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# Policy BUDDIES: BUilding Demand for evidence in Decision making through Interaction and Enhancing Skills

## Evaluation Report

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## **Authorship Statement**

JS, TY and CN were involved in the design and planning of the evaluation. TY and CN secured the ethical approval and scheduled interviews. JS and TR collected and analyzed data and interpreted results.

This evaluation was funded by the Policy BUDDIES project as a sub-contract through their project grant through WHO. Neither the funders nor Policy BUDDIES staff had any say in the interpretation or presentation of findings.

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## List of Acronyms and Abbreviations

ART	Antiretroviral therapy
CDBPH	Centre for Development of Best Practices in Health
CEBHC	Centre for Evidence-based Health Care
DMPA	Depot medroxyprogesterone acetate
DOH	Department of Health
EIHP	Evidence-informed health policy
FGD	Focus group discussion
HAST	HIV/AIDS, STI and TB
HIV	Human immunodeficiency virus
KT	Knowledge translation
LMIC	Low- and middle-income countries
NCD	Non-communicable diseases
PI	Principle investigator
PICO	Population, Intervention, Comparison, Outcome
PMTCT	Prevention of mother-to-child transmission
Policy BUDDIES	BUilding Demand for evidence in Decision making through Interaction and Enhancing Skills of policymakers
RCT	Randomized controlled trial
TB	Tuberculosis
TOC	Theory of change
WHO	World Health Organization
WoW	Western Cape on Wellness

# Executive Summary

Evidence-informed health policy (EIHP) describes the process of using high-quality and relevant research evidence to inform health policy-making. Despite its many potential benefits, EIHP does not happen in practice as often as it could. Relevant and high-quality up-to-date research evidence is not always easy to find, or often policy-makers do not have the specialized training or time to find and interpret it.<sup>[1]</sup>

Policy BUDDIES is a collaborative project between researchers in South Africa, Cameroon and the United Kingdom with the aim of increasing policy-makers’ demand for research evidence during health policy-making by building the capacity of policy-makers to find and interpret it, but most notably by building formalized linkages with local, objective researchers in the fields of health evidence, evidence-based healthcare, or knowledge translation. Project teams undertook situational analysis interviews to identify sub-national policy-makers’ capacity and enablers and barriers to demanding evidence during policy-making. Based on these findings, project teams implemented a capacity-building workshop for sub-national policy-makers. After the workshop in South Africa, ‘buddying’ was implemented and researcher buddies were linked one-to-one with provincial policy-makers on six policy cases in order to build relationships, ongoing dialogue and researchers’ and policy-makers’ capacity. In Cameroon, the workshop was not followed by sustained linkages. Future efforts in Cameroon should consider targeting fewer sub-national policy-makers or focusing instead on central-level policy-makers who have more decision-making authority.

## Evaluation approach

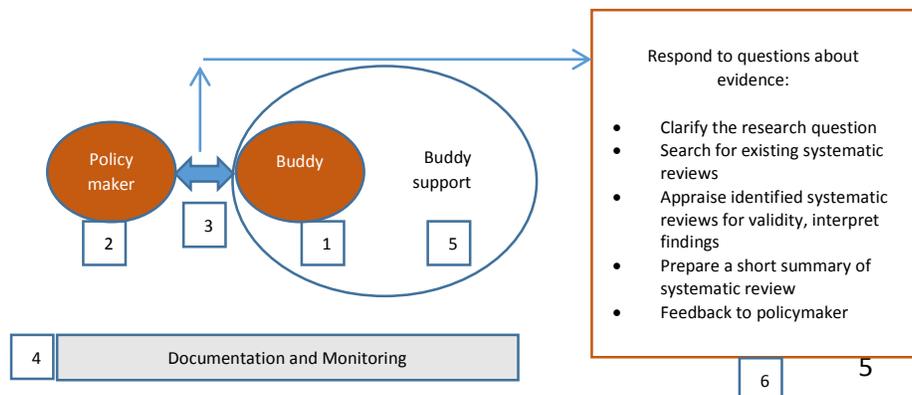
This report presents the findings from a mixed-methods, realist evaluation carried out in May 2015 by PATH. Evaluation data and methods include document review of policy and project documents, in-depth interviews with policy-makers and project staff, and a focus group discussion with researcher buddies. The evaluation had two main objectives:

Evaluation objective 1: To describe how the intervention was implemented, barriers and successes during its implementation and uptake, and learning strategies developed during this process.

Evaluation objective 2: To describe the impact of the intervention on policy-makers’ use of research evidence to inform their decision-making.

## Findings

The Policy BUDDIES intervention was implemented with high intensity and fidelity in Western Cape, South Africa, but not in Cameroon. This was attributed to differences in policy-makers demand for evidence related to their baseline capacity but also to the overall culture and institutional environment of EIHP in each jurisdiction. Western Cape demonstrated an existing awareness of evidence-based medicine and/or healthcare, which was



not the case in Cameroon. The sub-national policy-makers in Cameroon were thought to have limited opportunities to make decisions due to long planning cycles and limited authority at the sub-national level.

The intervention theory of change was explored in detail and we found that in the Western Cape, the intervention generally succeeded in addressing the barriers to EIHP identified during the project's situational analysis. Participants were generally knowledgeable about how to find and interpret evidence, and felt that Policy BUDDIES gave them more confidence to address the claims of powerful experts in policy discussion. The barriers that were not addressed were mainly related to the broader institutional environment of the Western Cape Department of Health. While it was notable that guidance on policy development exists, this guidance does not say anything about research evidence. Other persistent barriers to EIHP include lack of time and access to research publication databases.

Detailed narratives of each policy case suggest that researcher buddies played a helpful and useful role. In fact, their engagement has been formalized and will be ongoing in some cases; in others, they were referred to other provincial and national policy-makers. However, researcher buddies and policy-makers noted that without the formalized mechanism for engagement, they would be less likely to request assistance (the policy-makers) and would be less timely in providing assistance (the researcher buddies), stressing the importance of dedicated time and resources from both parties.

The evaluation observed an increased demand and use of evidence at the individual policy-maker level. Use at the policy case level also occurred, although not always 'instrumentally' as the researcher buddies thought ought to happen. Continued, formalized engagement in Western Cape could expand the reach and impact of EIHP. Cameroon and other low-income countries should consider other models that do not assume a baseline demand for or capacity to use research evidence.

### **Key lessons learned**

- Relationships open the door to mutual respect and learning. Researcher buddies benefited in learning about the policy-making world
- Individual champions must be located in a network
- EIHP faces opportunities – and barriers – in sub-national contexts
- Evidence plays an objective and neutralizing role beside powerful experts
- Organizational-level systems and processes could be improved to support EIHP
- Progress cannot be sustained without dedicated time and resources
- Policy BUDDIES is diffusing within South Africa, but its transfer to other countries will require consideration

## Introduction

Evidence-informed health policy-making (EIHP) is an approach to informing policy decisions with the best available research evidence. It is characterised by systematic and transparent approaches to access, appraisal and use evidence as an input to the decision-making process.<sup>[2]</sup> Evidence-informed policies coupled with well-executed implementation are likely to enable the achievement of health-related goals, lead to the reduction in the burden of disease, and strengthen health systems.<sup>[3]</sup> On the other hand, poorly informed decision-making may contribute to problems related to effectiveness, efficiency and equity in health systems.<sup>[2]</sup>

While the practice of EIHP may be growing in popularity<sup>[1]</sup> and gaining stature from normative bodies,<sup>[4]</sup> its application remains under-optimized. This is partly attributable to the complex and political nature of policy-making, but also partly attributable to mutable factors related to policy-makers' access to and capacity to use evidence. At the macro level, research evidence is only one of many potential inputs into complex policy-making processes, with other forms of information, ideas, interests, and context- and institutional-factors vying for policy-makers' attention.<sup>[5, 6]</sup> Even at the macro- or political level, these barriers are not impossible to address. Some jurisdictions have seen success in building a supportive culture and introducing institutional rules that incentivize EIHP.<sup>[1]</sup> Interventions such as deliberative dialogues can help make political interests more transparent.<sup>[7]</sup>

But even when policy-makers have the inclination to consider evidence, they report barriers to finding and using it, including the lack of time and skills required to acquire and appraise research evidence,<sup>[1]</sup> unavailability of research at the time that it is required,<sup>[1, 8]</sup> irrelevance of research to the needs of decision-makers and presentation of research in formats that decision-makers cannot utilize.<sup>[1, 8]</sup> On the other hand, facilitators and interventions to support and increase EIHP have also been identified, targeting any or all of policy-makers, researchers, the exchanges between them, and their environment.<sup>[1, 9]</sup> These strategies are sometimes referred to as “producer-push” strategies (such as producing summaries of systematic reviews), “user-pull” strategies (where policymakers seek evidence), and “linkage and exchange” (where exchange about what research synthesis can offer is debated, and appropriate questions framed).<sup>[10]</sup> Systematic reviews of “what works” in knowledge translation (KT) and EIHP consistently identify the facilitating role of interpersonal relationships between research users and research producers,<sup>[1]</sup> thus encouraging the development of knowledge broker strategies<sup>[11]</sup> and the application of network science to identify opportunities for strategic linkages.<sup>[12, 13]</sup>

In theory, research evidence could be used at all stages of the policy process: in defining the problem, assessing potential policy and programme options, and in identifying implementation considerations. At each of these policymaking steps, different types of evidence are required to inform decision-making.<sup>[10]</sup> Systematic reviews are well-recognised as among the most internally valid sources of evidence<sup>[14]</sup> and the efficiencies of their use in policy-making have been argued extensively.<sup>[10, 15]</sup> A systematic review is a summary of evidence in which bias has been reduced by the systematic identification, appraisal, and synthesis of all relevant studies on a specific topic according to a predetermined and explicit method. They are more rigorous than traditional reviews and involve a serious attempt to reduce bias and statistical imprecision, thus minimising the risk of wrong conclusions.<sup>[14, 16]</sup>

In a recent systematic review of the barriers and facilitators of evidence use by policy-makers, Oliver et al. (2014) included 33 studies (23%) from low- and middle-income countries (LMIC), indicating a growth

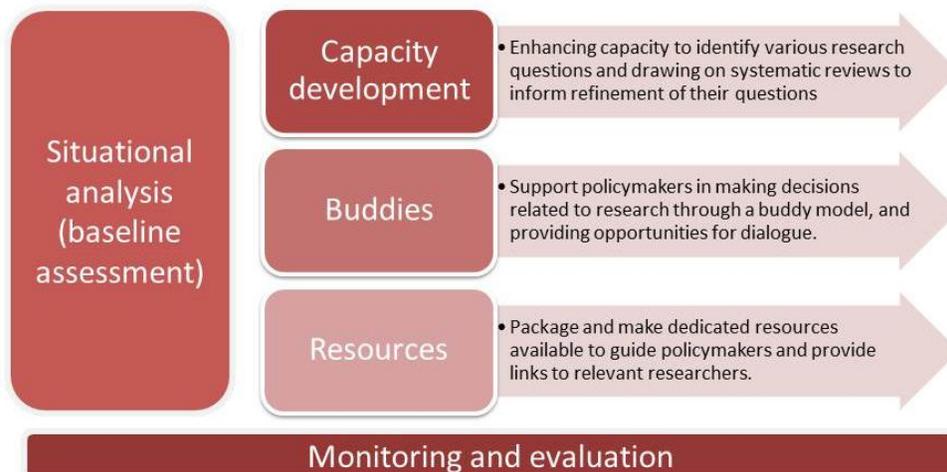
in EIHP (or at least the study of EIHP) in these settings.<sup>[1]</sup> In South Africa and Cameroon, little is known about the implementation of EIHP and the related capacity of policy-makers to follow this approach when making decisions, which is why this project – Policy BUDDIES – set out to understand and enhance the capacity of policy-makers to demand research evidence, as well as the capacity of researchers to understand policy-making and provide timely and relevant support.

### About Policy BUDDIES

Policy BUDDIES was implemented between 2012 and 2015 with funding from the Alliance for Health Policy and Systems Research, World Health Organization. The project team includes researchers from the Centre for Evidence-based Health Care (Stellenbosch University, South Africa), the South African Cochrane Centre, the Centre for Development of Best Practices in Health (Cameroon), and the Liverpool School of Tropical Medicine (UK). The project focused specifically on EIHP in sub-national settings in South Africa (the Department of Health of the Western Cape Government) and Cameroon (four health regions). Policy BUDDIES consists of five phases (Figure 1), commencing with a situational analysis to understand policymakers' capacity, as well as enablers and constraints, related to demanding evidence during policy formulation and implementation, and to map existing communication between policymakers, research intermediaries and researchers in South Africa and Cameroon. The results of the situational analysis phase informed the development of capacity development initiatives and resources to support policymakers and researchers and to enhance their linkages. This included workshops for sub-national policy-makers in both countries on finding and interpreting systematic reviews, followed in South Africa by efforts to build one-to-one relationships between selected policy-makers and the researcher buddies.

*Figure 1 Policy BUDDIES project phases*

## Policy BUDDIES project phases



## Evaluation objectives

This report presents findings from an independent, end-line evaluation commissioned by the Policy BUDDIES project. The evaluation was carried out by the Monitoring and Evaluation department at PATH, led by Jessica Shearer (JS).

The evaluation questions were decided between the project and the evaluation team. They target the intended objectives and outcomes of the project as articulated in the original proposal.

**Evaluation objective 1:** To describe how intervention was implemented, barriers and successes during its implementation and uptake, and learning strategies developed during this process.

Sub-objective 1.1: To describe in detail *how* the intervention was implemented over the course of the project, including the successes and challenges experienced by the project and its personnel.

Sub-objective 1.2: To describe in detail the Policy Buddies intervention (its key features, target audience, theoretical framework, etc.). If the intervention diverged from what was planned, both the initial and final interventions will be described and reasons for the change in intervention design will be described.

**Evaluation objective 2:** To describe the impact of the intervention on policy-makers' use of research evidence to inform their decision-making.

Sub-objective 2.1: To describe the policy issues faced by policy-makers in the intervention and the policy-making context around those issues (i.e., interests, ideas, institutions and external events) in order to understand how these factors might affect the outputs, outcomes and impact of the intervention.

Sub-objective 2.2: To describe whether policy-makers sought, interpreted, exchanged and used research evidence to inform specific health policies before and during the intervention.

## Evaluation design and methods

We undertook a theory-driven evaluation design informed by a realist philosophy which identifies what works in which circumstances, for whom, and why, instead of simply 'does it work.'<sup>[17]</sup>

The evaluation used a mixed-methods case study approach,<sup>[18]</sup> where the cases were each policy issue addressed by Policy BUDDIES. Data were collected through review of documents (i.e., project proposals, project technical reports, the project workshop report, project meeting minutes and emails, messages between researchers on an online forum, policy documents, technical/evidence inputs from the researcher buddies, and news media), in-depth interviews with policy-makers (South Africa), in-depth interviews with researcher buddies in Cameroon, a focus group discussion (FGD) with researcher buddies (South Africa), and structured reflections from researcher buddies (South Africa). See Annexes 1-3 for the data collection tools.

Seven in-depth, semi-structured, in-person interviews were done with policy-makers based in Cape Town during May 2015. One interview was done on the telephone with a former policy-maker from the Department of Health. Two interviews were done on the telephone with project implementers in Cameroon. The focus group discussion included five researcher buddies. All qualitative data collection

was performed by the lead evaluator (JS) who used open-ended lines of questioning based on pre-determined topic guides around themes related to the policy case, the engagement and relationship between the policymaker and buddy, and the use of evidence at both individual and organizational levels for the particular policy case. Interviews were audio recorded and notes were taken by a note-taker. Following interviews, the lead evaluator and note-taker expanded the notes with the aid of the audio recordings. Expanded notes were coded in AtlasTi using a pre-defined codebook based on the evaluation questions and KT theory. The evaluation team (JS & TR) analysed the coded data, with an emphasis on emergent themes, negative data, and triangulation across the multiple data sources. Neither the lead interviewer (JS) nor note-taker were members of the project team, and the evaluator/interviewer identified herself as an “independent evaluator” at the start of each interview in an attempt to reduce bias.

Permission to conduct the study was obtained from the Western Cape Government Department of Health Department in South Africa and the Ministry of Health in Cameroon. Individual consent forms were signed by participants that fully explained the purpose and conduct of the study. Participation in this study was voluntary and participants were informed of their right to withdraw at any moment. The confidentiality of the participants was protected and data were analysed using participant numbers. Ethical approval was obtained from the Stellenbosch University Health Research Ethics Committee (N13/02/021) for the situational analysis and was amended for the final evaluation.

## Findings

*Table 1 Summary of the data sources used in the evaluation*

Data source	Quantity	Characteristics	Country
Documents	~40	Ranging from policy documents, to project documents, to researcher buddies’ structured reflections.	Both
In-depth interviews with policy-makers	7	All provincial-level; all but one directly engaged with Policy BUDDIES	South Africa
FGD with researcher buddies	5 participants in one FGD	Researchers in evidence synthesis and health services research affiliated with Stellenbosch University or the South African Cochrane Centre	South Africa
In-depth interviews with project implementer in Cameroon	2	Project implementer/researcher based in Centre for Development of Best Practices in Health	Cameroon

### Overview of policy-making context of the Western Cape Province and Cameroon

South Africa is a constitutional democracy and consists of three structures of government, namely, national, provincial and local governments. It is divided into nine provinces, each with its own provincial legislature. Provincial governments are bound by laws and policies passed at national level, but can

develop their own laws and policies within this framework to suit their specific needs. Provincial legislatures may pass their own constitutions subject to the provisions of the Constitution of the country.

The Western Cape Province has a different majority political party in the provincial legislature (Democratic Alliance party) than in the national government (African National Congress party), creating additional potential veto points as compared to other provinces. The Western Cape Department of Health is responsible for all aspects of policy-making, adaptation, implementation, planning, and evaluation; decisions are made in the department and signed by the provincial Minister of Health.

The Western Cape Province has a GDP/capita of USD \$8964 – the second highest in the country -- with an annual budget for the Department of Health over USD \$1 billion for 5.8 million population.<sup>[19]</sup> WHO reports that South Africa spends USD \$593/capita on health expenditures compared to USD \$67/capita in Cameroon.<sup>[20]</sup>

The national health system in Cameroon consists of three levels, namely: the central level, which is responsible for formulation of strategies for implementing the national health policy as defined by the Head of State; the intermediate level consisting of 10 regional delegations of health, which is responsible for strategic technical support to the districts; and the peripheral or district level, which is the operational level. Health care in Cameroon is guided by the Health Sector Strategy, which represents a holistic response by the Government of Cameroon to major health challenges as well as the need to protect and preserve public health. Cameroon’s GDP/capita is USD \$1328.<sup>[21]</sup>

## 1.1 Implementation of the Policy BUDDIES project

Policy BUDDIES was implemented differently in the Western Cape Province and Cameroon. Overall, the Western Cape Province experience demonstrated substantially more fidelity to the original intervention design. Table 2 shows the status of key planned project components by country.

*Table 2 Project activities by jurisdiction*

Activity	Cameroon	Western Cape (South Africa)
Situational analysis	Four focus groups completed in 2013.	Ten policy-makers interviewed in 2013.
Workshop	Completed in January 2014 with 25 policy-makers from four regions.	Completed in November 2013 with 24 policy-makers from Western Cape Province Department of Health.
Buddying	Did not occur.	Researcher buddies were matched with policy-makers based on need; relationships built over duration of project; relationships have extended to other policy-makers and issues.
Resources made available	One summary of a systematic review on community-based strategies to increase immunization coverage was shared with policy-makers.	Numerous technical inputs provided by researcher buddies in response to requests from policy-makers

In the **Western Cape Province**, the bulk of the project time was devoted to the buddying component. Individual researcher buddies varied in terms of how much time they spent working with and responding to questions by policy-makers, but overall their level of effort was quite substantial.

Research buddies in the project were primarily selected for their experience and expertise in evidence-based health care and policy. Some researcher buddies were compensated for their role as staff members of the Centre for Evidence Based Health Care, for which this activity was part of their job role. Researcher buddies did not receive formal training, but were encouraged to use each other as resources and support, including informal ad hoc mentorship, as needed, and exchanges at dedicated monthly buddy meetings. Researcher buddies participated in workgroups, presented at meetings, called, and/or e-mailed with their policy-maker and teams from the Department of Health.

In **Cameroon**, the project team organized a workshop to build the capacity of regional policy-makers to find and interpret systematic reviews, as well as the overall rationale for EIHP. While the workshop was well-received according to workshop evaluations, it did not lead to ongoing engagements between the project and the policy-makers. The project staff noted that repeated efforts were made to contact and engage with policy-makers, but that policy-makers did not have the time to engage, as they were busy managing a number of other specific and general crises in their roles as sub-national policy-makers. Further, project staff noted that sub-national policy-makers in Cameroon lack the institutional support, culture, and incentives to use evidence: “They have responsibility without authority.” (Buddy, Cameroon) At the sub-national level, they apparently have very limited opportunity to make their own decisions; the decision-making culture is sufficiently hierarchical in Cameroon to limit a given policy-maker’s likelihood of suggesting a solution (or problem) to his/her superior.

Despite the notable challenges and barriers to using evidence in Cameroon, the project might have been able to accomplish more by changing course mid-project. As suggested by the project staff during interviews, they might have had greater success by strategically targeting and working with a smaller number of strategically selected regional policy-makers, perhaps around socialization of research and evidence in general. The project team might have also considered changing course and targeting a small number of national-level policy-makers who might have had greater opportunities and incentives to demand and use evidence. Indeed, these suggestions came out in interviews, suggesting that the project staff learned from the implementation of the project and have ideas for how to improve it. The experience in Cameroon illustrates the need for KT and EIHP interventions to be flexible, adaptable, and iterative.

## 1.2 The Policy BUDDIES theory of change

The final Policy BUDDIES intervention and accompanying theory of change (TOC) was developed following the situational analysis. As required through the grant, they were required to develop an intervention “to enhance the capacity of policymakers to ask for, demand, and use systematic review evidence to inform research question formulation and prioritization to inform policymaking.”<sup>[22]</sup>

The original proposal demonstrated a good understanding of the barriers and facilitators of evidence use in policy-making. The proposal included citations of the empirical research on this topic, including systematic reviews of “what works” in KT and EIHP.<sup>[22]</sup> To contextualize these factors for South Africa and Cameroon, the team performed a situational analysis comprising of interviews with provincial/regional level policy-makers (Western Cape=10; Kwazulu-Natal=2; Cameroon=four FGDs in four regions, Centre, Littoral, Adamawa, and North West Regions). The situational analysis identified some of the same, and some slightly different, barriers and facilitators to research use. These factors are summarized by the evaluation team in Table 3 based on the updated version of the systematic review cited in the Policy BUDDIES proposal<sup>[1, 23]</sup> and the factors identified in the project’s situational analysis.

*Table 3 Barriers and Facilitators to EHP based on systemic review and situational analysis*

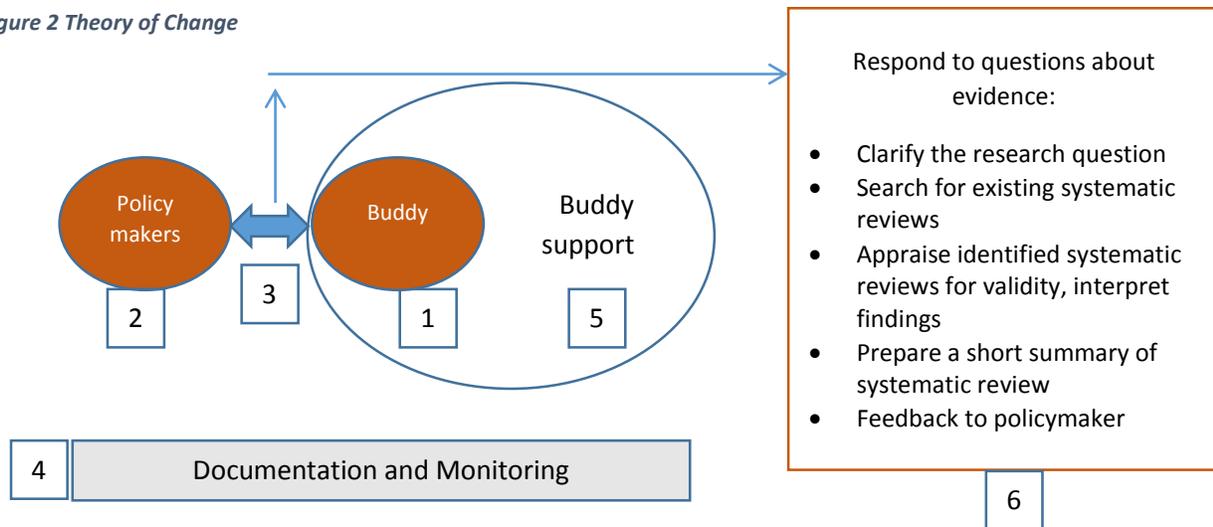
<b>Barriers to using research evidence (Oliver et al. 2014 systematic review)</b>	<b>Facilitators of using research evidence (Oliver et al. 2014 systematic review)</b>
Lack of availability of research	Availability and access to research/improved dissemination
Lack of relevant/reliable research	Collaboration
Having no time or opportunity to use research	Clarity/relevance/reliability of research findings
Users not being skilled in research methods	Relationship with policymakers
Costs	Relationship with researchers/info staff
<b>Barriers identified during situational analysis interviews with policy-makers</b>	<b>Facilitators identified during situational analysis interviews with policy-makers</b>
Research is not the only driver in policy decisions (other important drivers include personal expertise, costs and feasibility of the policy, preferences of managers)	Good relationships between policymakers and researchers are essential
Policy-makers don't have time to search for evidence, often evidence isn't available when they need it	

Following the situational analysis, the project developed the following intervention theory of change. This theory of change was first described in the Year 1 Report and included the following figure (Figure 2). The following rationale was provided for this 'linkage and exchange' <sup>[9]</sup> model:

*Drawing on the literature described above and on findings from our situational analysis, we are linking policymakers and researchers in order to enhance their interaction and dialogue, to present an opportunity to learn more about each other's worlds and identify areas of work related to evidence-informed decision making. This is not following a mentorship model, but rather an approach we call 'buddying' where both role players are working together. The process is detailed in the following section.*

One notable difference from what was planned was the fact that the project initially intended to build capacity within policy-makers, but following the situation analysis they realized that capacity must also be built within researchers. Thus, the following theory of change was proposed:

Figure 2 Theory of Change



Each mechanism (1-6) was originally described as follows:

- 1) Researcher buddies are experts in evidence-based healthcare and KT;
- 2) Policy-makers (health programme managers and coordinators) selected to participate in the programme have priority questions identified through the situational analysis interviews and capacity-building workshops;
- 3) Researcher buddies and policy-makers are linked 1:1 with the buddy driving the process for the identified question. They will meet face to face, through email, telephone, text messaging and Skype;
- 4) Researcher buddies will document all interactions as well as each case, to be written up as case studies;
- 5) Researcher buddies engage with each other on a monthly basis to create a researcher support group;
- 6) Leading to researcher buddies' awareness of requests for evidence from policy-makers. Researcher buddies will relay requests to the larger group, and the project team will work together to respond.

While the original TOC did not explicitly include evidence use as an outcome or impact of this project, the evaluation team believes it would be remiss to ignore it. Thus, the evaluation will also explore a seventh domain: "Evidence-informed policy-making" or the increased *use* of research evidence at the individual and organizational levels.

### Was the intervention 'fit for purpose'? Unpacking the assumptions behind the theory of change

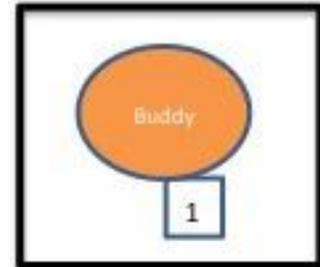
The following section proceeds as follows. For each numbered mechanism in the TOC, a brief overview of the intervention activities, as originally planned, is provided. This follows with a description of the assumptions underlying each mechanism, and whether these assumptions were addressed by the intervention or not. It is important to note that while many of these assumptions were articulated by the project (implicitly or explicitly), the evaluation team sought to identify additional assumptions and unpack them in order to identify potential mismatches between the problem and the intervention, and

whether a failure to address those mismatches (or gaps) may have reduced the intervention's effectiveness.

This section ends with a Fit for Purpose Scorecard (Table 4) denoting whether the intervention ultimately addressed barriers to and facilitators of the use of evidence identified in Table 3.

***Mechanism 1: Researcher buddies are experts in evidence-based healthcare and KT***

The assumption behind the first point in the diagram was that in order to effectively fulfil the envisaged duties of a researcher buddy, researcher buddies would need to be experts in the field of health evidence, evidence-based healthcare, or knowledge translation (KT). Namely, they should have the skills and time/resources to gather and critically appraise evidence, synthesize information, and interpret information for the specific policy issue/context.



Planned duties included:

- Provide input on identifying and clarifying research questions; draw on systematic reviews and existing summaries of systematic reviews e.g. SUPPORT summaries, existing policy briefs and related resources e.g. SURE policy briefs, SURE Rapid Responses
- Link policymakers with relevant research organisations and other appropriate researchers
- Assist policymaker in making decisions related to research and finding pertinent available research through regular interaction with the designated policymaker

**The following programmatic assumptions were ultimately addressed through the intervention:**

*Assumption 1.1: Adequate numbers of researchers exist who are willing to act as researcher buddies; some of these individuals are paid through the project and some will be willing to volunteer their time.*

The project implementers, CEBHC and South African Cochrane Centre, are in a unique position to offer a deep pool of talented human resources for evidence synthesis, KT, and EIHP. Some researcher buddies received salary support through the project although others volunteered. They tended to view their participation to align with their personal and institutional mandate around EIHP. Researcher buddies from more traditional research backgrounds or without such an institutional mandate might perceive the same positive incentives and motivation to participate.

*Assumption 1.2: Researcher buddies have adequate time and institutional support to do this work.*

Researcher buddies consistently responded that the time commitment was their largest challenge during the project. While the time spent was also viewed positively – in that it succeeded in building relationships and producing high-quality technical inputs for the policy-makers – it was thought to be limiting for the sustainability of the project. One researcher buddy noted that their responsiveness was partly related to the fact that they were bound by project deliverables. This is an honest reflection that bears consideration by project funders and managers.

*Assumption 1.3: Researcher buddies have enough generalist knowledge across a range of health content areas that they are able to respond to evidence requests in a timely way, while being able to appropriately assess the quality of the evidence.*

The researcher buddies comprised researchers with content expertise across a range of issues relevant to policy issues in the Western Cape Province, including nutrition, health systems, and HIV clinical guidelines.

*Assumption 1.4: Researcher buddies possess behavioural traits that make them effective knowledge brokers, including superior interpersonal skills, communication skills, motivational skills, being a skilled mediator, flexible and diplomatic (see review of knowledge broker interventions in <sup>[1]</sup>).*

Researcher buddies did not receive training in communication or knowledge brokering, per se, but were well regarded by the policy-makers. Incorporating training, or selecting buddies according to positive traits might be considered in future projects.

*Assumption 1.5: Researcher buddies are located externally leading to their neutrality and credibility.* <sup>[1]</sup>

Nearly all policy-makers stated that one of the benefits of the buddies was their neutrality and objectivity. However, their perceived neutrality was not attributed only to their external location. Researcher buddies were frequently contrasted with other internal and external academic and clinical experts involved in policy-making who were *not* perceived to be neutral. In contrast to these other experts with fixed research agendas, and thus a perceived bias towards their findings, or their research agendas, the researcher buddies were perceived to be much more objective, as was the evidence they brought to the table, and the system used for bringing that evidence:

*There were many pro-breastfeeding advocates, and they quoted only quoted evidence that supports their position, but evidence obtained from Buddy is objective and answers the question. (Policy-maker 1)*

*Yes, because of the system that is being used. It's not just 'let's look at our publications.' It's the bias issue. We're policy-makers, we're not only interested in seeing publications that our names are attached to. (Policy-maker 3)*

*[Buddy] is somebody neutral who is an evidence specialist, [buddy] can verify what academics tell us. (Policy-maker 7)*

As has been observed elsewhere, the researcher buddies' neutrality was also viewed as a drawback, but only by one policy-maker, "Big thing is the objectivity of buddies which is great; but sometimes they are too neutral." (Policy-maker 1)

Many policy-makers reported feeling more credible themselves upon receiving evidence from Policy BUDDIES:

*Respondent: We [policy-makers] would look for evidence here and there but it's not formal academic work, so being linked to Centre for Evidence Based Healthcare for this purpose, I feel more comfortable because they're experts in their field. If I said "I searched for evidence" I'd feel comfortable but if I say I worked with the Centre I feel more confident. So you know the difference between comfort and confident in a setting like this is big.*

*Interviewer: And do you think it makes you come across as more credible?*

*Respondent: I think so, yes. Absolutely. (Policy-maker 3)*

As suggested by the TOC, the evaluation found that the effective provision of high-quality evidence by researcher buddies ultimately induced further demand for evidence amongst policy-makers who recognized its value to their daily work.

*Assumption 1.6: Researcher buddies will enhance their understanding of policy-making in order to be able to translate between the fields of research and policy.*<sup>[1]</sup>

While many of the researcher buddies did not begin as experts in policy-making, they reported having learned a great deal through their experience, but that this learning must continue. Future project should consider training buddies in theories of policy-making.<sup>[24]</sup>

*As a buddy, I learnt that we have much to learn about decision-making in our government environment. (Buddy 5)*

### **The following programmatic assumptions were not addressed through the intervention:**

*Assumption 1.7: In addition to evidence on the effectiveness of health interventions, researcher buddies have expertise in finding, critically appraising, and synthesizing other forms of evidence, including evidence on implementation strategies, policy models, etc.*

Policy-maker respondents stated a desire for examples of operational strategies, implementation strategies. During interviews, while policy-makers expressed satisfaction with the evidence (largely on effectiveness of interventions or strategies) that was shared, they expressed ongoing desire for examples of policy models and operational strategies. Part of this mismatch might be due to the focus put on conventional systematic reviews of effects. While there are many reasons to draw first, or solely, on conventional systematic reviews, they might not always be the best research paradigm for policy-makers' questions (see text box).

Similarly, the intervention placed significant weight on the utility of the "PICO" framework (Population, Intervention, Comparison, Outcome) to guide framing policy-makers' questions, but some researcher buddies wondered whether this framework was ultimately too inflexible. However, researcher buddies demonstrated growing flexibility and reflexivity, which will serve the project well in the future.

*This often means that you need to not be constrained by a stringent "one size fits all" theoretical approach, but rather 'think on your feet' and be less prescriptive about how evidence should inform decisions. (Buddy*

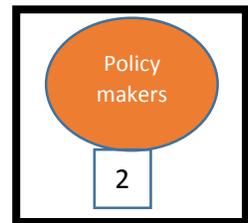
### **"What works?" or "Why does it work?"**

Conventional systematic reviews follow an aggregative approach, in that they use systematic and rational processes to find, appraise, and interpret results of primary studies in order to *test* theory, describing "what works?"<sup>[50]</sup> However, not all questions posed by policy-makers need a "what works" answer. They might want to know "why does it work (or not work)?"

Interpretive syntheses, including meta-ethnographic and critical interpretive syntheses, are designed to *generate* theory through induction and interpretation, and thus may be better suited to asking "*why* does it work (or not)?"<sup>[51]</sup> The distinction between interpretive and aggregative methods might be a useful one to consider when framing policy-makers' questions and looking for rigorous, complex evidence to answer them.

5)

**Mechanism 2: Policy-makers (health programme managers and coordinators) selected to participate in the programme have policy questions for which they want evidence-based research to inform their decisions.**



By choosing policy-makers in a selective manner, Policy BUDDIES hoped to gain champions who would be invested in using evidence and incorporating the researcher into their work. By using the workshop and also individual situational analysis interviews, Policy BUDDIES helped policy-makers to identify research questions for their researcher buddy. The intervention also assumed that policy-makers' demand for research evidence and capacity to find it is increased through their participation in a systematic review workshop.

**The following programmatic assumptions were ultimately addressed through the intervention:**

*Assumption 2.1: Policy-makers are open to using research evidence and have some unmet demand for it.*

Independent of Policy BUDDIES, policy-makers were aware of evidence-based medicine, evidence-based health care, and evidence-informed policy, apparently stemming from a previous deputy director of the Department, who advocated for evidence-informed policy, "He said 'if there's no evidence, I don't want to hear it.'" (Policy-maker 1)

At an individual level, all policy-makers expressed demand for evidence, as well as a perception that they should be finding and using evidence in their jobs. The following quote is from the respondent who had not yet engaged fully with Policy BUDDIES:

*I know I have to do it, but I want to leave it to the last minute because the whole process doesn't make sense to me yet. If I were more comfortable and knew what to do, it would go faster. (Policy-maker 5)*

As was the case in the situation analysis, most policy-makers attributed their ongoing unmet demand for evidence to their lack of time to search for and interpret evidence, as well as limited or no access to research article databases.

*Assumption 2.2: Policy-makers, with the help of researcher buddies, will be able to define the problem and pose a question in a format that is answerable and valid.*

## Demand for evidence in Cameroon

The project team in Cameroon reported limited demand for research evidence from policy-makers following the workshop. Plans to follow up from the workshop were never realized, despite frequent outreach from project staff to attendees. The project attributed this limited demand for research evidence to:

- Policy-makers have no training and very little exposure to EIHP. It is not required of them and they have yet to observe its benefit.
- Policy-makers, particularly at the regional level, are extremely busy and have very little time to engage
- Policy-makers at the regional level have limited authority to make their own decisions; they implement what is decided at the central level. When they have a problem they must go up the hierarchy to solve it.

An example was provided of one policy-maker at the central level who requested and used research evidence because he had a specific problem to solve, and evidence could help solve it.

The intervention addressed this assumption through the workshop. Significant time in the workshop was spent on developing and framing questions according to PICO. Policy-makers with clear questions of effectiveness appreciated this format and found it useful.

As noted in Mechanism 1, the PICO format did not always seem to be the best fit for the types of questions posed by policy-makers. This is not to say that policy-makers lacked skills or practice in formulating questions, but rather that PICO lacks flexibility in accommodating real-world questions that policy-makers are faced with.

*Assumption 2.3: Policy-makers have the individual-level capabilities, capacity, motivation, or incentives to use evidence in their professional decision-making.*<sup>[1]</sup>

Evidence may inform individuals' perceptions and understanding of a policy issue through their reflections on it or through sharing it or discussing it with others. In theory, the policy-makers in the Western Cape Province all had the capabilities and motivation to use evidence to inform their work, and to share it with colleagues. Their capabilities were explicitly addressed through the workshop and ongoing engagement and capacity-building. Through analysis of the interviews, we found that policy-maker respondents were generally able to articulate the generalities of the evidence that they had engaged with. Only one policy-maker was truly able to articulate the findings, sources of bias, and interpretations of the evidence he/she received. Others seemed to have been informed on a more conceptual, or confirmatory level. Overall, interaction with research evidence is a skill that requires practice (as noted by nearly all policy-makers), and ongoing engagement and practice is necessary to sustain and further built this skill in the Western Cape Province, "It was new for me... It was good. Challenging. Application of the new skill is always an issue." (Policy-maker 3)

When it came to exchanging or discussing evidence with colleagues, only one policy-maker reported doing so outside of formal meetings or presentations. Those who did not exchange with colleagues reported a desire to do so, but lacked dedicated time.

**The following programmatic assumptions were not addressed by the intervention:**

*Assumption 2.3: Policy-makers have the individual-level capacity, motivation, or incentives to use evidence in their professional decision-making (some components addressed above).*

While part of this assumption was addressed (see above), the intervention did not address all aspects of their job environment, which continues to pose a significant barrier to evidence use. Lack of time to dedicate to searching for and interpreting evidence was a barrier reported by all policy-makers: "I must say, I still didn't have time to practice it." (Policy-maker 7)

Some respondents reflected that the formalized nature of Policy BUDDIES helped in that it structured time in their diaries to participate. Respondents reported a desire for more structured follow-up in the future as an impetus to practice their new skills and continue to find and use evidence.

## Linkages in Cameroon

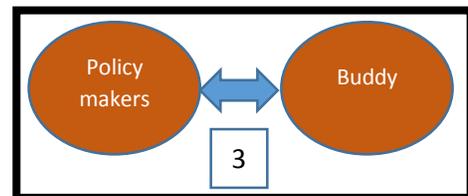
The project in Cameroon did not lead to linkages between researchers and policy-makers, despite repeated offers to the policy-makers. The team suggested the following options to build linkages:

- A longer workshop, which would culminate in a KT product, might help;
- Sending the researcher buddies and a research assistant to the field to work directly together for a period of days or a week;
- Purposively identifying ‘champions’ likely to use evidence might increase the successful outcome of the linkage.

Respondents also noted the lack of supportive structures and processes in their organization. One policy-maker notes that there were no “forums for critical thinking” in which to engage with colleagues around evidence (Policy-maker 3). Other lamented the lack of structure in general in policy-making:

*There’s not much structure in policy development, or there wasn’t. This was improving, even before policy buddies, but Policy BUDDIES helped... Helped us develop all of policy-making into a more structured process. (Policy-maker 7)*

Others noted that while rhetoric around evidence-informed policy may exist, actual processes or rules to use it were lacking. Of note, a departmental circular on how to formulate a policy makes no mention of the potential role for research evidence.<sup>[25]</sup> When asked, policy-makers could not think of any documentation or written guidance on evidence use in the department.



### **3: Researcher buddies and policy-makers are linked 1:1 following situational analysis interviews and capacity building workshop**

It is assumed that a 1:1 linkage between researcher buddies and policy-makers will create the strongest sense of ties and allow for researcher buddies to have clear deliverables and policy-makers that will use those to shape policies.

#### **The following programmatic assumptions were addressed through the intervention**

*Assumption 3.1: Policy-makers and researcher buddies will have time and motivation to engage with each other.*

Both parties reported challenges in schedule time with each other. Researcher buddies, in particular, noted that policy-makers would often re-schedule planned meeting due to last-minute conflicts inherent with their roles. Thus, researcher buddies were required to be flexible, adaptable, and client-oriented.

*Assumption 3.2: Policy-makers will trust the researcher buddies and the quality of their work.*

The existence of trust between researcher and policy-maker has been observed to increase the likelihood that evidence will be exchanged and used.<sup>[1]</sup> Policy-makers reported strong levels of trust for their researcher buddies, in large part due to their perceived objectivity and neutrality.

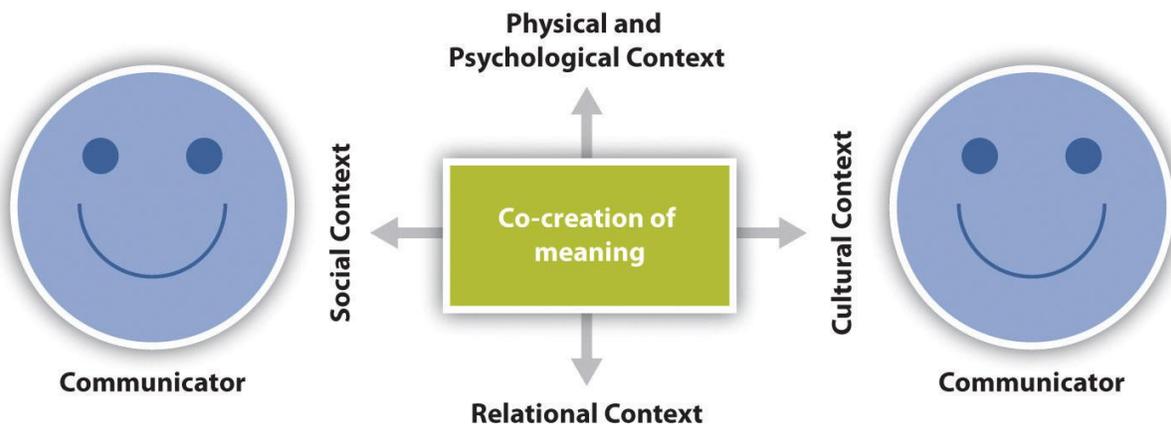
*Assumption 3.3: The linkage results in the effective exchange of evidence.*

Communication is a dynamic, complex and reciprocal social process (see Figure 3). Communication models posit that senders and receivers are mutually responsible for the effectiveness and effect of communication, but that communication (and the meanings extracted) also depends heavily on personal and environmental filters. This is to say, the ultimate effectiveness of Policy BUDDIES depends on the quality of communication between the parties. The effectiveness or quality of this communication was aided through the workshop that facilitated shared meaning between the researcher buddies and policy-makers. Ongoing interactions will continue to smooth the communication between the parties by developing shared meaning and ability to understand elements of social, physical and psychological, cultural, and relational context.

*It takes a lot of time just to talk and build relationships. One week for example I felt I didn't get any work done, because all I did was talk. But actually I did because I was building relationships. Just talking does achieve a lot but it takes time. (Buddies' FGD)*

*The policy-maker and researchers speak different languages, particularly if not both familiar with evidence-informed policy-making concepts. (Buddy 3)*

**Figure 3 Transaction model of communication**



As to be expected from any intervention, some linkages were more successful than others. Some researcher buddies reported sending evidence, or question clarifications, and never hearing back. In one case the researcher buddy posited that perhaps the lack of follow-up was because the researcher buddy had asked the policy-maker to clarify the question in the PICO framework.

Ultimately, the 1:1 linkage was viewed positively by both parties, and indeed the central component of the intervention:

*We don't have their capacity/skills and they don't have ours. The linkage is the key to make the process smoother. (Buddies FGD)*

**Mechanism 4: Researcher buddies document their process**

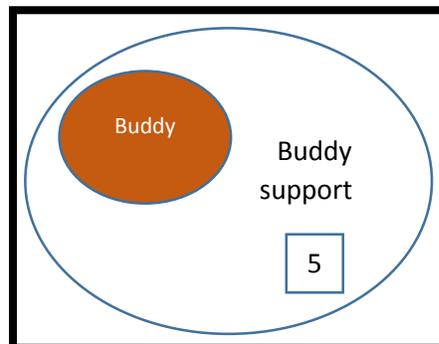


Documentation at the level of the project has been helpful in communicating to the donor and for the final evaluation. However, researcher buddies generally did not find the written documentation through the online SharePoint to be very useful, and instead preferred the face-to-face interactions during the monthly meetings.

**Mechanism 5: Researcher buddies engage with each other to create a researcher support group**

By creating a Policy BUDDIES community for researchers they will be better able to navigate challenges that occur in the Policy BUDDIES programme and be able to see connections and leverage networks for the benefit of evidence-informed policy.

**The following programmatic assumptions were addressed through the intervention:**



*Assumption 5.1: Researcher buddies will produce higher quality work if they're able to trouble-shoot problems and seek clarity around evidence with each other.*

Researcher buddies commented that they appreciated the opportunity to meet monthly and trouble-shoot. All researcher buddies reported exchanging evidence with each other during these meetings, and helping each other answer policy-makers' questions. In this way, the researcher buddies were fully networked.

*Assumption 5.2: Researcher buddies will be made aware of others' networks and will have the skills or time to engage with these other networks.*

Researcher buddies did not report accessing other researcher buddies' networks, although they did receive support from project colleagues in other institutions.

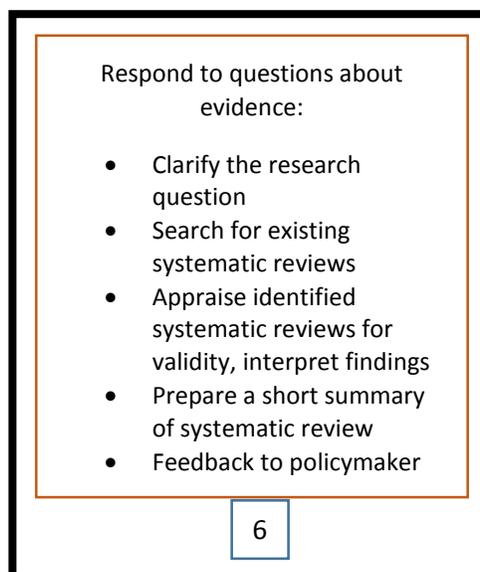
**Mechanism 6: Leading to increased demand for evidence from researcher buddies**

By regularly meeting and interacting with researcher buddies, policy-makers will have access to tailored research in order to best inform their policies, and will further demand it.

**The following programmatic assumptions were addressed through the intervention:**

*Assumption 6.1: The policy-maker: researcher buddy interaction will lead to demand for evidence.*

While in many ways the policy-makers already had an unmet demand for evidence prior to Policy BUDDIES, the project has succeeded in creating (or at least in making transparent) additional demand from within and outside the original policy-maker participants. As noted earlier, an ongoing engagement builds trust and shared understanding, facilitating the effective communication of evidence.



Many policy-makers appreciated the structured process of the project, and requested further, ongoing, formalized engagement. One buddy noted that ongoing, regular meeting may stimulate thinking even in the absence of an immediate evidence need.

Figure 4 shows the evolution of the network of evidence exchanges over the course of the project. Panel A shows the original project network, where all researcher buddies are connected and each researcher buddy is formally connected with one or two policy-makers. Panel B shows the end of the project (May 2015) where additional linkages were formed between and within researcher buddies and policy-makers. Linkages within policy-makers are fewer than other types of linkages, and a number of policy-makers said that they would like to have more discussions with their colleagues, but lack the time and structure to do so.

*Additional linkages we have made are a big success. We are now getting additional requests from other policy-makers who were not involved in the project. So our network has expanded through our collaboration with policymakers in the project. (Buddies' FGD)*

*Figure 4 Networks of evidence exchange at start of project (Panel A) and end of project (Panel B)*

Panel A. Evidence exchange network at start of project    Panel B. Evidence exchange network at end of project



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Figure legend:

Circles represent actors in network. Red circles are researcher buddies; blue are provincial policy-makers; green represents national policy-maker in Panel B. Ties represent whether evidence was exchanged as reported during interviews.

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*Assumption 6.2: Relevant/reliable research evidence exists.*

The TOC assumes that there is evidence to exchange. For some cases – as is to be expected – relevant evidence did not exist. In these cases the researcher buddies did their best to draw on single studies, or to help contextualize evidence from other settings. The relevance issue was particularly problematic for newer policy issues. For cases where the issue was new to the Western Cape Province, such as the issues related to chronic disease adherence and integration, evidence from high-income countries was considered for its relevance. It is important to note that the Western Cape Province health system more closely resembles that of a high-income country than that of a typical Sub-Saharan African country in terms of resources and organization. For issues related to HIV, which comprise a large part of the department’s policy agenda, the province and nation are uniquely situated to produce relevant research. Thus, although evidence transferability posed somewhat of a challenge in the Western Cape Province, the transferability of evidence would be even more difficult in other African countries.

***Mechanism 7: Demand for evidence will lead to its use in policy-making***

The original TOC does not include evidence use as an outcome, but we include it here.

**The following assumptions were not addressed through the intervention:**

*Assumption 7.1: “Evidence use” means that high-quality and relevant evidence (i.e., systematic reviews) is used instrumentally to identify and inform the choice of policy options.*

The researcher buddies’ focus group discussion identified the tension between what researchers thought “evidence-informed health policy” ought to mean, and what it seemed to mean in reality for policy-makers. In unpacking these differences, it appears as though the researcher buddies defined

“use” as a systematic, transparent, and instrumental process, akin to “instrumental” or direct, problem-solving use as defined in the literature. [26-28] Researcher buddies thought that perhaps policy-makers were less concerned with evidence use as an open-ended process, but rather an outcome (i.e., that one could claim their policy was “evidence-based”). While instrumental, problem-solving use occurred in some cases, it is worth setting expectations that symbolic or conceptual uses occur far more often in policy-making. [6, 26]

*Buddying taught me that when engaging with policymakers about evidence, one needs to be flexible and depending on the nature and format of the engagement, one needs to try and find the most feasible mode of communicating the evidence. This often means that you need to not be constrained by a stringent “one size fits all” theoretical approach, but rather ‘think on your feet’ and be less prescriptive about how evidence should inform decisions. (Buddy 5)*

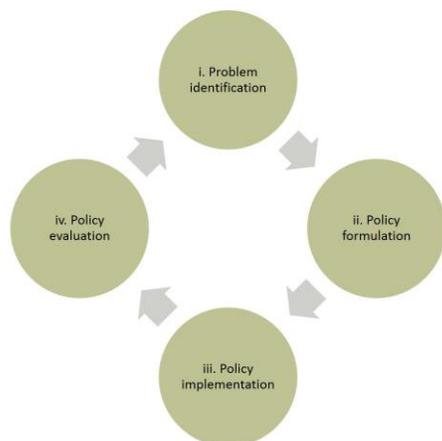
**Assumption 7.2: The policy issue is amenable to being informed by evidence.**

The project did not only select issues that had a clear opportunity, or window, for evidence to inform policy instrumentally. Such criteria might pertain to characteristics of the issue (i.e., whether it is highly salient or uncertain), or aspects of the process (i.e., policy-makers in this context had more experience with using evidence instrumentally to inform problem identification, instead of using it to identify policy options or implementation considerations). As noted by one buddy upon reflecting on the policy stages diagram (see Figure 5) in the focus group:

*The government focuses basically only on problem identification and implementation. The two circles on the side (policy formulation and evaluation) are two gaps. The people lack the knowledge and skills for policy formulation. (Buddies’ FGD)*

However, interviews with policy-makers demonstrated that there remained an unmet demand for evidence (or guidance, perhaps) on policy models and operational considerations, somewhat contradicting the buddy’s assertion.

*In terms of community based services, what is it we need to deliver -- what are supply chain, HR, finances -- best applied to give effect to what is expected in terms of outcomes. If we need to put systems in place centrally so that all others have access to same platform or whatever... Yes, models... we didn’t find models. (Policy-maker 3)*



**Figure 5 Policy stages**

It may be an issue that different forms of evidence are required for different policy stages (and issues) and that this clarity has yet to be agreed upon by all parties.

Aside from instrumental uses, the typical use of evidence is to justify a pre-determined position (i.e., symbolic use) either to operational colleagues, or to the national level. Reflecting on the fact that evidence supported task-shifting – after the decision had already been made – one respondent commented:

*The evidence showed that we were on track, more than national (Policy-maker 1).*

Another responded:

*Maybe a study from Botswana was quoted. The meeting minutes might include these details. But this was not for policy formulation, it was for preparing to defend our position to the national government. (Policy-maker 7)*

When asked, most policy-makers did not agree that some issues were more amenable to evidence than others (but rather responded that all should be informed by evidence). One, however, did articulate when evidence might be more important:

*Evidence is more important for controversial policies. The WoW initiative is less controlled, in that it is implemented in schools, workplaces, etc. Through the broader community. Yes, more complex. (Policy-maker 6)*

Another noted that one of their team’s recent attempts to find evidence was also for a contentious issue:

*We did some research for IPT [Isoniazid prevention therapy for treatment of latent TB infection in HIV infected patients] – it was a more contentious issue. (Policy-maker 7)*

Finally, one of the more potentially controversial, salient, and visible policy issues was the association between DMPA and HIV acquisition, which is an issue in the problem identification stage being tracked very closely by the department. Initial exchanges of evidence were used instrumentally by the policy-makers, and the intention is to monitor the results of the first RCT on the question to instrumentally inform policy. This was the only issue in the problem identification stage.

*Assumption 7.3: Evidence does not conflict with other inputs in policy-making, including popular opinions, values, beliefs, or powerful interests.*

The situation analysis found that “Research is not the only driver in policy decisions (other important drivers include personal expertise, costs and feasibility of the policy, preferences of managers).” Despite identification of this important organizational-level barrier, it was not directly addressed through the project. The evaluation interviews consistently identified the powerful voice of experts as a barrier to systematic and transparent EIHP.

*Experts use their clinical experience to make decisions, there is a big push from experts based on*

### Decision space in Cameroon

Unlike the Western Cape Province, where policies are made and updated regularly, and where there is a clear demand for research evidence, respondents in Cameroon suggested that there was no “decision space” for evidence use in sub-national policy-making. Policies are made at the central level, but not often, and then sent to the regions for implementation. Where should evidence enter this cycle?

In addition to identifying ‘champion’ policy-makers who are open to EIHP, the project might consider identifying strategic policy issues that are in early planning stages.

*their experiences, practice. But sometimes experts also take into consideration the evidence, they do quote it (and new research) to back up their opinions. (Policy-maker 2)*

*People feel intimidated by [an academic]. Group dynamics are not ideal, it is not balanced. (Policy-maker 5)*

*There are a “few big opinion formers”, mostly professors. They really persuade us. We trust them, but they have their own research agendas. (Policy-maker 7)*

And yet respondents felt that Policy BUDDIES could give them the tools and confidence to present evidence back to these experts or to truly understand the evidence that is being presented by others:

*It would be helpful to get the evidence, get consensus, and then bring it to the meeting to say, ‘look, this is what the Cochrane library says.’ (Policy-maker 7)*

*Policy-maker: One of the neonatologists would just say ‘no’ and that would be a dead end. Because they are an expert.*

*Interviewer: If you had this training would you debate the expert?*

*Policy-maker: I think, not really debate, but to inform myself to take part in the discussion and understand the discussion. If they do quote studies, to be aware of that. (Policy-maker 5)*

It is critical that Policy BUDDIES continues to build the skills of policy-makers to engage critically with the evidence, and the project might also consider including ‘experts’ and other stakeholders in the training.

### Section Conclusion: Was the project Fit for Purpose?

Table 4 again presents the table of barriers and facilitators to EIHP identified in systematic reviews and through the Policy BUDDIES situation analysis. Overall, the project addressed many of the barriers, and leveraged many of the facilitators.

*Table 4 Fit for Purpose scorecard (bold indicates barrier/facilitator was addressed)*

<b>Barriers to using research evidence (Oliver et al. 2014 systematic review)</b>	<b>Facilitators of using research evidence (Oliver et al. 2014 systematic review)</b>
<b>Lack of availability of research</b>	<b>Availability and access to research/improved dissemination</b>
Lack of relevant/reliable research	<b>Collaboration</b>
Having no time or opportunity to use research	<b>Clarity/relevance/reliability of research findings</b>
<b>Users not being skilled in research methods</b>	<b>Relationship with policymakers</b>
<b>Costs</b>	<b>Relationship with researchers/info staff</b>
<b>Barriers identified during situation analysis interviews with policy-makers</b>	<b>Facilitators identified during situation analysis interviews with policy-makers</b>
Research is not the only driver in policy decisions (other important drivers include personal expertise, costs and	<b>Good relationships between policymakers and researchers are essential</b>

feasibility of the policy, preferences of managers)	
<b>Policy-makers don't have time to search for evidence, often evidence isn't available when they need it.</b>	

Overall, the Policy BUDDIES TOC addressed most of the factors influencing the use of evidence in health policy identified locally and through a systematic review. The factors not addressed in this iteration of Policy BUDDIES were largely related either to characteristics of the policy-maker or his/her environment. The evaluation team recommends that these could be addressed by leveraging CEBHC's strong relationship with the Department of Health. Specific recommendations to the DOH might include:

- Update Circular H166/2014 <sup>[25]</sup> to incorporate principles of evidence-informed health policy, perhaps incorporating specific guidance on where to search for and how to assess research evidence.
- Engage in annual planning and make those priorities and plans available to researchers and other stakeholders so that they can be prepared for questions that may arise.
- Consider interventions, such as a neutral chairperson, to improve the dynamics at technical committee meetings. <sup>[7]</sup>

Respondents noted that EIHP was not expected to happen overnight, but required a facilitating culture. The Policy BUDDIES project seemed to have accelerated that culture within its participants. To Policy BUDDIES, we recommend:

- Widen the pool of participants to include additional policy-makers, as well as experts and stakeholders.
- Encourage formalized peer-to-peer exchanges amongst policy-makers, either through internal researcher buddies or a regular forum.
- Have dedicated consultation/meetings with policymaker even in the absence of a question to stimulate thinking and continue linkage.
- Review appropriateness of PICO to a range of complex and operational questions.
- Use questions that were not answered to inform future systematic reviews.

### Applying the TOC to other contexts

Data collected on the determinants of evidence use in the Western Cape Province showed similar barriers and facilitators as in other contexts. However, the capacity of the project team at CEBHC to address those barriers is unique. The South African project benefited from fast internet access, a specialized team of world-class experts in evidence review and synthesis, institutional linkages to the South African Cochrane Centre, and a PI who was notably effective at coordinating and motivating the researcher buddies. In general, awareness of EIHP and demand for evidence exists in the Western Cape Province, which was not the case in Cameroon, and may not be the case everywhere. Other countries and settings might consider whether they need to spend more time on advocacy for EIHP, and in developing a few strategic and successful case studies of how evidence can be used. This would require knowledge of the policy and planning cycle, and which issues would be amenable to evidence use.

One of the most often cited benefits of the project was its level of formalization. Policy-makers found this formalized relationship opened a door and removed barriers to entry in asking questions to researchers. Researcher buddies noted the positive influence of incentives tied to formalized project deliverables.



## 2.1 Policy cases in Western Cape Province

The second objective of the evaluation was to describe the effectiveness and impact of the intervention. To do so requires an in-depth understanding of the policy cases. In general, evidence is known to be one input among many others in policy-making processes. Previous research on the determinants of evidence use by policy-makers has identified issue and context characteristics and their specific influence on the use of evidence.

The section that follows will provide a detailed description of each policy case from the Western Cape Province, with a focus on: the issue (salience and uncertainty); proposed policy instruments, objectives and goals; the current status quo and any policy legacies; any relevant interests and stakeholders; and evidence and other inputs by the researcher buddies. These characteristics are defined in Table 5 along with their relationships to the demand and use of evidence.

*Table 5 Selected characteristics of the issue in relation to evidence-informed health policy*

Characteristic	Definition	Relationship to evidence use
<b>Salience</b>	The visibility of the issue to mass publics.	Issues that are more salient will be less amenable to direct/instrumental use of evidence, and instead will involve political models of decision-making. <sup>[29]</sup>
<b>Uncertainty</b>	The level of technical uncertainty around the causes of the problem and the effectiveness of proposed solutions.	Issues with greater uncertainty will generally be more amenable to direct/instrumental evidence use. <sup>[29]</sup>
<b>Proposed policy instruments, objectives, and goals</b>	The substantive content of the policy instruments, objectives and goals, either as stated publicly or as understood among stakeholders.  Instrument types can include: mandates and regulation, economic incentives, information provision to providers or consumers.	Some instruments are more amenable to evidence use than others, i.e., guidelines and information provision.
<b>Status Quo Prior to the proposed policy</b>	A description of how the issue was managed, either through formal policies or informally or not at all, prior to the proposed policy.	The status quo will determine lock-in effects and interests. The more a policy proposal diverges from the status quo, the more likely instrumental evidence will be needed. <sup>[30]</sup>
<b>Interests and Stakeholders</b>	The actors involved, their stake in the issue, and their policy preferences.	The composition and preferences of interests will inform whether, what type, and how evidence is used. <sup>[5, 31]</sup>
<b>Evidence and other inputs provided by the buddy</b>	A description of all technical and evidentiary inputs provided by the buddy during the course of the intervention.	The availability, and provision of evidence will be correlated with its likelihood of use. Efforts to summarize the evidence in a digestible manner will improve this likelihood. <sup>[32]</sup>

## Adaptation of the National Guideline on Prevention of Mother to Child Transmission (PMTCT)

**Summary:** South Africa first implemented a PMTCT programme in 2002. The World Health Organization published consolidated guidelines on the use of antiretroviral drugs in 2013,<sup>[33]</sup> including for PMTCT programmes. South Africa updated their national guidelines in December 2014<sup>[34]</sup> and the Western Cape Province plans to release their update in May 2015.<sup>[35]</sup>

**Health issue/problem that the policy addresses:** Prevention of mother-to-child transmission of HIV, which has an existing clinical guideline. The updated provincial guideline follows the national guideline released in December 2014 in combining ART and PMTCT into one guideline, changing the CD4 criteria, and introducing Option B+ (lifelong ART for HIV-positive pregnant women).

**Saliency of the issue:** High. The establishment of a PMTCT policy in South Africa was fraught with court battles and political opposition.<sup>1</sup> However in more recent years it has become less controversial, with President Zuma endorsing it in 2009, and with a national action framework developed in 2011.

**Uncertainty around the issue:** Medium. This issue is highly technical, and involves clinical procedures and have changed rapidly over the last ten years. Normative standards are frequently updated by WHO, and by the national level. The Western Cape Province has many clinical experts in this area.

### Proposed Policy Instruments/Objectives/Goals:

Proposed policy instruments	Objectives	Policy goals
Updated treatment guidelines to include Option B+ (lifelong ART regardless of CD4 count).	To streamline ART process and integration between ANC and primary care.	To increase health of mother and child.

**Status Quo Prior to Intervention:** Prior to June 2014, the Western Cape Province recommended ART for pregnant and breastfeeding women with CD4<350.

**Responsible Department:** HIV/AIDS Sexually Transmitted Infections and Tuberculosis (HAST), a working group that meetings every 6-8 weeks composed of members from universities in the province, non-governmental organisations, expert clinicians from province; pharmacologists; clinical epidemiologists and staff from the provincial government office (managers and policy makers). All invited by the provincial government of the Western Cape Province.

**Role of Participating Policy Maker within Department:** Senior Manager.

**Present stage in policy cycle:** Policy implementation. The 2014 updated guidelines were released in June 2014. The 2015 updates will be released in May 2015.

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<sup>1</sup> “ 2001: the South African Ministry of Health endorsed the establishment of two research sites in each of the nine provinces for a period of 2 years to understand better the operational challenges of introducing antiretrovirals during pregnancy to reduce mother-to-child transmission.<sup>15</sup>

2001: this policy was challenged in the courts. In December 2001, the government was ordered by the court to develop a fully capable and effective national programme to reduce mother-to-child transmission by the following year.

2002: the government challenged the court order, but was unsuccessful. The PMTCT programme commenced.”  
<http://www.who.int/bulletin/volumes/91/1/12-106807/en/>

**Policy BUDDIES timeline:** This working group previously existed, and in fact the research buddy was a member of it from 2008-2010. Although the buddy took a break in attendance, after the Policy BUDDIES workshop her participation was renewed with a focus on creating guidelines.

**Evidence and other inputs provided by the researcher buddy:** Researcher buddies provided feedback on various circulars, most prominently on the draft guidelines using the AGREE II tool <sup>[36]</sup> to score the guideline. Suggestions included: Wording change in scope and purpose, more stakeholder participation (in particular patients), greater transparency for which stakeholders contributed to the development of the guidelines, rigor of development, inclusion of additional job aids, and increased editorial independence. New clinical guidelines were released in June 2014. One suggestion (wording change in scope and purpose) was fully implemented, two (emphasis of stakeholder participation and transparency of stakeholders) were partially implemented, the rest were not.

**Impact of Policy BUDDIES:** The revised guidelines were based on the WHO guidelines, and adapted from South Africa National guidelines. The WHO guidelines are based on the GRADE system, but written for a broad audience and meant to be adapted to local implementation context. <sup>[33]</sup>

It is implied that the researcher buddies also provided more technical guidance, but it is not clear which of those recommendations were taken into account. Policy-makers reported not having much time to engage with evidence. This case is one with a high level of engagement by clinical and academic experts, who brought evidence – sometimes their own research -- to the discussion.

**Other External Events:** The original chair left the province, but the buddy continues to engage with the new chair

### Adherence Support for Chronic Diseases

**Summary:** Chronic diseases, including non-communicable diseases such as diabetes and communicable diseases such as HIV, comprise the largest set of risk-factors of premature morbidity and mortality in South Africa. <sup>[37]</sup> HIV/AIDS accounted for an estimated 500,000 deaths in 2010 HIV/AIDS in South Africa. <sup>[38]</sup> Non-communicable diseases are newer to the public health agenda in South Africa, where a 2013 survey from the Human Sciences Research Council calls the increase of noncommunicable chronic disease in South Africa an “emerging epidemic.” <sup>[39]</sup>

Chronic diseases typically require life-long medical treatment, and poor adherence compromises the effectiveness and impact of treatment. The Western Cape Province established a sub-directorate of Adherence Support in 2013 within the Community Based Services directorate and requested that the newly appointed Deputy Director begin to develop a policy framework for adherence support that would cover all levels of healthcare and all chronic conditions.

**Issue/Problem that the policy addresses:** Medication adherence for chronic diseases, including HIV and NCDs.

**Salience of Issue:** Medium-Low. Although there is agreement among health professionals that high adherence rates are needed for successful treatment, and thus health outcomes, the issue is not highly visible to the general public. It is not generally an issue found in the news.

**Uncertainty Around Issue:** Medium-High. Adherence support has been studied in depth, but there isn't clarity around which interventions will work depending on context. In addition, the evidence tends to address either communicable or non-communicable diseases, whereas the context in the Western Cape Province requires that a policy framework cover both types of conditions.

## Proposed Policy Instruments/Objectives/Goals:

Proposed policy instruments	Objectives	Policy goals
Policy framework.	To identify best practices and strategies.	To increase treatment adherence amongst patients with chronic conditions.

**Status Quo Prior to Intervention:** Prior to the establishment of the Adherence sub-directorate, the Western Cape Department of Health addressed adherence within the chronic disease sub-directorate, the HAST, and mental health sub-directorate. Examples of existing policy interventions include providing adherence counsellors, patient support interventions, and training of counsellors.

**Responsible Directorate:** Adherence Support sub-directorate

**Role of Participating Policy Maker within Directorate:** Deputy Director of Adherence Support.

**Present stage in the policy process:** Policy formulation (early)

**Timeline:** The buddy first engaged with the policy-maker in February 2014 over email. The question was clarified over several emails but the policy-maker fell ill and the process stalled until early 2015. In early 2015, the buddy sent a copy of a recent Cochrane review on interventions for medication adherence.<sup>[40]</sup> The policy-maker spent time at the buddy's office to discuss and work together in person, and participated in evidence searches. The policy-maker presented the co-prepared document at a high-level meeting in the Department of Health to gain clarity regarding next steps. The senior policy-makers further refined the questions, partly in response to a change in language from "adherence support" to "self-management support" being encouraged by the Minister of Health. The buddy recommended members to participate on a formal task team; the researcher buddy will continue as a member of this team in a formal role.

**Evidence and other inputs provided by the researcher buddy:** The researcher buddies sent an electronic copy of a recently published Cochrane review on interventions for medical adherence. The researcher buddies and policy-maker co-produced a 1-page and 14-page summary of the systematic review.

**Impact of Policy BUDDIES:** It is unknown in which direction the policy framework will go.

**Other External Events:** Key Policy maker suffered illness, she returned in early 2015 when buddy work seemed to pick up.

### DMPA and HIV Acquisition

**Summary:** Depot Medroxyprogesterone Acetate (DMPA) is an injectable progesterone-only hormonal contraceptive that lasts for 12 weeks. In practice it tends to be more effective and acceptable than oral contraceptives, as it requires a single shot every three months instead of a daily dose; DMPA is the most common hormonal contraceptive method in the Western Cape Province, as reported during interviews. In February 2012, a WHO expert panel reviewed all the available studies on hormonal contraception as a risk factor for HIV acquisition. Independent experts used the GRADE standards for rating scientific evidence and judged this body of data to be "low-quality".<sup>[41]</sup> In early 2015, the HAST unit was asked to prepare a policy statement on the link between HIV acquisition and DMPA.

**Salience:** High. This is a very controversial issue, and came to a Director's attention through a new meta-analysis published in *Lancet Infectious Disease* in January 2015.<sup>[42]</sup> Media and editorial coverage of the issue is common.

**Uncertainty Around Issue:** High. All studies that met the criteria for inclusion were observational in nature, and few of them met minimum quality standards. These studies do not agree on a conclusion. A randomized controlled trial is currently in progress in South Africa.

**Responsible Directorate:** HAST Directorate: HIV Treatment Programme

**Role of Participating Policy Maker within Directorate:** Medical Officer

**Proposed Policy Instruments/Objectives/Goals:**

Proposed policy instruments	Objectives	Policy goals
Policy statement (information)	To determine if any intervention (i.e., guideline revision or information/education) needed to be taken at all.	To balance the risks and benefits of HIV acquisition and unintended pregnancy.

**Status Quo Prior to Intervention:** The prevalence of modern contraceptive amongst women in South Africa is estimated at 65%.<sup>[43]</sup> DMPA is the most commonly used hormonal contraceptive in South Africa according to policy-maker respondents, and is included in the provincial drug plan. In 2014, WHO released a revised guidance statement on “hormonal contraceptive methods for women at high risk of HIV and living with HIV,” which was based on commissioned systematic reviews and an expert panel. The ultimate recommendation was:

*“Women at high risk of HIV who are using progestogen-only injectables should be informed that available studies on the association between progestogen-only injectable contraception and HIV acquisition have important methodological limitations hindering interpretation. Some studies suggest that women using progestogen-only injectable contraception may be at increased risk of HIV acquisition; other studies have not found this association. The public health impact of any such association would depend upon the local context, including rates of injectable contraceptive use, maternal mortality and HIV prevalence. This must be considered when adapting guidelines to local contexts.”<sup>[41]</sup>*

**Policy BUDDIES Timeline:**

The researcher buddy was approached in January with a request from the DOH. The engagement was an extension of their existing relationship in the department.

**Evidence and Other Inputs Proposed by Researcher Buddy:** With the help of a post-doctoral researcher, the buddy produced a summary of four systematic reviews and shared it with the policy-makers in a timely manner. The researcher buddies found that the evidence was inconclusive; a randomized controlled trial is currently underway in South Africa. Involvement by policy-makers in question clarification, evidence searching, and evidence synthesis was nominal.

**Proposed and Adopted Policy:** The policy-maker shared the findings of the systematic reviews in a written memo to his/her Director, but the discussion has not yet been brought to a policy forum.

### Integration of Care for Chronic Diseases

**Summary:** Integrated care is an organizing principle for care delivery that aims to reduce fragmentation in patient services and better coordinate the delivery of care across levels and types of providers. For

chronic diseases specifically, patients are often cared for by multiple health providers and specialists, and integration of care ultimately aims to improve the effectiveness and efficiency of delivery of services to these patients. The existing guidelines were due to be updated and the DOH involved Policy BUDDIES by requesting the best available evidence on the issue.

**Issue Addressed:** The original Chronic Disease Management Guidelines were issued in 2009 and due for an update. Chronic diseases are presently treated through a vertical model, but the Department has been asked to explore whether services can be better integrated to improve patient outcomes.

**Salience:** Low. Integration of Care for Chronic Diseases is not considered a salient issue. Even the government’s website doesn’t have much in the way of bulletins or information on this, especially in comparison to other issues researcher buddies have been tackling.

**Uncertainty Around Issue:** Medium-low. The Western Cape Province benefits from the presence of the Chronic Disease Initiative for Africa who regularly provide information and evidence to the policy-maker. Otherwise, the issue of integration faces a good amount of operational uncertainty, and is very context-sensitive from a health systems lens.

**Proposed Policy Instruments/Objectives/Goals:**

Proposed policy instruments	Objectives	Policy goals
Update guidelines.	Increase effectiveness and efficiency of the delivery of health services for patients with chronic disease.	Reduce morbidity and mortality from chronic disease.

**Status Quo Prior to Intervention:** A ‘vertical’ model was in place, which means each disease was treated in a siloed method according to 2009 Chronic Disease Management guidelines.

**Responsible Directorate:** Directorate: Facility Based Programmes, Sub Directorate: Chronic Disease, Geriatrics, Rehabilitation, Prevention of Blindness

**Role of Participating Policy Maker within Directorate:** Deputy Director

**Policy BUDDIES Timeline:** Although not initially part of the Policy BUDDIES workshop, the policy-maker reached out to the team and asked for advice on drafting a chronic disease management policy framework. The policy-maker reported that it took some time to clarify the question, with many emails back and forth. Ultimately, it appears from interviews that the policy-maker was seeking assistance in developing a policy model (i.e., help in writing the policy), whereas the buddy saw their role as providing evidence to inform the policy-maker’s development of such a model.

**Evidence and Other Inputs Proposed by Buddy:** The Buddy provided an overview of a systematic review of continuity of care from 2011, as well as more recent systematic reviews. The buddy perceived the policy-makers had difficulty interpreting the findings of this review, as the issue is complex and “new.”

**Impact of Policy BUDDIES:** The policy-maker reported reading the inputs from the buddy and finding them helpful, but felt they were still unable to interpret many of the findings without help.

## Task Shifting from Doctor to Nurse-Led Delivery of Antiretroviral Treatment for Adult and Pediatric Patients

**Summary:** Since 2010, clinical nurse practitioners (CNP) had been given the authority to diagnose and manage HIV/AIDS using clinical algorithms (NIMART).<sup>[44]</sup> The national government revised the policy in 2012 to allow registered nurses (RN) to apply NIMART guidelines with the expectation that provinces would implement this change. The Western Cape Province adapted the policy to incorporate greater training and mentorship of RNs but still approached Policy BUDDIES to provide evidence on the issue. The present policy addresses adult patients, but the Western Cape Province is potentially also interested in task-shifting for paediatric patients.

**Saliency of the issue:** Medium. Discussions around how to care for HIV/AIDS patients can be fraught with tension in South Africa, and so can issues around labour.

**Uncertainty around the Issue:** Medium. Features of the problem (i.e., rising costs, limited access, too few medical doctors and CNPs) are agreed upon. Safety and effectiveness of task-shifting to RNs is less well understood and had no historical legacy in South Africa.

### Proposed Policy Instruments/Objectives/Goals:

Proposed policy instruments	Objectives	Policy goals
Regulation (allow registered nurses to initiate and maintain ART for paediatric patients)	Increase timely access to ARVs; reduce health systems costs.	Reduce morbidity and mortality from HIV.

**Status quo prior to policy change:** Prior to this policy change, patients in the Western Cape Province could be initiated and managed on ARVs by either medical doctors, or CNPs under the supervision of doctors.

**Present stage of policy process:** Implementation.

**Responsible Directorate:** HIV/AIDS Sexually Transmitted Infections and Tuberculosis (HAST)

**Role of Participating Policy Maker within Directorate:** Senior Manager

**Policy BUDDIES Timeline:** The national Department of Health recommended in 2010 that NIMART be extended to RNs. The Western Cape Province saw a need to add additional training and mentorship on what the national policy had recommended and implemented a four-stage process for training and mentorship of RNs in 2012. Meanwhile, one of the researcher buddies were asked to co-author a systematic review of task-shifting for ARTs in 2001; this review was published in 2014.<sup>[45]</sup>

Following the 2013 Policy BUDDIES workshop, HAST approached this buddy and asked her to participate in the HIV Policy Advisory group/Policy Advisory Committee. The committee's Terms of Reference specifies a role for a clinical epidemiologist in order to provide methodological expertise. Other members include members from universities in the province, non-governmental organisations (e.g. Medicins Sans Frontieres), expert clinicians from province; pharmacologists; clinical epidemiologists and staff from the provincial government office (managers and policy makers).

In the meantime, task-shifting was one of the questions raised in the Policy BUDDIES workshop, and this provided the basis for engagement of researcher buddies on this particular issue. After pairing, the researcher buddies worked on clarifying the question and sending requested data and presented at a

HAST meeting in September 2014. The policy-makers at this meeting greeted the presented evidence with relief: “They were glad that the evidence supported the policy which they were already implementing.” (Buddy 4)

After the presentation was over, HAST asked whether any evidence related to children existed. The researcher buddies summarized a 2014 non-Cochrane review on the topic and sent it to HAST. HAST are unlikely move forward with paediatric task-shifting, largely because of the small number of paediatric patients in the Western Cape Province (due to early scale-up of PMTCT).

**Evidence and Other Inputs Proposed by Researcher Buddy:** The researcher buddies sent a summary and the full text of a Cochrane systematic review on task-shifting from doctors to non-doctors for initiation and maintenance of antiretroviral therapy to provincial policy-makers. The researcher buddies presented this and another review at a HAST meeting and engaged in discussion.

**Impact of Policy BUDDIES:** Because the policy had already been formulated, the evidence acted to provide confirmatory support to the policy, and particularly the changes that the Western Cape Province had made to the national level recommendations.

*The evidence showed that we [Western Cape] were on track, more than national. The scenarios in the systematic reviews were aligned with what the Western Cape was doing. The evidence gave us more confidence. (Policy-maker 1)*

*The request to understand the evidence better [maybe] indicated that there is break in the communication between national and provincial levels. If this is the case, it might explain why provincial teams were not yet fully 'bought-into' the notion and still wanted to reflect on the evidence; else it might indicate that the manner in which the evidence has been presented previously was not in an accessible manner. (Buddy 3)*

In this case it is not clear whether the national government used evidence to inform the update of their task-shifting policy or whether it was adopted directly from the WHO update; either way, if evidence was used, it was not communicated to provincial-level policy-makers, leading to a lack of confidence in the policy at that level.

### WoW! Initiative- Western Cape on Wellness

**Summary:** WoW! Was launched as a six-month pilot in March 31<sup>st</sup>, 2015 in the Western Cape Province. It targets school children, government employees, and community members to encourage them to get involved in physical activity, screen for physical risk factors such as high Body Mass Index, and increase healthy eating habits. According to IOL, a South African newspaper “The project, which is being piloted over a six-month period in 10 schools that had no physical education, would also include 13 provincial government departments and 10 communities. It has been built on the Walk4Health programme – the wellness pilot which was launched by Premier Helen Zille two years ago – to promote a culture of wellness through encouraging the adoption of healthy lifestyles.”<sup>[46]</sup>

**Issue/Problem that the policy addresses:** WoW! addresses rising rates of NCDs and physical inactivity amongst children and adults in the Western Cape Province. WoW! programme documentation frames this problem in terms of empowering the community to not suffer from preventable diseases.

**Salience of issue:** Medium. Disease prevention and wellness are strategic priorities of the Department of Health: “Strategically the province must focus on prevention of disease: wellness as opposed to dealing

with the burden of disease; we must turn around the tide of preventable illnesses and empower our community to take charge of their own health.”<sup>[47]</sup> The initiative launch was reported in local newspapers.

During the interview with the policy-maker, they repeatedly framed the issue (healthy eating) as controversial: “Healthy eating was a hot topic, was contentious. So we needed to put together reputable group.” (Policy-maker 6)

**Uncertainty around issue:** Low. The causes of NCDs are well-established, as is the scope of the problem in the Western Cape Province. Healthy behaviours to prevent NCDs are widely known (i.e., exercise and healthy eating), but evidence on the effectiveness of policy instruments to encourage these behaviours is less established.

**Proposed policy instruments, objectives, and goals:**

Proposed policy instruments	Objectives	Policy goals
<ul style="list-style-type: none"> <li>Information flow to providers (guidelines development)</li> <li>Information flow to consumers (school children and workplaces)</li> </ul>	Encourage and increase the adoption of physical activity and healthy eating.	Reduce non-communicable diseases (NCD).

**Status Quo Prior to Policy:** Prior to the implementation of WoW!, school tuckshops and workplace cafeterias did not have dietary guidelines. In terms of the physical activity component, WoW! is the programmatic heir to Walk4Health, which was a month long challenge in the Western Cape Province in 2013. Walk4Health had individual and team challenges, and also screened for physical risk factors. Unlike WoW! which targets schools and the larger community, Walk4Health was a competition between different government departments.

**Responsible Directorate:** Department of Health Working Group on Healthy Lifestyles

**Role of Participating Policy Maker within Directorate:** Deputy Director of Nutrition

**Policy BUDDIES timeline:** WoW! was still in the policy formulation stage at the start of the Policy BUDDIES project. The issue was identified during the project’s situation analysis. In July 2014, a buddy with expertise in dietary sciences was invited to participate in a Technical Reference Group for Healthy Eating. The buddy’s engagement was initially centred on advising the development of program content for the initiative, including the WoW! Resource Guide,<sup>[48]</sup> but was later expanded to include a role in implementation and inputs on the monitoring plan for the healthy eating components of the initiative.

**Evidence and other inputs provided by the researcher buddy:** The research buddy performed a search of [healthevidence.org](http://healthevidence.org) for systematic reviews but ultimately did not have time to critically appraise or summarize that evidence, and instead used an existing summary of Cochrane systematic reviews on healthy lifestyle interventions in schools and workplaces. The buddy tried to verbally communicate non-summarized evidence during meetings “to start sensitizing [the policy-maker] and others about the role of systematic review evidence can play in decision-making.” (Buddy 5) The fact that the interventions had already been decided limited the possibility of evidence being used instrumentally for the overall

policy framework, but it was used instrumentally for some of the specific instruments, such as the catering guidelines.<sup>[49]</sup>

*The WoW! programme had already been designed by the time I was engaged, so there was not much scope to provide evidence-informed inputs on types of interventions to include in the programme and so there was an element of using the evidence to try and enhance the included interventions. In some ways this was also about “endorsing” the included interventions. (Buddy 5)*

Of additional note, the policy maker was already collaborating with the researchers during previous policy initiatives, as far back as 2006, according to researcher reports on their private forum.

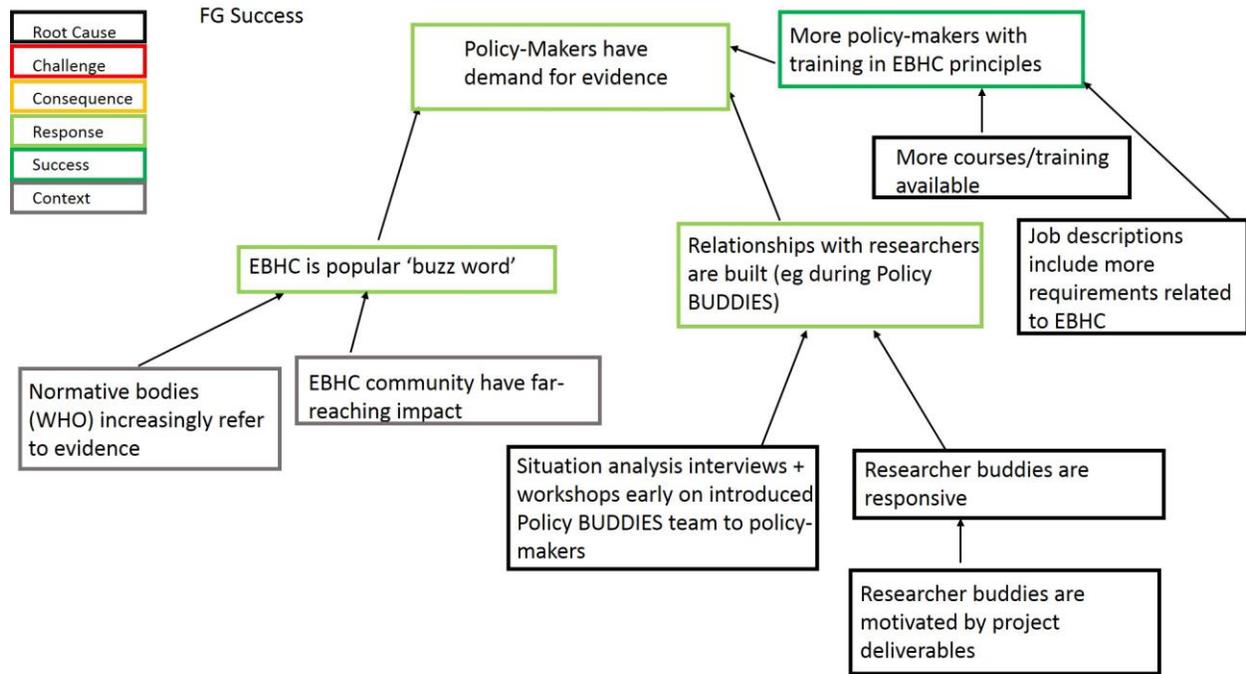
**Impact of Policy BUDDIES:** Upon the buddy’s engagement, WoW! had come up with the specific interventions and activities to be included in the initiative. The buddy’s contributions led to some adaptations of the healthy eating guidelines.

The buddy first proposed two specific interventions based on their review of the research evidence: 1) Guideline development for tuckshops and workplace canteens in order to create an enabling environments for healthy food choices, and; 2) Development of Resource Guides aimed at improving nutrition education and advocacy. The focus on tuckshops was reported to be in response to the short timelines in the policy process, but similar guidelines for workplace canteens were identified as a longer term goal.” (Buddy 6)

## 2.2 Use of evidence and its impact on policy outputs

Policy-makers and researcher buddies agreed that the project led to an increased demand for evidence. This process is reflected through the analysis of the TOC in Section 1.2, but also through Figure 6 which shows a root cause analysis (RCA) of what the researcher buddies perceived to be a success of the project. This RCA was done by buddies at the FGD held with researcher buddies.

Figure 6 Root cause analysis of increased demand for evidence



The evaluation team observed various uses of evidence across the cases that could be linked to Policy BUDDIES, according to types of use defined by Beyer and Trice (see Table below for definitions of types of use).<sup>[27]</sup>

Table 6 Models of evidence use according to Beyer and Trice

Category	Definition
Instrumental use	Specific, direct use of research evidence to identify or solve a policy problem.
Conceptual use	Evidence indirectly influences users over time. Users may not be able to explicitly name conceptual or “enlightening” uses.
Symbolic use	Symbolic use legitimized a pre-determined policy position. Also referred to as “political” or “tactical” uses. <sup>[26]</sup>

Table 7 describes the observed type of use at the macro, policy-case level for each case (as opposed to at the level of the individual decision-maker). It is important to note that a major limitation of these case studies is that they draw on interview data from only one or sometimes two policy-makers per case, as well as documentary data, thus limiting the confidence of our assessment of use at the policy case level.

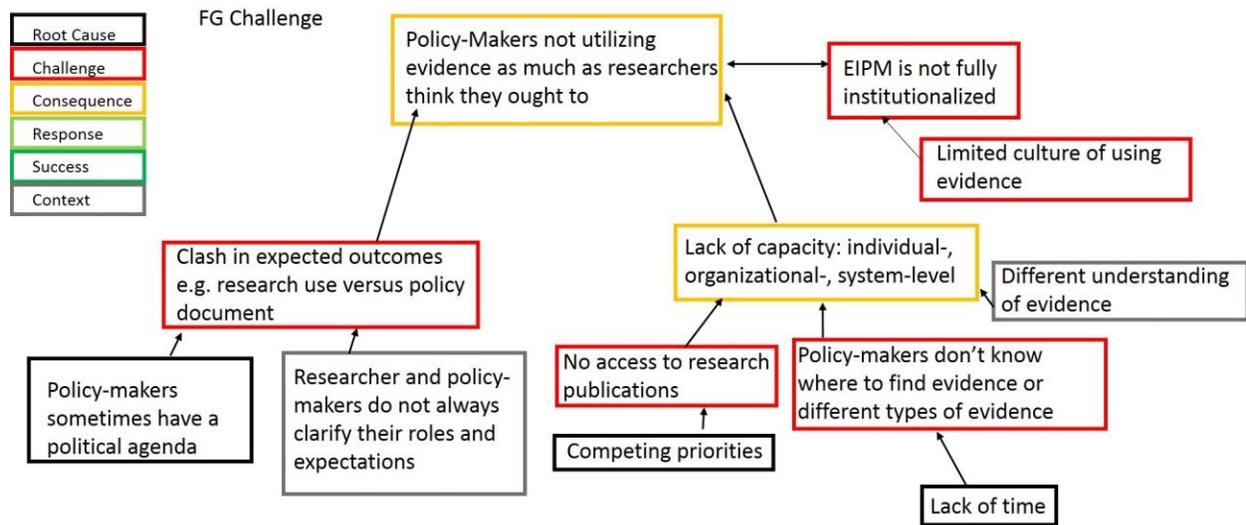
Table 7 Organizational-level uses of evidence across the policy cases

Policy case	Policy stage	Question to BUDDIES	How was evidence used?
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<b>Adherence support</b>	Formulation	What are the most effective interventions to improve adherence?  What are most effective strategies to improve performance of healthcare workers?	In process (efforts made to use it instrumentally)
<b>DMPA and HIV acquisition</b>	Problem identification	Is there an association between DMPA and HIV acquisition?	Instrumental
<b>Integration of care for chronic diseases</b>	Formulation	How do we improve on the existing integration policy?	In process
<b>PMTCT guideline update</b>	Formulation	How do we adapt the new national guidelines?	Symbolic
<b>Task-shifting ART to nurses</b>	Implementation	How do we adapt the new national guidelines?	Symbolic
<b>Wow nutritional guidelines</b>	Formulation	What are the recommendations in terms of healthy eating?	Symbolic for policy framework; instrumentally for catering guidelines and specific instruments.

Researcher buddies perceived many gains in evidence use during the project, but thought that one of the larger challenges of the project remained the fact that policy-makers still did not use evidence to inform policy as researcher buddies thought they could have or ought to. By this, researcher buddies clarified that they thought policy-makers ought to use research evidence transparently, systematically, consistently and in a way that could be repeatable/replicable. The cause of this observation is explored in Figure 7.

Figure 7 Root cause analysis of policy-makers' sub-optimal use of research evidence according to researcher buddies



## Discussion

This section summarizes the main findings and lessons learned across evaluation objectives and sections.

- Relationships open the door to mutual respect and learning. Researcher buddies benefited in learning about the policy-making world.
- Individual champions must be located in a network
- EIHP faces opportunities – and barriers – in sub-national contexts
- Evidence plays an objective and neutralizing role beside powerful experts
- Organizational-level systems and processes could be improved to support EIHP
- Progress cannot be sustained without dedicated time and resources
- Policy BUDDIES is diffusing within South Africa, but its transfer to other countries will require consideration

Relationships open the door to mutual respect and learning. Researcher buddies benefited in learning about the policy-making world.

Positive relationships between researchers and policy-makers were a successful outcome of Policy BUDDIES, as intended by the intervention theory. Individual relationships were fostered through multiple forms of frequent communication, and through researcher buddies providing useful inputs and services for their policy-makers. Nearly all of the research buddies said that their understanding and perception of policy-making had changed over the course of the project, suggesting mutual benefits for

both parties. Other researcher buddies demonstrated a sense of pride for being invited onto technical committees related to their engagement.

Organizational relationships between the Department of Health and the Centre for Evidence-based Health Care were also perceived to have been strengthened through this intervention, perhaps suggesting greater opportunities for scale and sustainability.

Policy BUDDIES strengthened, and in some cases built, collegial professional relationships within the researcher buddies' cohort. The researchers said they benefitted from having a community of practice to draw on; they all reported exchanging research evidence with each other.

#### Individual champions must be located in a network

The role of 'champions' was mentioned by multiple respondents in relation to both the project PI and policy-makers who championed their issue. In the case of a committed champion for the implementation of Policy BUDDIES, the South Africa experience suggested that a highly motivated PI may have increased the likelihood of the intervention's effective implementation and impact. The researcher buddies noted the time-intensive nature of the intervention – some were compensated as part of their salary and others were volunteers – and it is likely that the project's positive momentum was at least partly a result of the strong leadership of the PI.

On the other hand, it was noted that if a policy-maker (or PI) left (due to sickness, job transfer, etc.) they left a gap. Because the project trained and then worked with individuals, the loss of a given individual meant "you have to start again from scratch" (Buddy 6). This is observable from the network graphs (Figure 4) which show high centralization particularly around the PI. When asked, policy-makers did not report many internal exchanges with colleagues around evidence, although at least one noted that it would be helpful, particularly in the context of a formalized forum within the organization. The intervention could be strengthened substantially in terms of resilience and diffusion potential if it were to include a component formalizing linkages amongst policy-makers. Other policy-makers with institutional mandates to find and use evidence (such as the medical officers and those in the Health Impact Assessment unit) should be incorporated into this network. Similarly, in settings where the PI alone cannot manage such an endeavour, networks must be built to ensure nimble responses to policy-makers and ongoing motivation and support amongst the researcher buddies' group.

#### EIHP faces opportunities – and barriers – in sub-national contexts

There were cases of apparent instrumental use of evidence across the cases, which seemed to occur when the question was posed in the problem identification stage (DMPA/HIV) or for specific guidelines that had no policy predecessor (catering guidelines for WoW). Researcher buddies agreed that problem identification is where evidence is usually used in policy-making, for example disease surveillance or other administrative data meant to understand the size and scope of a problem. The other potentially instrumental use is ongoing for the adherence support policy framework, where that policy-maker is attempting to inform the policy options on evidence of effectiveness and has some flexibility to instrumentally inform policy options.

In general, however, the sub-national context meant that many policy frameworks had already been developed at the national level, and the Western Cape Province policy-makers were left to adapt them. This reduces incentives (and opportunities) for true instrumental use of evidence on one hand, but suggests the need to sharpen skills in other applications of evidence-informed health policy, including cost-effectiveness analyses and health impact modelling. This may be the role of the Health Impact

Assessment unit moving forward, suggesting again the importance of involving them in the Policy BUDDIES network.

#### Evidence plays an objective and neutralizing role beside powerful experts

The situation analysis identified the powerful voice of clinical and academic experts in the Western Cape Province. These individuals bring evidence to the table, but were sometimes perceived to be biased towards their own research findings or agendas. In contrast, researcher buddies were considered to be neutral and objective. The HAST team recently decided to hold a permanent seat for someone from CEBHC, ensuring representation of an expert in evidence synthesis and critical appraisal on that committee. This is a positive step that is partly attributable to Policy BUDDIES.

Numerous respondents mentioned that some experts created a difficult dynamic in meetings – a perceived barrier to EIHP and participation in general. On one hand, policy-makers felt increasingly empowered by the skills they learnt, and evidence received, through Policy BUDDIES. However, additional organizational-level steps could be taken by the Department of Health to introduce meeting rules and procedure that ensure fair representation of ideas and perspectives. Policy BUDDIES might consider looking for evidence on this issue. Finally, Policy BUDDIES should consider including these experts in their workshops.

#### Organizational-level systems and processes could be improved to support EIHP

Aside from meetings, policy-makers identified other systems and processes that could be improved in their daily work. Many found that policy-making (i.e., formulation) was generally unclear. This view was shared by the researcher buddies. While a recent circular exists, it does not include guidance around the inclusion of evidence in policy-making.<sup>[25]</sup> Policy BUDDIES could suggest guidance/wording to that effect. Policy BUDDIES should also strongly consider holding more frequent workshops, which was a request that came from nearly all policy-makers interviewed.

Other processes could be improved to increase the likelihood of EIHP. One policy-maker suggested that the upcoming year's policy priorities and updates could be shared with stakeholders so that they could begin to prepare technical inputs or evidence. Another suggested that meeting agendas could be shared further ahead of meetings for the same purpose. These are relatively simple suggestions that should be made to the Department.

#### Progress cannot be sustained without dedicated time and resources

Policy BUDDIES was effective in the Western Cape Province because of the formalized linkages and protected time and resources that project funding ensured. Both researcher buddies and policy-makers noted that having time set aside was a facilitator of their ability to find and use evidence. Now that researcher buddies are embedded on task teams, they will continue to get requests for evidence, but may not have as much time to provide information promptly without specific funding. Ultimately, Policy BUDDIES is a labour-intensive and time-intensive model, which is part of the reason it worked. At this early stage of success, the evaluation team recommends that funding be provided to continue the linkages and opportunities to build demand for evidence – and to show the impact of EIHP – in the Western Cape Province.

In Cameroon the model is not sustainable at the present scale. The model here should be scaled back to working with a few key policy-makers who might act as champions for EIHP, and whom work on issues that are amenable to evidence, and which are in the earlier stages of planning processes. In both

settings, continued training and education related to EBHC should be encouraged. This has been particularly important in developing a supportive culture in South Africa.

Policy BUDDIES is diffusing within South Africa, but its transfer to other countries will require consideration

We think that the intervention could be scaled-up or transferred to other jurisdictions in South Africa as a natural extension of the current project. This is already happening organically through referrals of researcher buddies through the networks of policy-makers. It is also possible the same will happen from provincial to district levels in the Western Cape Province, or across to other provinces. This type of intervention scale-up is likely the most feasible and efficient for Policy BUDDIES.

Whether the intervention is transferable to other countries and policy-making contexts is another question. The 'linkage and exchange' model driving the Policy BUDDIES TOC seems particularly well-suited to the decision-making context of the Western Cape Province (see Figure 6: RCA of increased demand for evidence). In this provincial health department, there is an existing and growing positive culture of EIHP, increasing numbers of policy-makers with the capacity to find and use evidence, and the growing normative influence and popularity of EIHP in South Africa. In contrast to Cameroon, policy-makers in the Western Cape Province clearly have a mandate and the authority to drive all stages of policy-making, and opportunities for policy change exist far more frequently. Further, the individual impact of the PI (and the overall intensity of the project) in the Western Cape Province is notable, and may further reduce the likelihood of transferability.

If Policy BUDDIES were to be transferred elsewhere, the TOC would require amendment based on lessons learned from Cameroon. In settings such as Cameroon where EIHP is extremely nascent, the effectiveness of a KT/EIHP intervention likely depends on how well the intervention can target specific policy processes and policy-makers who demonstrate some potential for being informed by evidence.

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# Annex 1. In-depth interview topic guide (South Africa)

## Context of policy issue

1. Tell me more about the need to update the PMTCT guidelines. Where did that request come from? Was it a priority for the department? If so, why?
2. What was the question that you were trying to answer with the help of the buddy? How did this question change over time?
3. Who was involved in the development of the PMTCT policy at provincial level? Can you describe how the HAST group is structured?
4. What was your role in the PMTCT policy development?
5. What is the current status of the guidelines? Have they been adopted and signed? How will they be implemented?
6. Compared with other policy processes, did you find that there was more or less of a role for research evidence? Why? What were some of the barriers to using research evidence during this policy process? What were some of the facilitators?

## Use of buddy

1. Why did you decide to involve the buddy at the stage of creating guidelines?
  - a. Probe: Issue characteristics (uncertainty, etc.)
  - b. Probe: Context
  - c. Probe: Convenience/project pull
2. What technical inputs did the buddy give?
3. Which of these were adopted?
4. Were there research based evidence from any other sources besides the buddy?
  - a. Probe: Existing WHO guidelines and how to adapt these to the local context.
5. Which information sources were used for creating the guidelines besides the above two?
6. Did you ask anyone else for research evidence or other technical inputs during the adherence policy process? [If so, record names]
7. Did anyone request evidence or technical inputs from you during this policy process? [If so, record names]
8. Were you satisfied with the buddy you were matched with? In your opinion, what criteria should be considered by programs like Policy BUDDIES when matching policy-makers and researchers?
  - a. Probe: Trust, content expertise, availability, timeliness.

## Use of evidence

1. [If the respondent participated in the situation analysis]: I'd like you to reflect on some of the barriers to using evidence that you articulated during the first set of interviews that you participated in for Policy BUDDIES, prior to participating in the intervention. Can you recall what these barriers might have been? Have these changed at all? Why or why not?
2. Can you provide an example of when, since the start of the programme, you searched for research evidence on a particular topic? Please describe the process. What were some of the

challenges you faced doing so? The successes? [*Probe: influence of programme on perceived barriers and successes of finding evidence*]

3. Can you provide an example of when, since the start of the programme, you read research evidence related to a policy issue that you were working on? Can you summarize the findings of that evidence in the context of your policy issue? [*Probe: influence of programme on perceived barriers and successes of reading and interpreting evidence*]
4. Can you provide an example of when, since the start of the programme, you discussed research evidence with a colleague related to a policy issues you were working on? Do you find yourself discussing evidence more or less than before the start of the programme?
5. Can you provide an example of when, since the start of the programme, you explicitly referred to evidence in a document you wrote or a presentation you gave on the policy issue you were working on? Do you find yourself making explicit references to evidence more or less often than before the start of the programme?
  - a. Probe: Symbolic/political use
6. Can you provide other examples of how evidence changed your thinking on a policy issue?
  - a. Probe: Conceptual use
7. What are some of the barriers to using evidence that still remain? Do you have any suggestions on how to address these?

#### Overview of the intervention and its implementation

1. I'd like to begin by asking you to summarize your engagement with your buddy. How often did you meet, and for how long? What was discussed during these meetings?
2. How did you typically communicate? Was it scheduled or ad-hoc?
3. Can you describe the features of the Policy BUDDIES programme that you found most helpful? Why?
4. Can you describe the features of this intervention that were least helpful? Why?

## Annex 2. Focus Group Discussion topic guide (South Africa)

### Welcome

**9:30-9:35**

*Interviewer: Good morning! Thank you for taking time this morning to critically engage in a discussion around Policy BUDDIES and evidence-informed health policy. This is a safe space, everyone's ideas are welcome and appreciated.*

- *Sign consent form*

### Overview of the intervention

**9:35-10:00**

*Interviewer: Now I'd like for us to talk about the Policy BUDDIES intervention broadly.*

- What have been the major successes of the project?
  - Probe: Process; relationships; activities and tools; outcomes in terms of capacity building and evidence use
  - Which features of the intervention do you think the policy-makers found most helpful?
- What have been the major challenges you faced as buddies? Challenges of the project?
  - Probe: time commitment, logistics, working with the right/wrong people, characteristics of the policy issues, characteristics of the evidence
  - How could these challenges be overcome?
  - Which features of the intervention do you think the policy-makers found least helpful?

*[By end, Interviewer to write down one success and one challenge for the group activity]*

**Break-out: Root cause analysis activity (Supplies needed: Markers, printed out colour guide, notecards blank and with identified parts, string, thumbtacks)**

**10:00-10:15**

*Interviewer: Let's analyse the root causes of one of the successes and one of the challenges you identified. "Root cause analysis" is a method that helps us brainstorm and identify the root causes of outputs or outcomes we observe in programmes. Here is an example [show example]*

*Now let's develop root cause analysis diagrams in two small groups. The first group will brainstorm and analyse the causes of the positive outcome we observed (INSERT SUCCESS) and the second will brainstorm and analyse the causes of the challenge we identified (INSERT CHALLENGE)*

*Please spend 15 minutes discussing as a group, and we will reconvene to present and discuss each diagram.*

**10:15-10:30**

*Discussion for the RCA diagrams:*

- Which of these could be addressed by the project? Should they? How would you address them?
- During the course of the intervention, which course corrections did you make? What would you change next time?
- What would be the biggest success/impact? How would you get there?

### **Barriers and facilitators to evidence-informed policy**

#### **10:30-10:45**

- After observing your policy-makers' experiences in real-world policy processes, what would you say are the barriers to policy-makers using evidence? To evidence being used at the organizational level?
  - Probe: timeliness and relevance; capacity to find it; no demand/incentives to use it; features of the policy issue; features of the policy/political context
  - Were these barriers addressed by the intervention? How would you address them?
- After observing your policy-makers' experiences in real-world policy processes, what would you say are the facilitators to using evidence in policy? To using evidence at the organizational level?
  - Probe: access to evidence; knowing how to find and use it; incentives to use it; relationships with others; features of the issue; features of context.
- Were these opportunities leveraged? How could they be more so?

*[Note: Situation analysis identified barriers as time and capacity; role of other ideas/opinions; trust & shared understanding]*

*Map out policy process. Discuss availability of, and uses of evidence at each stage. Which stages are easier or more difficult? Where do you think the policy-makers have the most questions? Where do you have the most expertise/experience?*

**Network activity** (Supplies needed: Chart paper with title "People who exchanged research evidence for Policy BUDDIES," string in 2 colours, notecards with names of all policy makers/researchers)

#### **10:45-11:00**

*Interviewer: In this next section we will begin to discuss the scalability and sustainability of the intervention. To start, I'd like to do an activity to help us visualize who has been touched by Policy BUDDIES, and whether this network has evolved over time. You can see up here on the paper that we have each of the buddies and their policy-makers. They are connected or linked if they exchanged evidence. Now, let's add other exchange links to these people, and let's also add new people. Please come up either with string (for a new link) or with a note card (to add a new person).*

### **Views on scaling up the intervention**

#### **11:00-11:15**

1. In your opinion, how sustainable is Policy BUDDIES?

- a. Do you think you will continue your relationship and mentoring of your buddy?
  - b. What motivated you to participate in BUDDIES?
  - c. Do you think the model could involve fewer researchers, or less time commitment?
  - d. Could it exist or continue without external funding?
2. Is the intervention transferable to other contexts? What would need to be changed, removed or added?

## Annex 3. Structured Reflection tool for buddies

### Policy BUDDIES – BUilding Demand for evidence in Decision making through Interaction and Enhancing Skills

#### Structured reflection on buddying by buddies

As part of the Policy BUDDIES project evaluation, we want people that have been buddies to give us some idea of how it has gone, what has happened, and what you have learnt from this.

“Structured reflection” encourages the writer to step back from their immediate experience and make sense of it in new ways, enabling critical reflection of the overall experience. Please provide approximately two pages of structured reflection. Please could you consider the points below to guide your responses, but also feel free to add anything else that you think is important in reflecting on your experience as a buddy.

Send your response to Jessica Shearer [jshearer@path.org](mailto:jshearer@path.org) by 10 April 2015. Thank you.

- Who have you buddied? What positions do they hold?
- What topics/questions have you covered?
- How did the question come about? Why was it in the policy maker’s mind?
- Did the question emerge during development of a new policy? Or during implementation of an existing policy?
- How often were you in touch with the policymaker(s)? Tell us about this. Was it mainly by email, phone, or face to face?
- When did you start working with them (month and year), and when did you end?
- How did you provide the information about the systematic review(s)?
- Did you give the policy makers the reviews or did you summarise them?
- Did anyone critically appraise the information?
- Do you think the review(s) were adequate? How could the reviews have been better?
- Did you receive feedback from the policymakers about the evidence and your inputs? What happened with evidence responses submitted?
- Do you think the exercise was worthwhile? What do you think it achieved?
- As a buddy, what kind of support did you need?
- Did you engage with other buddies? Tell us about this.
- What have you learnt in the process of being a buddy?
- What went well about the Policy BUDDIES project?
- What did not go so well about the Policy BUDDIES project?
- How could a project with these aims be done better in the future?