Confronting the role of research in policy development and implementation

A case study of community service for doctors in South Africa

Gcinile Buthelezi
Health Systems Trust
Durban, South Africa

Haroon Wadee
Centre for Health Policy,
Johannesburg, South Africa

Nonhlanhla Makhanya
Health Systems Trust
Durban, South Africa

October 2002

The Alliance for Health Policy and Systems Research
Executive summary

The introduction of a one-year period of compulsory public service for health professionals, starting with doctors, was intended to respond to the poor supply of medical personnel in rural and underserved areas. It was designed to redress the inequalities of the past, as well as addressing the issue of overconcentration of doctors in urban areas.

This paper provides an analysis of the above policy. The overall contextual factors, the policy development process, the influence of actors and the substantive content of the policy are scrutinized, with the primary aim of establishing the role of research in policy development and implementation.

The policy was adopted as part of the Medical, Dental and Supplementary Health Service Professions Amendment Act of March 1998. Notably, the successful enactment of the policy was underpinned by the ideology of redressing the imbalances created by the apartheid government. This ideology was, in turn, reinforced by the strong political will of the ruling party to deliver on its promises of a better life for all.

It is hoped that successful or promising research management strategies will be distilled from this and similar case studies and subsequently inform discussions on the organizational and institutional factors that influence the research-to-policy process.
## Contents

**Executive summary** ...........................................................................................................2  
**Acronyms** ..........................................................................................................................4  
**Prologue** .............................................................................................................................5  

1. **Community service for doctors** ..................................................................................8  
   1.1 Background ..................................................................................................................8  
   1.2 Methodology ................................................................................................................8  

2. **Development of the community service policy** .........................................................9  
   2.1 Content .......................................................................................................................9  
   2.2 Context .......................................................................................................................10  
   2.3 Policy process and actors .........................................................................................10  

3. **The research–policy interface** ....................................................................................13  
   3.1 What is health research? ...........................................................................................13  
   3.2 Understanding research and its potential role in policy implementation ..................14  

4. **Policy lessons** ............................................................................................................16  
   4.1 Enhancing interaction among stakeholders ................................................................16  
   4.2 Promoting key skills ..................................................................................................16  
   4.3 Promoting evidence-based decision-making .............................................................16  
   4.4 Role of a national research coordinating body ..........................................................17  
   4.5 Lessons from the Health Systems Trust (HST) ..........................................................17  

**Annex 1** ................................................................................................................................19  
 Health Systems Trust .............................................................................................................19  

**Further reading** ................................................................................................................20  

**References** ........................................................................................................................20
<table>
<thead>
<tr>
<th>Acronyms</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>COHRED</td>
<td>Council on Health Research for Development</td>
</tr>
<tr>
<td>ENHR</td>
<td>Essential National Health Research</td>
</tr>
<tr>
<td>HCFC</td>
<td>Health Care Financing Committee</td>
</tr>
<tr>
<td>HPCSA</td>
<td>Health Professions Council of South Africa</td>
</tr>
<tr>
<td>HST</td>
<td>Health Systems Trust</td>
</tr>
<tr>
<td>JUDASA</td>
<td>Junior Doctors’ Association of South Africa</td>
</tr>
<tr>
<td>NAMDA</td>
<td>National Medical and Dental Association</td>
</tr>
<tr>
<td>NGO</td>
<td>nongovernmental organization</td>
</tr>
<tr>
<td>NPPHCN</td>
<td>National Progressive Primary Health Care Network</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>SAIMDC</td>
<td>South African Interim Medical and Dental Council</td>
</tr>
<tr>
<td>SAMA</td>
<td>South African Medical Association</td>
</tr>
<tr>
<td>SAMDC</td>
<td>South African Medical and Dental Council</td>
</tr>
</tbody>
</table>
The aim of the Alliance for Health Policy and Systems Research (AHPSR) is to contribute to health development and the efficiency and equity of health systems through research on and for health policy. Its objectives are as follows:

- to promote capacity for health policy and systems research (HPSR) on national and international issues
- to collect information for policy decisions in the health sector and other sectors influencing health
- to stimulate the generation of knowledge which facilitates policy analysis and improves understanding of health systems and the policy-making process
- to strengthen international research collaboration, information exchange and learning across countries
- to identify global-level influences on health systems and promote appropriate research.

As we pursue these objectives, we have realized that we do not know enough about how research actually affects policy in lower-income countries.

- How are research topics identified and priorities set?
- How are funding and other resources mobilized to produce evidence?
- What have been the consequences of exercises in priority-setting in the past?
- What has been the impact of research on policy?
- What are the factors affecting this process?

In order to answer these questions, in early 2001 the Alliance launched two series of case-studies. The first dealt with the enabling environment, relating donors, clients, users and producers of research throughout the life of a research project. The second approach concentrated on the structure of innovative, research-based policy development institutions in relation to the external environment. Different processes were followed to produce the case-studies, although all produced working papers which were peer-reviewed.

Enabling environment

These case-studies identified relevant indicators for assessing effectiveness in the relationship between research funding, production and utilization. The studies would also be used for training in the research-to-policy process, forming part of a curriculum being developed in an international collaboration. Case-studies were prepared to encourage discussion about the processes and mechanisms which affect support for research and its impact. To achieve this, the case-studies followed the “management school” format, where specific decision situations are described. Researchers were trained to undertake and write case-studies for this purpose.

The case-studies then sought to identify challenges in the setting of research priorities, decision-makers’ support for research and the benefits they gained from the research process and its results. They investigated the interplay of institutional
mechanisms which bring stakeholders together in an “enabling environment”. Attention was therefore given to the factors which bring actors together to agree on funding, support and utilization of research.

The Alliance launched a call for proposals and selected six researchers from five countries:

- C.A.K. Yesudian (Tata Institute of Social Sciences, Maharashtra, India)
- Francisco Yepes (Colombia)
- Mahmoud Abdel Latif Salem (Egypt)
- Absatou N’Diaye Soumare (Mali)
- Godfrey M. Mubyazi and Joseph Mwanga (Tanzania).

In each country, a policy issue was identified and at least one research project undertaken. Policy issues were selected according to various criteria: relevance for the health sector within countries, diversity across countries, and the researcher’s familiarity with the policy process and research in question. Within each policy and research area, researchers were given the choice of focusing narrowly on priority-setting, project financing or utilization, or covering all three aspects in a single case-study.

Particular attention was paid to describing the influences shaping project selection and the establishment of research programmes, the role of diverse mechanisms and actors, and the incentives available to increase relevance for national and local problems. The financial and human resources available to support the research-to-policy process were also described by examining resource flows for specific projects and stages of the project.

The impact of HPSR was analysed by observing research inputs and decision outputs in specific policy development situations. Research inputs would be studied from the supply side by analysing problems of HPSR dissemination, and from the demand side through an examination of the participation of researchers as part of the policy-making process. The influence of different types of knowledge — from empirical findings in data-driven design situations to broad conceptual frameworks, for example for health sector reforms — was to be explored. Case-studies would focus on policies with explicit decision points, ample choices and scope for technical design, as well as on those which operated in a more restricted or political environment.

**Research institutions**

The second series of case-studies focused much more closely on a single institution, with the primary aim of influencing the policy process through research and analysis. The main perspective was therefore the institution’s internal organization and its relations with the external environment.

Four Alliance partner institutions were selected to develop the case-studies:

- Health Systems Research Institute (HSRI), Thailand (researcher: Wiput Phoolcharoen)
- Mexican Health Foundation (Guillermo Soberon et al.)
- Health Systems Trust in South Africa (Gcinile Buthelezi)
- Colombian Health Association (ASSALUD) (Francisco Yepes).
These institutions have in common a focus on policy development based on research. Three of them are private, non-profit agencies with close links and working relationships with ministries of health and other government units, while HSRI is a public agency with a Board of Directors including non-government participants.

The terms of reference of the papers were quite broad, asking a member of the institution to describe its structure and organization as well as its relationships to decision-makers in the country concerned. More specifically, the researcher was asked to identify promising HPSR management strategies, to analyse their benefits and challenges, and to discuss the applicability of research management innovations for other developing countries and the lessons to be learned.
1. Community service for doctors

1.1 Background

South Africa’s transition from an authoritarian to a democratic state has been acclaimed as one of the world’s major political achievements. When the new democratic Government, led by the African National Congress (ANC), came to power in 1994, its mandate was to tackle the inequities created by apartheid. The distribution of income and wealth in South Africa is amongst the most unequal in the world. Under apartheid, the majority of South Africans were denied access to quality services and amenities, including education, housing, electricity, water and sanitation - crucial determinants of health.

South Africa’s new constitution makes provision for three spheres of governance - national, provincial and local - each of which has legislative powers and distinct responsibilities. In the health sector transformation plan, three levels of policy responsibility are identified. The national department provides leadership in the formulation of national health policy and legislation. The provincial health department provides guidelines for health promotion and monitoring within the province. At the local level, health services are provided for a defined population using the district health model. A clear understanding of the relationship between the political and administrative arms of governance is critical for understanding policy development and implementation processes in South Africa.

The Department of Health has developed a wide range of policies designed to improve access to health care services for all people in South Africa. This case study will critically reflect upon the research-to-policy and implementation process by examining the compulsory one-year period of community service for newly qualified doctors which was introduced in July 1998. The process followed in developing the policy, the factors that influenced it and the use of research will be examined. The analysis is intended to generate recommendations for the improvement of the research-to-policy linkage.

1.2 Methodology

This study will use the model for policy analysis developed by Walt and Gilson (1994:354). It takes into account overall contextual factors, the policy development process, the influence of actors and the substantive content of the policy (see Figure 1). The key factors in the analysis may influence one another: for instance, the context may determine which actors are powerful in shaping the process and content of the policy.
In order to assess the research-policy interface, the analysis will build on the theory of research and health policy discussed in Walt (1994) and a Mexican case study exploring how researchers influence decision-makers (Trostle et al., 1999). The theory of research and policy provides useful frameworks with which to assess the role of health research in both the policy development and implementation stages. It addresses the difference between the physical and biological sciences and the social sciences, and the way in which these may, in turn, influence policy-making. These frameworks will be used in the discussion of the role of research in the development and implementation of the community service policy in South Africa.

2. Development of the community service policy

2.1 Content

Community service for doctors is part of a broader policy governing the medical profession in South Africa, which aims to promote and reinforce standards of excellence in the provision of health care.

The Medical, Dental and Supplementary Health Service Professions Amendment Act, adopted in 1998, established the Health Professions Council of South Africa (HPCSA), a statutory body regulating the medical profession, and professional boards for the various health professions. The Act lays down the policy on community service for doctors, stating that “… any person registering for the first time for a profession listed in the regulations of this Act … shall perform remunerated community service for a period of one year” … [and] on the completion of such service, be entitled to practice the profession in question …” (Republic of South Africa, cited in Wadee, 1999). On completion of the year’s service, doctors are allowed to register with the HPCSA and practise their profession freely. Doctors were the first group of professionals to be subjected to the policy. Prior to this policy, prospective doctors were required to complete a medical internship upon completion of their studies.
This policy challenged the legitimacy of the then health minister, Nkosazana Zuma, and was highly contentious, dominating the headlines and creating a furore among young doctors, medical students and the opponents of the ANC Government, who viewed the policy as tantamount to military conscription.

2.2 Context

Context refers to the environment surrounding the research and decision-making process (Chunharas, 2000). In South Africa, a notable legacy of the apartheid era was the concentration of medical services, and therefore medical personnel, in urban areas. More than 75% of doctors were based in metropolitan areas and small towns, but half the population resided in rural areas where only 5.5% of doctors practised - a maldistribution aggravated by the forced relocation of blacks to the rural bantustans (Wadee, 1999). Historically, the private sector has been allowed to flourish, consuming up to 61% of health care resources in 1992 (McIntyre et al., 1995; HST, 1995), and employing the majority of health personnel, while catering for only 23% of the population. The public sector is a key provider of health care for nearly two-thirds of the population yet, in 1990, about 50% of doctors, 80% of dentists; 92% of pharmacists and 20% of nurses were employed by the private sector (Benatar & Savage in Wadee, 1999).

The introduction of free health services for children and pregnant women at primary health care level in 1994 and the free health care policy in public primary health care in 1996 resulted in a significant increase in the number of patients visiting clinics and outpatient departments. The increased workload was not always matched by an increase in health personnel.

Community service for doctors thus became a symbol of commitment of the Department of Health and the medical establishment to improving access to health care provision, while also addressing equity in the distribution of health personnel. Other short-term measures taken by the Department to address poor staffing in rural areas included the recruitment of foreign health personnel through bilateral agreements.

2.3 Policy process and actors

Actors in this context are viewed as individuals, institutions and pressure groups which played an active role in supporting or opposing the policy, often using research to back up their arguments. Actors central to the community service policy were health professional bodies, academic institutions, nongovernmental organizations (NGOs), political organizations, the media, health practitioners and the Government. Figure 2 shows the separation between the State and civil society, while mapping the potential interactions between actors.
Around 1989, some organizations were already playing an active role in developing policies for a future national health service. The National Medical and Dental Association (NAMDA) and its subsidiary, the National Progressive Primary Health Care Network (NPPHCN), were structures within the ANC which ultimately came into power after 1994. Redistribution of health personnel and compulsory community service were some of the issues discussed by these groups. Discussions about community service in the ANC health policy forum were subsequently reflected in the ANC health plan (ANC, 1994). The health plan argued for community service of doctors as a way of meeting a national need, ensuring that medical professionals paid back the State’s investment in their medical training and ensuring that doctors served the public sector before emigrating or moving into the private sector.

Also around 1989, the predecessor of the HCPSA, the South African Medical and Dental Council (SAMDC), had released a proposal on vocational training. The Council proposed the introduction of two years’ vocational training for doctors completing their internship, arguing that new graduates are ill-equipped for general practice and require further training.

In 1994, the Ministerial Committee on Human Resource Development proposed a two-year period of remunerated vocational training for health professionals, starting with doctors, as a prerequisite for registration, again arguing that this would prepare new doctors for general practice.

In 1994, the Ministry of Health appointed a Health Care Financing Committee (HCFC) of technical experts appointed from the departments of health and finance and from private-sector organizations. Four international consultants were also appointed as members of the Committee. The HCFC decided that the option of two years’ post-internship training was not feasible and suggested alternative options such as: certification of general practitioners only after non-tertiary public-sector experience; registrar training to include one period of public-sector
experience in the rural health service; bursary holders to meet contractual commitments; incentives to attract people to rural areas (Health Care Financing Committee, 1994).

The report of a commission of enquiry appointed by the Minister of Health in 1995 (Restructuring the national health system for universal primary health care, Department of Health, 1995) considered the introduction of compulsory community service, but also considered alternatives such as allowing graduates to repay the cost of their training. The report proposed the development of a “policy that would enable new medical graduates to undergo formal training equivalent to a registrarship, prior to being allowed to enter general practice. Part of this training would be spent working under supervision in public PHC facilities”. A related recommendation from the same report was “a policy requiring new medical and other health professional graduates to spend a defined period working in the public sector prior to being allowed to enter private practice”.

Both the human resources committee and the commission of enquiry into a national health insurance system used a variety of mechanisms to inform their deliberations, including formal hearings, written evidence, research (either commissioned or available from other sources) and consultations with interested stakeholders. The Commission of Enquiry also held formal hearings in all nine provinces of South Africa, allowing for wider engagement with civil society.

In 1996, the Department of Health released a policy proposal stipulating a mandatory two-year period of service for doctors on completion of their internship. A few months later, the South African Interim Medical and Dental Council (SAIMDC) - an interim body set up as part of the transformation of the SAMDC into the Health Professions Council - also revived its earlier proposal and announced the introduction of two years’ vocational training for all doctors completing their internship. The draft policy by the Department of Health was subsequently made available for public comment to interested stakeholders, including the Junior Doctors’ Association of South Africa (JUDASA), the South African Medical Association (SAMA), the National Interns Association and university representatives. The Portfolio Committee for Health held public hearings on the draft policy in mid-1996. Because of the similarity of the Government draft policy to the two-year vocational training proposed by the SAIMDC, the two proposals created confusion and anger amongst medical students and junior doctors, (represented by SAMA, JUDASA and the National Interns’ Association) who speculated that the two proposals were in fact one.

Submissions made by student and intern bodies at the public hearings of the Portfolio Committee did not protest against community service per se, but argued that a two-year vocational training programme would not succeed because of the poor infrastructure and lack of support in the areas where new doctors were expected to serve. JUDASA argued that the policy was an admission that the current undergraduate medical curriculum was inappropriate and needed revision. The organization felt that six years of medical training should be long enough to make graduates competent to practise, provided that the curriculum was appropriate. Fifth-year students were mostly opposed to the policy, and emphasized their preference for incentives to attract health personnel to areas

1 Portfolio Committees are committees for each minister and Government department. They include representatives of all the political parties in the National Assembly. Committees are responsible for discussing and scrutinizing bills and for consultation with the public by means of public hearings. After the portfolio committee has finished its work, the bill goes to the National Assembly to be debated by all political parties.
where their services were most required.

At the time when this policy was being debated, a survey conducted by the Department of Community Health at the University of Natal found that the majority of private practitioners, academic consultants, registrars and first-year medical students were in favour of a one-off compulsory period of service in rural areas following internship (Wadee, 1999). Senior health service managers felt that compulsory service should be a requirement only for doctors who wished to specialize. In view of the widespread opposition to a two-year period of service, the policy decision which was eventually adopted was for a one-year remunerated period of community service for health professionals, starting with doctors.

The policy was finally approved in late 1997, and the President signed it into law in December 1997. Regulations were subsequently published and discussed. It was agreed that community-service doctors would be allowed to choose the area where they would serve from a list of approved health facilities which were to be the initial beneficiaries of the policy. The first cohort of 26 doctors started their community service in July 1998, followed by a further 1088 doctors in January 1999.

The community service policy was intended to redress the imbalances created by the apartheid government. It was reinforced by the strong political will of the ruling party to deliver on its promises of “a better life for all”. And while there may have been disagreement about the best way to redistribute personnel to underserved areas, the universal support for the principle behind the policy was not in question.

3. The research–policy interface

3.1 What is health research?

Historically, basic physical or biological research has almost always enjoyed more recognition in policy development than social science research, which has played a somewhat limited role. According to Hearst and Blas (2001) both national and international forces behind health reform generally have little interest in policy research.

Health research may include:

- pure or basic laboratory–based research
- epidemiological research
- anthropological research
- economic research.

(Walt, 1994)

In terms of the policy discussed in this study, the types of health research most relevant to the policy were epidemiological, anthropological (to a limited extent) and economic. Epidemiological research provided useful health systems information about disease profiles and mortality by demographic and geographical profile, which informed the debate about the persistent health inequities in South Africa (Yach & Buthelezi in HST, 1995; Bradshaw & Buthelezi in HST, 1996). Anthropological - more qualitative - research provided an insight into likely provider responses to the policy (Reid in HST, 1999). Economic research was
able to provide useful insights into the resource allocation problems plaguing the South African health system - information that was used throughout the policy development process to support and legitimize the Government’s position that a policy of remunerated community service was necessary to address health system inequities (McIntyre et al., 1995; Savage & Benatar, 1990; de Beer et al., 1988).

This brings us to the important question: how does research affect policy? There are two main approaches: the rational and the enlightened (Walt, 1994). The former theory suggests that there is a rational process by which research feeds into policy development, with research providing empirical evidence to tackle a policy problem, or generating knowledge that can be applied to policy. Weiss (cited in Walt, 1994:181) suggests that the enlightenment model is more useful: this states that there are a multitude of overlapping policy networks that feed into a dynamic process of information exchange, with research permeating the policy process. From this viewpoint, research raises new questions, sheds light and has a cumulative effect rather than a direct and/or immediate influence as implied by the rational approach.

Weiss’ enlightenment approach provides an insight into the role of research in the development of the community service policy in South Africa. Furthermore, it is consistent with the liberal democratic political system adopted by the post-1994 Government, in which the Government provides a framework for wider participation by interest groups, political parties, the media etc. As shown by the development of the community service policy, a multitude of actors interact with one another and the Government in an open process. The epidemiological, anthropological and economic research had a cumulative effect and was used as a tool to strengthen the position of the Department of Health and ensure that the policy came to fruition.

Walt (1994) cites three key characteristics of research:

- data
- ideas
- argument.

Data is used when a consensus exists, ideas when there is uncertainty and argument when there is conflict. In the development of the community service policy, data was the key research characteristic influencing policy development: it was used by policy-makers and policy advocates alike to build consensus in support of the policy. One of the key reasons why the policy was implemented with minimal opposition was that even those who opposed the policy on technical grounds supported it ideologically. The data highlighting the need to address the maldistribution of doctors were continually reinforced by the Government and those actors supporting the policy (Wadee, 1999). Furthermore, the Government’s ability to use research findings to highlight the existing inequity made it easier for it to strengthen its policy position and hence muster the political will needed to ensure that the policy development went ahead as planned.

### 3.2 Understanding research and its potential role in policy implementation

According to Walt (1994) the distinction between research and evaluation is often unclear, with the term “evaluative research” coming to the fore. It is this evaluation that is most relevant to policy, especially in terms of community...
service. It was at the implementation stage of the policy that research played a more direct and rational role in the policy process. The rational approach (see above: Walt, 1994) is in this instance more relevant, since the research aims to address a particular issue or problem, and the findings have a direct bearing on policy implementation and hence a direct line of contact with decision-makers. This is rational in that it follows a clear pattern with a direct relevance for research in the policy process, with research feeding clearly into policy. In this case, there was a clearer role for research in policy implementation. Once the policy was implemented, the Government conducted an assessment to determine whether the first round of the policy implementation had been successful, which contributed to future implementation.

A qualitative study to monitor compulsory community service for doctors in its first year of implementation was commissioned by the Health Systems Trust with close support from the National Department of Health (Reid & Conco in HST, 1999). Two basic issues were investigated; the experiences of the doctors concerned, and the effect of the scheme on the hospitals and the health services as a whole. The study revealed that the policy to implement compulsory community service was not adequately backed up by clear guidelines to support implementation. This led to some confusion and creative interpretations of what was originally intended by the concept of community service. Furthermore, the implementation of the scheme was devolved to institutional level, where managerial capacity was extremely variable. Some hospital managers and superintendents capitalized on the opportunities afforded by the extra medical staff, and went out of their way to accommodate the community service doctors by incorporating them into an existing team. However, in other situations, particularly smaller hospitals and health centres where leadership was weak and medical services poorly coordinated, the community service doctors were forced to find their own place in the hospital system. The study also mapped out the distribution of community service doctors. Only 45% of the doctors were placed in primary health care facilities: the remaining 55% were accommodated in regional, tertiary and specialized hospitals.

Research therefore played a far more substantial role after the policy had been implemented, with the Department of Health interested in an evaluation of the policy. This was more rational and reflected a direct research-policy interface. Nonetheless, in terms of policy development there was little interaction with research. It was more enlightened in that research was used indirectly to inform the policy development process as much as it was used to support the Government’s ideological position. Hearst and Blas (2001) state that research can play a role in the evolution of policy, but this was not evident. There was little thought and hence research into the actual design of the policy in terms of developing a strategy for implementation. The Department of Health was able to make full use of a political window of opportunity to get the policy into the lawbooks.

Little attention was devoted to: how the policy would be implemented; where doctors would be allocated; how they would be allocated; what the costs and administrative requirements would be; what supervision there would be to provide support; how doctors’ training needs would be met; how the policy would address the health needs of the population. Ideologically, there was support for the policy

---

1 The Health Systems Trust (HST) is an independent nongovernmental organization set up in 1992 as an agent for health systems reform in South Africa. See Annex 1 for additional information.
as addressing the needs of the population, backed up by cumulative research highlighting the current inequitable health system. Yet there was no rational engagement with the research community about how best to implement the policy to meet both the ideological and the practical requirements of the health system.

Research only played a more direct, rational role following implementation. This echoes the South African experience of free maternal and child health care, which was declared in 1994 with no research involvement, but a small-scale evaluation undertaken independently (McCoy, 1996) with Government interaction. At the policy development stage, a multiplicity of civil society actors influenced policy-makers, with researchers seeking to win the ear of the Government in a competitive environment. Perhaps researchers also failed to take advantage of the opportunity to engage more directly with policy-makers when the policy was being designed. This failure may be attributable to lack of health systems research capacity, both within civil society and in the State itself. It was only when the policy was implemented that researchers were able to engage directly with policy-makers in evaluation research. Perhaps, if policy-makers had seen research as playing a more rational role at the development stage, the research-policy interface would be stronger now. Unless this situation improves, the research-policy interface is unlikely to become one that contributes to the call by Hearst and Blas (2001:2) for “… sound research on which to base reforms and guide their evolution”.

4. Policy lessons

4.1 Enhancing interaction among stakeholders

Research needs to relate to the major problems of policy-makers, decision-makers and health managers at all levels, rather than being researcher-driven. If research results are to effect changes in policy and practice, then the researchers need to work hand-in-hand with relevant decision-makers and service providers. Researchers should be encouraged to communicate with the health service, and health service managers should become partners in research and be encouraged to voice their problems.

4.2 Promoting key skills

There is a need to foster new skills and ways of thinking among the various key players within the policy process. For instance, researchers need to foster both policy analysis skills and communication skills.

An understanding of decision-making and policy development is crucial for informing appropriate research. Researchers need to participate in policy development and implementation in order to distil crucial research questions from any of the phases of the policy development or implementation processes.

It is equally important to increase the receptivity of potential users of research. They should be carefully identified from the outset, and efforts made to strengthen the demand for research from this group.

4.3 Promoting evidence-based decision-making

A lot of research results do not succeed in influencing policy change and bring no improvement in services. The main problems are often poor communication of the
results to those who need them, and presentation of the results in a format that is inaccessible to many users. A proactive approach to the dissemination of research information is critical, and needs to be built into the research process right from the proposal development phase. Interaction with potential research users from the earliest stages of the research may help to increase the chances of research results being used. Similarly, research findings need to be packaged and communicated effectively to each group, bearing in mind their different roles, perceptions and attitude to the issues.

In addition, it is important to realize that a single research study can have implications for more than one policy, and even beyond one particular sector. Similarly, policy decisions are often informed by more than one research study. Furthermore, research findings can be used to inform various stages of the policy development process - including facilitating implementation. It therefore becomes imperative for researchers to identify opportunities to make research results known to and discussed by potential users. For instance, consideration may be given to producing research outputs during the research process, as well as at the end of the project, as a way of marketing research findings. Alternatively, research findings and recommendations may be packaged and disseminated in a manner that targets potential users and/or beneficiaries.

4.4 Role of a national research coordinating body

A national research coordinating body (e.g. one which follows the principles of essential national health research (ENHR), an integrated strategy for organizing and managing health research promoted by the Council on Health Research for Development - COHRED) can play a key role in facilitating evidence-based decision-making and fostering interaction among relevant stakeholders throughout the research and policy development processes.

4.5 Lessons from the Health Systems Trust (HST)

National agreement on studies of national importance

HST often prefaces commissioned research with facilitation of a process of multi-stakeholder priority-setting by liaising closely with the health ministry. Key issues for research are identified and appropriate researchers are commissioned to undertake the research projects.

Marketing of research

HST has attempted to ensure that its publications are well produced and made easily available to policy-makers. Media conferences and meetings with relevant officials help to ensure that research results and recommendations reach their target. The employment of a part-time health journalist has meant that more research finds its way to the media and many health policy developments are reported more substantively.

Electronic discussion groups

HST is careful not to advocate any particular viewpoint itself, other than the most general ones, such as commitment to strengthening primary health care, working towards equity, etc. Instead, the organization sees its role as that of providing a platform for dialogue and discussion of key health issues, including policy developments. Some of the initiatives in promoting this approach include hosting
a number of electronic discussion groups aimed at specific target audiences.

**Sustained support for research systems**

HST supports funded projects from development of the proposal to the dissemination of results and recommendations. This means linking researchers with relevant technical support and with their peers; facilitating interaction with the health services; developing a training component within research projects; creating opportunities for sharing information.
Annex 1

Health Systems Trust

The Health Systems Trust (HST) is an independent nongovernmental organization that was set up in 1992. It employs over 50 staff and is controlled by an independent Board of Trustees. HST positioned itself between health systems researchers and the health services, aiming to develop strategies that would create and enhance linkages between health managers and the research community. Specific objectives were outlined as follows:

- to define a systematic programme for addressing the priorities in health systems research, through ongoing consultation with a broad range of interested parties
- to provide funding for the health systems research programme by commissioning or accepting proposals for specific research projects; a conscious effort would be made to encourage and support health systems research in historically neglected institutions and areas
- to ensure that all research results are widely disseminated in order to inform health policy and planning
- to identify and support mechanisms whereby the skills of new researchers are developed, with particular emphasis on redressing colour, gender, class and urban bias; support for skills development would be in the area of health systems research, health planning, epidemiology, health management, health economics and financing
- to facilitate health planning discussions and initiatives.

There are three programmes working in collaboration to achieve the mission of the organization. The research programme is intended to facilitate delivery of primary health care, assess the impact of health policies at the local or district levels and address unresolved issues of equity in health and health care, with emphasis on the development of research capacity.

The Initiative for Sub-District Support (ISDS) operates in 21 district sites throughout South Africa. These are destined to become “best practice districts” from which important lessons can be learnt and fed into policy for the benefit of the entire health system.

HealthLink, the programme for information, communication, and advocacy, encourages and facilitates the use of information for decision-making by various stakeholders. This programme is responsible for electronic and hard copy dissemination of information produced by HST and other stakeholders. The South African health review, the monthly journal Update and the HST website and mailing lists are products of this programme. Another area of work is the partnership with national and provincial legislators for the promotion of equity in health and health care.
Further reading


References


