Author's response to reviews

Title: Translating research into maternal health care policy: a qualitative case study of the use of evidence in policies for the treatment of eclampsia and pre-eclampsia in South Africa

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Responses to reviewers’ comments

The reviewer’s comments are highlighted in italics and our responses are in plain text.

Reviewer One

*Overall this a very interesting article that addresses an important question where there have been few previous good studies from low and middle income countries. It uses highly appropriate methods to gather data that are then skillfully analysed against some of the main analytical frameworks in this field.*

We thank the reviewer for his positive feedback.

*Minor Essential Revisions:*
1. Page 4, 2nd para, 3rd line: should read 'have led' not 'have lead';

This has been changed.

2. Some of the headings do not quite match the journal style, eg Aim should be a sub-heading within the Introduction, and Ethical Issues should be a sub-heading within Methods.

This has been adapted to meet the journal style.

*Discretionary Revisions:*
3. Whilst acknowledging that it can often take some years to get from data collection to submission of an article, I think the paper might be strengthened if there was some attempt either briefly to describe the current policy position or, perhaps more realistically, to make an explicit statement of the period covered by the analysis. In the current version page 11 refers to, 'a review of the recent policies' and the timeline ends in 2003.

We have included on page 8 of the manuscript an explicit statement of the period covered by the analysis.

4. The Conclusion section of the abstract highlights the importance of networks and whilst this is clearly described in the Discussion and Conclusion, perhaps some mention of this should also come into the end of the first paragraph of the Discussion to balance the reference to the knowledge driven model.
A sentence has been added as suggested (page 25).

Response to Reviewer Two

Major Compulsory Revisions:

1. Although the authors state that they sought out respondents with differing views and explored “negative cases”, all the views and quotations presented in the manuscript are very much in agreement. One gets the impression that only those supporting the use of research evidence in health policy were interviewed. Were there no participants who emphasized the importance of other factors (clinical experience, feasibility, cost, etc.) in health policy formation?

We have now clarified this in the text (pages 13 and 14). During the course of our data collection it became clear that we were interviewing people who shared very similar opinions. In fact one respondent referred to there being a “club” within the obstetric community. Therefore we actively sought out respondents who might have had differing views. However we could only find one such person and he knew of no others. We are in the process of writing another paper describing how this apparent “culture of evidence based medicine” came about. It is interesting that this mindset was not limited to South Africa – our colleagues from the larger study found that largely similar views were held in obstetric communities of Mozambique and Zimbabwe.

It should also be noted that, because of the focus of this study on policy making for maternal health, we interviewed only clinicians and other stakeholders involved in this policy making process. It is possible that clinicians implementing these policies in the field had different views regarding the factors affecting policy making for maternal health.

2. It should be made clear that eclampsia treatment policies were selected for this study as one specific example of maternal health care policy development.

This has been done on page 8.

However, one also wonders about the generalizability of this example. Magnesium sulphate for pre-eclampsia/eclampsia is perhaps one of the evidence-based obstetric practices that is most simple, least controversial, and easiest to change. It would be useful to compare this with policy development for more complex evidence-based practices, such as the provision of emotional support during labor, active management of the third stage of labor, or abandonment of routine episiotomy. Perhaps this is being done in the context of
Regardless, the characteristics of this particular evidence-based practices should be brought into the discussion.

Despite being a relatively simple intervention, evidence suggests that magnesium sulphate is not used routinely for the treatment of pre-eclampsia and eclampsia in a number of low and middle income country settings, this even after an intervention to promote the Reproductive Health Library [1]. As indicated in the text, at the time of our study hypertension remained (and still is) the leading direct primary obstetric cause of maternal mortality in South Africa. Furthermore, although this paper reports on the findings from South Africa, the larger study also included research in Mozambique and Zimbabwe. As we have reported elsewhere [2], data from these settings suggest that, despite the cost effectiveness of the drug and the seeming ease with which it can be administered, structural factors hampered the translation into national policy of evidence regarding the effectiveness of this intervention. Thus despite the fact that this treatment is perhaps less complex than certain other obstetric interventions, we believe that magnesium sulphate for pre-eclampsia/eclampsia constitutes an interesting example of the process of knowledge translation as well as suggesting lessons for other areas of obstetric practice.

While our interest was limited to the treatment of eclampsia and pre-eclampsia, the policies and guidelines we explored covered maternity care in general and the key conditions that lead to maternal death in South Africa. As we mention in the paper, the evidence based approach described for the treatment of pre-eclampsia / eclampsia is also used throughout these policies for other common maternal health conditions. However, since we did not discuss with our respondents the development of policy for these other conditions, we cannot comment on those in more detail.

We agree with the reviewer that the generalisability of the study findings is an important consideration. Qualitative research is concerned with conceptual, or theoretical rather than statistical generalisability. While it was necessary to select a focus for the case study approach that we utilised, in part to allow one issue to be examined in depth, we believe that our findings are not so specific as to lack applicability or to offer no lessons for other contexts or maternal health conditions. Box 1 highlights the key factors identified by the study as influencing research use – most of these points have considerable generalisability to other settings and health conditions although, as we note in the paper, this must be done with caution. We give further consideration to the limits of the generalisability of the study findings as a fourth point under limitations (page 29-30) and note here that the intervention examined might be considered less complex, in terms of implementation, than certain other obstetric interventions.

It is also worth noting that the wider study in which this case study was nested explored what might be considered a more complex health issue: how evidence was used to inform decisions regarding the use of insecticide treated nets or
indoor residual spraying for the community-based control of malaria. The overall findings of the study for these two health issues and across the three study countries are reported in a forthcoming paper.

3. In the Data Collection section, data sources need to be spelled out more clearly. “the development of a timeline” is not a data source, but rather a method/task. “Relevant bibliographical and conference databases and websites of organizations” mentioned later in this section are data sources.

This has been addressed in the text (pages 11-12).

4. Better description of the interview methods is needed. When you refer to a “standardised interview schedule”, it is unclear if the interviews were qualitative open-ended interviews or structured questionnaires. Also, you have not specified who conducted the interviews. Perhaps there was a bias if the interviewer is known as an advocate of evidence-based medicine? How were the interview guides developed and what were the major topics covered in the interviews?

This has now been elaborated on in the text (pages 12-13).

5. In terms of the timeline, it seems difficult to tease out the effects of the changing political situation and the release of the compelling research evidence, since both happened around the same time (1994-1995). Perhaps the research results were so compelling that they would have been introduced into policy, even without the political changes? The argument that all these factors were necessary to bring about the policy change needs strengthening.

This is a difficult comment to respond to. Historically it is true that the evidence was released at more or less the same time as the change in government. We do not suggest that the change in government resulted in the evidence being taken up into policy; rather we suggest that it presented an opportunity for policy change. What we try and show in this paper is that it required policy entrepreneurs or lobby groups to take advantage of this opportunity and also, of course, for the evidence to be available in the first instance. It was the drawing together of these different threads, or policy streams to use the terms coined by Kingdon, that, we argue in the discussion section, was responsible for the development of evidence-based policy for the treatment of eclampsia. Of course, it is not possible to say what might have happened under other circumstances and any number of scenarios could be put forward. For us, the key issue is that this kind of study is not intended to prove causal links but rather to explore the constellation of factors that influence the uptake of evidence into policy making. These research methods cannot, and should not, be used to make definitive statements regarding the one most important or influential factor in this process. However, it is certainly noteworthy that the publication of the findings of the Collaborative Eclampsia Trial did not lead similar health policy changes in all
national jurisdictions, as we have described in an earlier paper in the BMJ[2] and as others have also noted[3].

We feel that these issues are well described on pages 27, 28, 30 and 31 of the manuscript. We have made some minor edits to the text of the conclusions section to further reinforce the points made above.

6. Given the specific South African context, the authors need to make an explicit attempt in the discussion and conclusions to draw out any lessons for other countries. It seems like a relatively rare situation of complete political change, in which there was a complete changing of the guard of health policymakers to those who were committed to evidence-based medicine. Will other countries be able to achieve this radical change?

We agree that it is important to draw out lessons from this study for other settings. As we note in our response to comment five above, what we have tried to show in the paper is that although the political change presented an opportunity for policy change, the impetus for this change was driven by a group of local academics. Although this group had been knocking on the doors of the national department of health before the change in government in 1994, it was only through the change that they were ‘let in’. While the event of the South African change in government may be unique, we believe that opportunities for change in policy (policy windows) present themselves in most settings, for example when elections bring in a new government or when there is a change of health minister or senior health department officials. The task then is for policy entrepreneurs, lobbyists and champions to make use of this opportunity. However it is necessary that they are prepared when the opportunity arises. The generalisable lesson that we discuss is that lobbying work is both necessary and requires long term commitment, because opportunities, or policy windows, are likely to be sporadic. We have not made changes to the text as we believe that this point is explained clearly in this excerpt from the discussion:

Our findings also confirm the importance of context to research utilisation [4]. The difficulty for those wishing to influence research utilisation is that they may not always have the power or authority to influence this context. Researchers may not be able to influence events to create windows of opportunity. However, researchers can ensure that high quality evidence is produced and is accessible to policy makers. They can also organise themselves into networks in order to enhance their influence and be willing to act as policy entrepreneurs when the opportunity arises. As Kingdon [5] suggests, policy entrepreneurs need to be attentive to when key policy influences are in alignment and when a window of opportunity opens for policy change. (page 28)

In addition, we have listed in Box 1 the factors identified in the study as influencing research use. These, we hope, will be useful to others who wish to increase the impacts of research evidence on health policy making.
Minor Essential Revisions

7. Results and conclusions of the abstract do not say anything about what the authors found regarding specific policies for use of magnesium sulphate for treatment of pre-eclampsia/eclampsia.

This has been rectified.

8. In the introduction, explain the link between hypertension and pre-eclampsia for a non-clinician audience.

This is now addressed in Box 2.

9. Renumber boxes according to their order of appearance in the manuscript.

This has been done.

10. Many of the quotations presented seem long and rambling, repeating similar points. They could be shortened and still give the same messages.

As qualitative writing goes, this paper uses quotations very judiciously. Being able to hear the voice of the respondents is what adds richness to the reports of this kind of research. We have re-read our quotes and disagree with the reviewer that they should be shortened. However, we have given further attention to the punctuation of these data extracts to improve their readability.

11. Box 3 is very difficult to follow as currently presented. It would be more useful if bullets could be used for the separate points and the points could be organized in such a way to make it easy to identify the similarities and differences among the three reviews. Perhaps the factors identified could be classified into groups presented in different panels of a table (landscape orientation).

Discretionary Revisions

12. The policy document review shows a strengthening of the use of research evidence in policy over time. This could be stated.

This has been added.

13. If possible, it would be helpful to have some information about actual implementation of the pre-eclampsia / eclampsia policies in South Africa in the Discussion section. Perhaps this will be included in a separate article?
It was not our in intention to study implementation. We recognize this as a limitation, and this is mentioned in the discussion section of the paper (page 29). Based on our interactions within this study our knowledge of this process is only anecdotal. In order to objectively understand the use of evidence in practice would have required a separate study with a quantitative design (as used in [1, 6]).

References cited:
3. Lumbiganon P, Gulmezoglu AM, Piaggio G, Langer A, Grimshaw J: Magnesium sulfate is not used for pre-eclampsia and eclampsia in Mexico and Thailand as much as it should be. *Bull World Health Organ* 2007, **85**:763-767.