in which research evidence is used; and (c) types of evidence that are considered important and used for policy-making.

The first phase of this study, which has been completed, focused on the process of health policy development, and the contribution of different stakeholders. The second phase focuses on specific tracer policies, and seeks to distill the use of evidence of various types of evidence that were used in the development of these policies. Four tracer policies have been identified, of which two are Health Systems Policies and the other two are Clinical Policies.

TRACER POLICIES			
	HEALTHSYSTEMS POLICIES		CLINICAL POLICIES
1	National Core Standards for Health Establishments in South Africa	1	Prevention of Mother-to-Child Transmission of PMTCT Policy
2	Primary Health Care Re- engineering	2	National Drug Policy

QUESTIONS

1. Based on your knowledge and experience in the development of **any of the 4 policies** cited above, what evidence was used when the policy was developed?
2. In your view, what factors influenced the selection of the types of evidence used in policy making for the policies you are referring to?
3. At what stage of policy development was evidence used?
4. Who used evidence during the policy development process (e.g. technical policy drafters; political leadership, etc.)?
5. How were these types of evidence used in the policy-making process? Can you provide some examples?
6. To what end were these types of evidence used in policy-making?
7. Based on your knowledge and experience, in what ways did different forms of evidence influence policy making processes – during the development of any of the 4 tracer policies?
8. With specific reference to the **2008 PMTCT policy guidelines**, what forms of evidence informed the process of revising them to produce the **2010 PMTCT Option A policy**?
9. With specific reference to the **National Core Standards in South Africa**, what forms of evidence informed their development?
10. With specific reference to the **National Drug Policy**, how were the voices of the different stakeholders, including the Private Sector, balanced against available evidence?
11. With specific reference to the **Primary Health Care Re-engineering Policy**, how were the voices of the different stakeholders, including the Community-based organisations, balanced against available evidence?
12. Based on your knowledge and experience, did the use of evidence vary depending on the nature of the policy being developed?
13. Were there any barriers to the use of evidence in policy making, in the policies you were involved in? What were these?
14. What role can policy-makers play in strengthening the evidence-to-policy interface in South Africa?
15. What role can researchers play in strengthening the evidence-to-policy interface in South Africa?

THANK YOU FOR YOUR TIME

ANNEXURE 8: EXAMPLE OF THEMATIC CONTENT ANALYSIS

EXAMPLE 1

EXAMPLE OF THEMATIC AREAS – KEY INFORMANT INTERVIEWS WITH FORMER SENIOR BUREAUCRATS IN THE PUBLIC HEALTH SECTOR ON THE DEVELOPMENT OF THE PMTCT POLICY		
	THEMATIC AREA	KEY ISSUES
1	AIDS denialism	Denial by government and politicians of the causal link between HIV and AIDS
2	Trust deficit	Lack of trust between researchers and policy makers; and suspicion of scientists by policy-makers
3	Alliance between the President and the Minister	Difficult political environment, alliance (unholy) alliance between President and Minister at the time. Idealism of 1994 of a democratic government serving the people was stifled by denialism. Lack of tolerance for alternative views. Anti-intellectualism was pervasive.
4	Global isolation of South Africa	International isolation of South Africa due to the aberration of the Minister of Health – Minister Tshabalala Msimang was like the present day Donald Trump, who denies that global warming and climate change are a reality
5	Different power levels amongst stakeholders in the policy process – with political leaders commanding the highest power	Differential allocation of power (a) politicians had political power – the most influential type of power for decision-making (b) communities had people's power, power of the masses (c) researchers had scientific power, the power of knowledge (d) bureaucrats had technical power
6	Role of powerful political actors	Powerful political actors such as the President and Minister dominated the policymaking space Political hierarchy comes with power. Powerful politicians did not want anyone who challenges that hierarchy.
7	Silencing of voices that promoted rational policy development, using evidence	Technical bureaucrats were sympathetic to the call for evidence-based policy-making, but powerless. Some politicians were sympathetic but silent to protect their positions. Silence of sympathetic politicians who were not as well read, eloquent and erudite as the President
8	Role of community activism	Community activism increased, with civic organisations demanding antiretroviral therapy
9	Role of scientist	Expert groups, scientists with both research and clinical experience advocated for the national implementation of the PMTCT programme – but in the final analysis, needed political approval
10	Acquiescence of subnational spheres of government	Initially, there was unwillingness of most Provincial MECs of Health to challenge the National Minister in 2001 • Political context was that the MECs belonged to the same political party, the ruling party • There was strong hierarchy in the ruling party • MECs were protecting their own political positions

11	Defiance of the policymakers in the subnational sphere of the health system	However, in 2002, a few courageous politicians, Provincial MECs for Health in ANC governed provinces emerged and challenged. They defied their own ANC-aligned political leadership – and supported the call for a national rollout of antiretrovirals. The book <i>Profiles of Courage</i> shows what happens to political leaders who stand up against the general view. They get voted out and lose their positions.
12	Common characteristics of Health MECs who defied the national sphere of government	These courageous leaders shared several common characteristics – they were qualified medical doctors, had insight into scientific issues, were from bigger Provinces, Gauteng and KZN, and had political clout
13	Turning point in the PMTCT debacle	Breakthrough started with the Court Judgement of 2002 Breakthrough was sustained when some Provinces broke ranks with the National Ministry - political dissonance
14	Importance of evidence in policy development	It is important for government to realise that the world is governed by a set of principles, and that realities can change as our knowledge base develops.
15	Lessons learnt from the PMTCT experience	Government does not work like Academia – sometimes the person with the loudest voice wins the debate. The country must have priorities, choices, based on evidence. We can't do everything. Policy-makers believe that once they develop a policy, and start implementing it, it becomes realty. But this is far from the truth. A series of steps are required to take policy from having it signed and adopted by NHC to having it implemented. There is a huge lack of assessment of capacity to implement policy

ANNEXURE 9: EXAMPLE OF THEMATIC CONTENT ANALYSIS

EXAMPLE 2

EXAMPLE OF THEMATIC AREAS – KEY INFORMANT INTERVIEWS WITH FORMER SENIOR BUREAUCRATS IN THE PUBLIC HEALTH SECTOR ON THE DEVELOPMENT OF THE PMTCT POLICY		
	THEMATIC AREA	KEY ISSUES
1	Bottom-up origin of the PMTCT policy and programme	Advocacy of paediatricians, concerned groups, clinicians, researchers and civil society groups who were seeing babies dying from AIDS and who called for the establishment of a PMTCT policy and programme, in 2001. PMTCT originated as a bottom-up policy, not a top-down one.
2	Urgency of the crisis of child mortality due to PMTCT	Advocacy groups believe that the death of babies meant something had to be done urgently, without any clear agenda set, but this had to be done to save babies. Emotional appeal was that babies were innocent, they were just born and contracted the disease.
3	Role of powerful political actors	Domineering political figures in the person of the President and Minister of Health, who did not believe that HIV causes AIDS. Political environment was hostile
4	Role of health care providers	Health professionals also experienced the impact of HIV/AIDS at a personal level, in their families, communities, and society broadly.
5	Ethical dilemma of health professionals	Health care providers also faced an ethical dilemma in that they believed in the efficacy of PMTCT, but the employers, national government, did not.
6	Role of champions of evidence	Individual efforts were made by clinicians and researchers to gather evidence at their own cost, including attendance of international and local conferences on PMTCT. Evidence was shared between clinicians. Evidence was emerging about the efficacy of PMTCT, including from other countries. Evidence was shared between Clinicians
7	Perceptions of existing evidence on the efficacy of a nevirapine-based PMTCT policy and programme as insufficient	Reluctance of the national sphere of the health sector to the development of the PMTCT policy and programme on the basis of their perception of the evidence-basis for PMTCT as insufficient
8	Influence of counter-evidence from AIDS dissidents	AIDS dissidents who believed the theories of Prof. Duesberg provided politicians and policymakers in the national sphere of the health sector with counter-evidence and conflicting messages. This led to contestations between those who opposed PMTCT.
9	Tensions and contestation around the PMTCT policy	Tensions between administrators, politicians and clinicians about the need to establish the PMTCT programme. Highly politically charged environment.

10	Global impact of South Africa's stance on HIV/AIDS in general and PMTCT in particular	Non-evidence based position on HIV/AIDS damaged the country's global reputation
11	Persecution of NGOs that provided antiretroviral treatment to patients	NGOs that provided antiretroviral treatment were chased out of public health facilities. Isolation and punishment of those who provided PMTCT, for instance in Mpumalanga province
12	Defiance by Provincial DoHs	Western Cape province provided PMTCT services in its health facilities, in defiance of the national DoH position. Two ANC-led provinces – GP and KZN - subsequently broke rank
13	Systematic growth in evidence	Progression in the amount of evidence on the efficacy PMTCT over time, consistently being vindicated by science
14	Turning point	Court judgement of 2001-2002 was the turning point. In 2002, the high court directed government to roll-out the PMTCT programme, based on existing evidence, including the results of the pilot of the PMTCT programme in 18 government health facilities. Also in 2002, the Constitutional Court upheld this judgement
15	Key lesson	Government policy should be based on evidence, not sentiment or political loyalty.

ANNEXURE 10: EXAMPLE OF THEMATIC CONTENT ANALYSIS

EXAMPLE 3

EXAMPLE OF THEMATIC AREAS – KEY INFORMANT INTERVIEWS WITH FORMER SENIOR BUREAUCRATS IN THE PUBLIC HEALTH SECTOR ON THE DEVELOPMENT OF THE NATIONAL CORE STANDARDS POLICY		
	THEMATIC AREA	KEY ISSUES
1	Policy origin	There was an outcry that the health system was in crisis, there were public complaints and media complaints. Six 6 priority areas were identified for quality improvement and to address the concerns of the public like values and attitude, availability of medicines, security in our health establishments, staff attitudes, infection prevention control. People were complaining about these issues.
2	Difference between core standards and national core standards	Core standards were developed during the time of Minister Tshabalala-Msimang and were never implemented. National Core Standard were developed and piloted. One of the major reasons was [inadequate] resources from the department of health and the other issue mainly was that the office of standard compliance did not have the chief director at the time. It was only the quality assurance directorate.
3	Consultative approach was used when National Core Standards were piloted	During the development of the national core standards, the national sphere of the health sector involved the quality managers, the private sector, and all stakeholders with expertise in quality improvement. It was also important to identifying whether the very same national core standard could be achieved by the health establishment or not. The process involved the quality assurance managers from all the 9 provinces, through quality consultative forums.
4	Role of Expert Teams outside the health sector in generating evidence	Technical expert teams were established comprising NGOs such as the URC and COHSASA and private sector structures such as Netcare and HASA (Hospital Association of South Africa) and academic institutions such as the Wits Reproductive Health and HIV Institute. Ministerial Advisory Committee was also established to advise the Minister on the establishment of the OHSC
5	Importance of political support	The work of the task team easy because we had political support from the deputy minister then the late Sefularo.
6	Importance of piloting the National Core Standards	Piloting the national core standards enabled the development of the one of the inspection tool to be using in future to inspect the health establishments
7	Complaints from the public about the quality of public health care services	There were lots of questions and comments from the public and complains from the public about our health system or health services. The team clustered them into 6 priority areas for quality improvement

	THEMATIC AREA	KEY ISSUES
8	Importance of establishing an independent Office of Health Standards Compliance	In the original National Health Act, No. 61 of 2003, the office of Standards Compliance was provided for but it was not independent. Chapter 10 of the Act was reviewed and revised to come up with the National Health Bill that provided for an independent Office of Health Standards Compliance. The Bill was presented in Parliament and in 2013 the President proclaimed the office of the health standards compliance as an independent juristic person. Office of Health Standards Compliance could not be a referee and a player.

ANNEXURE 11: EXAMPLE OF THEMATIC CONTENT ANALYSIS

EXAMPLE 4

EXAMPLE OF THEMATIC AREAS – KEY INFORMANT INTERVIEWS WITH HEALTH POLICY AND SYSTEMS RESEARCHERS ON THE USE OF EVIDENCE IN HEALTH POLICY FORMULATION		
	THEMATIC AREA	KEY ISSUES
1	Importance of policy impact	Economic evidence is important when trying to promulgate policy. Frequently in South Africa evidence for policies has been based largely on burden of disease. Schools of Public Health and government are taking a fresh look at things by looking at the real impact of policy in terms of number of lives saved and the return on investment of a particular policy or intervention.
2	Importance of prioritisation for policymakers	Policymakers do not want to invest their very scarce resources in health interventions that will affect few people or that will affect many people but be ineffective interventions that come with a high cost. Prioritisation cannot exclude economic evidence.
3	Policymaking involves political decisions	How the South African National Department of Health decides to add vaccines [into the Expanded Programme of Immunisation] is a political decision or a decision based on the fact that there are 160 countries around the world that have this vaccine, South Africa is not one of them, so we need to add that vaccine. But the opportunity cost of adding the vaccine, the trade-offs, and what will be lost from the budget if you add that vaccine must also be considered.
4	Capacity of the health system must be considered in health policy formulation	Human resource issues in the South African health system are fragile, even if a vaccine is effective, we must take into account the HR issues to take care of the vaccine.
5	The price of inaction should be considered in policy formulation	It shown over a period of three years what the impact of a 20% sugar tax would be, and most importantly, the cost of inaction , what would happen if we did nothing. The cost of inaction are very high, more and more people get sick and acquire conditions that are very expensive to treat/ We looked at evidence around the world, then did modelling of what would happen in South Africa if we did not do anything, what would happen to obesity, diabetes and stroke. This was done with specific South African data.
6	Researchers must avail themselves whenever policymakers need them	Sugar-tax officially became a policy of the RSA government on 1 April 2018. To achieve this, we lobbied not only the National DoH but also National Treasury . Presentations were delivered to the Director, Chief Director and Deputy Director-General in National Treasury. They were interested in the evidence. We availed ourselves whenever policy-makers needed us. National Treasury invited us to a lot of public forums to make presentations, and we did. This work was driven by an expert panel of 12 people (including Thulani Masilela) which consisted of policy-makers; academics; private sector; and civil society. The work on sugar-tax was presented to the Davis Tax Commission and to the Social Cluster of Government in the Presidency (at the request of Thulani Masilela). That was useful interaction and we (researchers) had not done this before

	THEMATIC AREA	KEY ISSUES
7	Contestations are inevitable in the health policymaking process	Contestations happened with Libertarians who challenged us and published in Business Day that people are entitled to make their own choices. Sugar industry pushed back and published false information in the media, scared people off by saying there would 80,000 jobs lost if sugar-tax was implemented, they revised their estimates to 50,000 and finally to 2,000. It was scare mongering. Industry also argued that the tax was regressive, that it would affect the poor mostly, which was not true. The tax would be progressive for the poor in terms of their health
8	Government's policymaking processes and the use of evidence have to be transparent	Policy-makers are not open to thinking about new ideas. Sometimes they are open, like in the case of the sugar-sweetened tax. Thinking things through with researchers, even if it's based on evidence, is difficult for policy-makers. People within policy-making circles have vested interests about how they want to do things. In the case of the policy in question, it was easy for the researchers to defend government in their policy-making in the media space, because government was transparent, and there were lots of discussions and consultations. As a result, government looked good. Transparent policy-making makes government look good. Government must be very clear as to where the evidence is coming from, whether it is independent academics or not.
9	Evidence produced by researchers is at times tampered with	Evidence produced by PRICELESS largely influenced the proclamation on sugar-sweetened beverages. Government first made the announcement in 2016, industry pushed back in 2017, and Treasury was forced to redo calculations. in 2018, the proclamation stipulated that sugar-tax had to be 10%, although the researchers originally proposed 20%. Fruit juices were excluded from the tax, because of strong lobbying from the fruit juice industry. Research evidence was used to some degree, but it was tampered with.