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# Knowledge translation methods of the Gauteng Provincial Government employee health and wellness programme

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# Knowledge translation methods of the Gauteng Provincial Government Employee Health and Wellness programme

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**Abstract**

The integration of new discoveries in health programmes has been an integral part of improving their implementation and outcomes. However, there is an information gap that tends to exist between policy developers, decision makers, researchers, and implementers. This often results in misunderstanding and inconsistencies from 'what is implemented' versus 'what should be implemented' due to differences in interpreting and using the knowledge available.

Using a qualitative research approach, this study set out to explore how the Gauteng Provincial Government's (GPG) Employee Health and Wellness Programme (EHWP) translates knowledge into implementation. It considers the different designated Knowledge Translation (KT) roles in the programme as well as the hindrances that exist in executing the identified KT methods.

Data was collected through reviewing relevant documents to the programme in the public sector, conducting two focus groups with ten participants as well as five in-depth individual interviews, using semi-structured questionnaires. The participants represented ten Gauteng provincial departments and two national departments. The data was analysed using the thematic analysis approach to establish contrasting and correlating information in the emerging themes. The themes were compared to the Knowledge to Action (KTA) model, to assess the correlation with the existing KT frameworks in literature.

The significant finding of the study indicated that the established GPG EHWP KT methods, have taken on the steps of the KTA model. However, they did not adopt its process sequence, nor did they have a specified clear path that was practised in the programme. This resulted in a knowledge gap, misinterpretation, and confusion at implementation level. Therefore, the programme may benefit from having a systematic framework, which will be able to guide KT, assess barriers, and clarify roles at each stage of implementation.

**Declaration**

I hereby declare the following:

I confirm that the work submitted in this course is my own unaided work. I have followed the required conventions in referencing the thoughts and ideas of others. I understand that the University of the Witwatersrand may take disciplinary action against me if I have failed to correctly acknowledge the source of the ideas or words in my writing.

Signature: Date:

**Dedication**

Special Dedication to the Lord, God, “I AM” who has seen me through all my struggles and provided me with love and support through family and friends.

This is dedicated to my Mother, for her undying support in my academic undertakings.

To my father for encouraging us to always strive to reach our educational goals.

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- My parents, Nonceba and Sthembele, for understanding my absence and offering emotional support.

- My work team members Mandu, Maki, Lerato, Mandla and Vuyo for granting me the opportunity and support to pursue my studies.

- To my daughter, Lumnene for behaving while Mommy had to be away for most afternoons and weekends.

**List of Acronyms**

| | |
|---|---|
| PRIME | Programme for Improving Mental Health Care |
| SHERQ | Safety, Health, Environment, Risk and Quality Management |
| WHO | World Health Organisation |

**List of Abbreviations**

| | |
|---|---|
| AIDS | Acquired Immunodeficiency Syndrome |
| DPME | Department of Performance, Monitoring and Evaluation |
| DPSA | Department of Public Service and Administration |
| EAP | Employee Assistance Programme |
| EHWP | Employee Health and Wellness Programme |
| GPG | Gauteng Provincial Government |
| HIV | Human Immunodeficiency Virus |
| HPM | Health and Productivity Management |
| ICAS-SA | Independent Counselling and Advisory Services- South Africa |
| KTA | Knowledge to Action |
| KT | Knowledge translation |
| MPAT | Management Performance Assessment Tool |
| OoP | Office of the Premier |
| M&E | Monitoring and Evaluation |
| SMT | Systems Monitoring Tool |
| WM | Wellness Management |

## List of Tables

Table 1: Overview of Theories assumed in KT

Table 2: Overview of Models assumed in KT

Table 3: Overview of frameworks assumed in KT

Table 4: Research Methods

Table 5: Sampled population

Table 6: Participant profile

Table 7: Results themes

Table 8: Summary of findings

## List of Appendices

APPENDIX A: Consent form for Participation in the research study

APPENDIX B: Consent form for audio taping of the interview for the research study

APPENDIX C: Participant information sheet

APPENDIX D: Semi-Structured interviews for Departmental implementers

APPENDIX E: Semi-Structured interviews for Provincial and National Departments

APPENDIX F: Research approval for DPME

APPENDIX G: Research approval for DPSA

APPENDIX H: Research Approval for GPG Provincial departments

**List of Figures**

Figure 1: The Ottawa Model of research use (OMRU)

Figure 2: The Knowledge-to-Action Model

Figure 3: Conceptual framework

## Table of Contents


Abstract ..... i

Declaration ..... ii

Dedication ..... iii

Acknowledgements ..... iv

List of Acronyms ..... v

List of Abbreviations ..... v

List of Tables ..... vi

List of Appendices ..... vi

List of Figures ..... vii

Definition of terms ..... xi

CHAPTER ONE ..... 1

1.1 Introduction ..... 1

1.2 Background and context for the study ..... 2

1.3 Problem Statement ..... 4

1.4 Study Rationale ..... 4

1.5 Research Objectives ..... 5

1.6 Research question ..... 6

1.7 Chapters outline ..... 6

CHAPTER TWO ..... 8

2. Literature review ..... 8

2.1 Introduction ..... 8

2.2 Literature review methodologies ..... 8

2.3 Knowledge translation and its establishment ..... 10

2.3.1 The definition and objective of knowledge translation ..... 11

2.3.2 Knowledge translation foundations in implementation science ..... 13

2.3.3 Knowledge translation in Africa ..... 14

2.4 Knowledge translation guiding theories and models ..... 17

2.4.1 Overview of Knowledge Translation KT theories, models and frameworks ..... 18

2.5 Planned Action Theory ..... 23

2.5.1 Classical approaches to Planned Action theory ..... 24

2.5.2 Process model approaches to Planned Action theory ..... 26

2.6 Knowledge Translation theories in healthcare programmes ..... 30

2.7 Key elements for Knowledge Translation implementation....32
2.7.1 Planning....32
2.7.2 Effective facilitation methods for KT....33
2.7.3 Evaluation of KT strategies....34
2.7.4 Assessment of Barriers in KT....34
2.8 Conceptual framework....35
2.9 Conclusion....36
CHAPTER THREE....38
3. Research Methodology....38
3.1 Introduction....38
3.2 The study methodology....38
3.2.1 Research Method....39
3.2.2 Implementation of the research methods....40
3.2.3 Sampling design and methods....41
3.2.4 Data Sources and Analysis....44
3.3 Ethical consideration....45
3.3.1 Credibility and trustworthiness....46
3.4 Conclusion....46
CHAPTER FOUR....48
4. Data Presentation....48
4.1 Introduction....48
4.2 Objectives of the research study....48
4.3 Profile of participants....48
4.4 Key result findings....50
4.4.1 Document findings....50
4.4.2 Presentation of Themes from interviews and focus groups....51
4.4.3 Presentation of results....52
4.5 Conclusion....71
CHAPTER FIVE....76
5. Results interpretation and discussions....76
5.1 Introduction....76
5.2 Discussions of results....77
5.2.1 Knowledge available for the programme implementation process and how it is used....77

5.2.2 Methods and processes available for KT (from concept or theory to implementation) 78
5.2.3 Barriers that exist in the KT process of the EHW Programme ..... 82
5.3 Content analysis of EHWP implementation documents ..... 85
5.4 Summary of findings ..... 85
5.4.1 Knowledge adequacy ..... 86
5.4.2 KT methods, processes and tools ..... 86
5.4.3 KT barriers in the GPG EHWP ..... 86
5.4.4 KT roles in GPG EHWP ..... 86
CHAPTER SIX ..... 88
6. Conclusion ..... 88
6.1 Introduction ..... 88
4.1 Overview of the study ..... 88
6.2 Strengths and Limitations ..... 90
6.3 Future research ..... 90
7. References ..... 91

## Definition of terms

### Knowledge translation

The ethically accepted approaches, technologies, assessments and systems in an organisation to convert research knowledge into practical applications and implementation processes (Graham, Logan, Harrison, Straus, Tetroe, Caswell, & Robinson, 2006)

### Knowledge

Knowledge refers to the process and/or combination of formally and unsolidified framed elements of information and data, these may include documented as well as non-documented evidence (Davenport & Prusak, 1998; Liebeskind, 1996). In this context, examples of knowledge are assumed to be information and data from policies, governmental strategic frameworks, innovation and evidence based knowledge obtained from practice.

### Implementation

The action taken towards the achievement of the set goals set forth for the specific policy and/or programme (Cloete, Wissink, & De Coning, 2006).

### Policy

A statement of commitment that outlines interrelated goals to a specific subject, which may include action plans in specific situations is referred to as a policy (Jenkins, 1978).

### Research Information

Information gathered through systematic and scientific enquiry with the aim of increasing knowledge and understanding to outline facts (Kusek & Rist, 2004).

### Implementation theory

An area in economic theory, designed to explore the interlinks between programme goals and the institutions designed to action on them (Palfrey, 2002).

**Employee Health and Wellness programme**

The strategic programme aimed at improving the employee's functionality through implemented health and wellness programs (DPSA, 2008).

**Implementation science**

Refers to the incorporation of research findings to improve healthcare programme by studying the behaviour of healthcare professionals and healthcare recipients with an intent of elevating uptake as well as public good (Madon, Hofman, Kupfer & Glass, 2007; Morrell, 2009)

**Evidence based knowledge**

Refers to researched and tested knowledge obtained through a systematic review of enquiry and/or effective implementation (Mullen, 2014)

**Knowledge Translation indicators**

Effective knowledge translation is indicated through having involvement of knowledge end-user, attainable knowledge transference channels, uptake of knowledge, implementation practice change and implementation evaluation measures as well as policy change reviews and alignment (Dobbins, Robeson, Ciliska, Hanna, Cameron, O'Mara & Mercer, 2009; Graham et al. 2006; Straus, S. E., Tetroe, & Graham, 2009).

**Concept**

Concepts in implementation refer to calculated ideas to unify theories, notions, assumptions and beliefs to direct social objectives (Thomson, 1996; Wilson, Petticrew, Calnan, & Nazareth, 2010)

# CHAPTER ONE

## 1.1 Introduction

This is a qualitative study that explores the knowledge translation methods, from concept to implementation, for the Employee Health and Wellness Programme (EHWP) in the Gauteng provincial government (GPG). This is researched through the discernment of the knowledge-to-action (KTA) process model by Graham et al. (2006), within the field of implementation science.

According to Titler, Herr, Brooks, Xie, Ardery, Schilling, Clarke (2009) and Walker, Fisher, Korner, Bitensky, McCluskey, & Carey (2013), effective integration of knowledge translation methods and knowledge use in programmes, tends to result in positive effects on implementation and addresses gaps that may exist in policy objectives.

The GPG EHWP programme has shown discouraging outcomes in health trends between 2009 and 2015, with the same problem profile throughout (GPG EHWP implementation report, 2014/15). This has led the researcher to study the knowledge translation (KT) methods of this programme to establish whether they may be flawed.

Possible challenges could exist in translating and converting knowledge into implementable activities, which may also result in minimal use and integration of research and experiential knowledge in the programme. A contrary view would require evidence to show that there was progress in implementation after learning had occurred from research and experience.

A number of local studies conducted on the programme, highlight the relevance and need for the EHWP services in the public sector. They further encourage innovations in programme implementation, support by management and the need for increase the programme's utilisation for users (Attridge, Amaral, Bjornson, Goplerud, Herlihy, McPherson, Teems, 2009; Madikologa, 2014; Mugari, 2011 and Stokols, Pelletier, & Fielding, 1996). However, they do not offer recommendations on how implementers and policy makers can adapt research discoveries into their strategies, how they can refine implementation and improve other gaps that may perpetuate poor outcomes.

This paper seeks to build on a number of locally conducted studies, including the above-mentioned, which have explored programme implementation gaps and possible interventions. It considers the uniqueness of the user groups, who are the programme implementers, coordinators and concept developers. Moreover, it places the emphasis on contextualising most conclusions and assumptions made by the EHWP field of practice within the GPG.

## 1.2 Background and context for the study

World War II saw significant discoveries in the field of health sciences, yet there was limited evidence of its integration into health institutions and traditional practices of medicine (Graham et al. 2006; Underhill, Operario, Mimiaga, Skeer, & Mayer, 2010). This tendency was also seen in the social research field in the 1960s as stated by Nelson, Roberts, Maederer, Wertheimer, and Johnson (1987). Such patterns were discouraging for researchers mainly because knowledge obtained from research and experience can improve the quality of rendered services and methods of implementation (Armstrong, Waters, Dobbins, Anderson, Moore, Petticrew, Moodie, 2013; Matland, 1995).

Nevertheless, this observation sparked a number of studies in the 1970s which investigated the possible reasons behind the under-utilisation of research knowledge by policy-makers and implementers. These included studies conducted by Van de Vall (1975) and Weiss (1979) who called for a theoretical framework for the use of social research in policy.

In the late 1970s, Caplan (1979) argued that the reason for the limited use of research is perpetuated by differences in communities of practice that exist between researchers and policymakers which he termed as the two-communities theory. This was however criticised for being just a metaphor and for lacking practical adoption (Dunn, 1980). Despite this criticism, Caplan's concept opened a gateway for a number of studies and assumptions in the knowledge translation and use ideology. These studies agreed that indeed researchers, policy-makers and implementers differ in their perception of knowledge and the effects of these differences may need to be explored further (Wehrens, 2014).

One argument made by Graham et al. (2006) stated that the minimal use of research information is exacerbated by the misunderstanding and confusion in converting the research recommendation into policy and implementable activities. Evans, Snooks, Howson, & Davies (2013) further amplified this notion by saying that because of the different communities of practice that exist, translating research data into policy may not be achieved in a meaningful way. As a result, newly discovered information may be underutilised, since there is no clarity on how adoption may be organized.

The Canadian Institute of Health Research (CIHR) (2012) defines KT as a dynamic process, since it involves a number of activities that may include the creation, delivery, exchange and ethically accepted application of knowledge translation to improve health care services. This definition gives an impression that making knowledge merely available is not enough. There should be comprehensive contextual applications put in place to assist in giving meaning of the new knowledge to implementers and policy developers.

These arguments provided the impetus for this assessment of the KT methods of the GPG EHW programme, given its developmental history. The programme evolved from being an Employee Assistance Programme (EAP) which was an HIV-focused programme in 2008, to a holistic employee health and wellness Programme (EHWP) introduced by the Department of Public Services Administration (DPSA). The services were intended to enhance human capacity in government through assessing and managing occupational risk, safety, health & productivity and wellness of government employees and their immediate families (DPSA, 2008).

The holistic approach of the programme is shown through its model, which displays an inter-relationship between four strategic pillars, namely: HIV and AIDS and TB; health and productivity; wellness; and safety health, environmental, risk & quality management. The shift from EAP to EHWP emanated from an increased awareness of best approaches in practice through new research and experiential knowledge from global institutions such as the World Health Organisation (WHO) Global Plan of Action on Workers Health (Pillay & Terblanche, 2012; DPSA, 2008).

The development and transformation of the programme in the global and local context is meant to ensure that the programme remains relevant to its users and buyers

(Hamilton & Streets, n.d.; Pillay & Terblanche, 2012). Moreover, it is an indication that new information is needed for continuous policy and implementation reviews if the programme is to reach its desired outcomes (Stokols, Pelletier, & Fielding, 1996). Yet, there is limited evidence to show that the assimilation of the newly discovered knowledge has been implemented, given the trends presented.

What may worsen the translation issues in this instance is that the implementation guidance framework, that was developed by DPSA in 2008, does not give direction on how new developments, innovation and research knowledge within the field can be managed and adapted into the programme's implementation framework. If that is the case, then what methods are used by the EHWP community in GPG to translate knowledge from concept to implementation?

## 1.3 Problem Statement

In the public sector, policy developers are often different from policy implementers. This then requires implementers to conceptualise strategies into implementable activities to provide effective interventions. However, the EHW programme in GPG shows limited evidence and efforts towards adapting research and experiential knowledge into the implementation (GPG EHWP implementation report, 2014/15).

Therefore, possible reasons behind the minimal uptake of research and experiential knowledge in the programme need to be understood through exploring the methods of knowledge translation and the barriers that may hinder the process.

## 1.4 Study Rationale

Locally, not much work has been done that focuses on the methods used by different sectors to include evidence-based knowledge in implementation. There is also limited research that seeks to identify gaps and barriers that may exist in translating knowledge into implementation.

Focusing on the EHW programme in GPG, the programme's execution is guided by an implementation strategic framework that is facilitated by the DPSA and has also

adopted the outcomes approach guide introduced by the Department of Planning, Monitoring and Evaluation (DPME). This guide emphasises that results obtained from implementation processes, need to give direction to the programme by providing evidence-based experiential knowledge of what works, what does not, and where and how, to improve the quality of services delivered. (DPSA, 2008; Guide to outcomes approach, 2010). Yet, despite all these guides, programme outcomes, as discussed in section 1.1, remain poor.

It is therefore hypothesised that there are challenges that may exist in the knowledge translation process. This hypothesis is based on the assumption discussed in section 1.1 that effective KT is often accompanied by improvements in programme practice and efforts in addressing gaps that may hinder policy outcomes (Titler et al. 2009; Walker et al., 2013).

Therefore, this study seeks to explore the KT methods and the barriers that may exist in this process, as advised by the implementation guide, outcomes approach and executed through the knowledge translation theories, with the intention of:

- Gaining understanding on how available knowledge is adopted and utilised in the GPG EHW programme and the barriers to its adoption and use;
- Raising the awareness of policy makers, researchers and implementers on the importance of knowledge translation applications and the benefits they provide for improved EHWP implementation;
- Adding value in the implementation practice of the EHWP through imparting operative knowledge translation methods; and
- Contributing knowledge to the knowledge translation field of study within the South African context.

## 1.5 Research Objectives

The primary objective of the study is to understand the KT methods used to translate available knowledge from concept to execution within the EHW programme implementation in GPG. This objective will be realised through:

- Presenting the knowledge available in the programme's implementation process and how it is used;
- Identifying methods and processes utilised to translate knowledge in the programme; and
- Identifying and defining barriers that exist in the knowledge translation process of the EHW programme.

## 1.6 Research question

The purpose of the study is to explore the practical process of KT in GPG. The central question of this research is: "What are the methods and processes used by the GPG EHW programme to translate knowledge from concept into implementation?" To respond to this query, the research will probe the following questions;

- What knowledge is available for the programme's implementation process and how is it used?
- What are the methods, processes and tools used to translate knowledge from concept to implementation?
- Are there any barriers that tend to hinder the knowledge translation process in the programme?
- What is the role of DPSA, DPME and the Office of the Premier (OoP) in assisting the provincial government with knowledge translation?

## 1.7 Chapters outline

The research report is subdivided into six chapters.

- **Chapter 1: Introduction**

Chapter one gives an introduction to the field of interest and focus of the study. It outlines the background and research context, the problem statement, the study rationale and provides an overview of the research objectives and questions.

- **Chapter 2: Literature review**

The literature review provides the background and history of KT with major findings and contradictory ideas in available research. This chapter further explores concepts in knowledge translation and contextualises it within the EHW programme practice.

- **Chapter 3: Research Methodology**

The research methods chapter details the research paradigm, design, data collection and validation methods.

- **Chapter 4: Presentation of research Findings**

This chapter is a presentation of the findings of the study as obtained from the collected data.

- **Chapter 5: Analysis of Findings**

This chapter provides an in-depth analysis of patterns and themes obtained from the findings to give meaning. This chapter also gives the researcher's reflection on the data collected.

- **Chapter 6: Conclusion**

This chapter seeks to draw conclusions in the light of the data obtained throughout the study. It further seeks to formalise research findings towards closing identified gaps in the EHWP knowledge translation practice.

# CHAPTER TWO

## 2. Literature review

### 2.1 Introduction

The purpose of conducting a literature review is to provide insight in to the primary research subject, through comparing opposing research findings and theories (Creswell, 2013; Wagner, Kawulich, & Garner, 2012). This chapter explores views, perspectives, and observations posited by various scholars in the knowledge translation concept in the context of healthcare programmes.

The outline of this review will include: the Literature review methodologies; the foundations of knowledge translation in Africa and abroad; guiding theories, models and framework; the theoretical framework for this research; the use of KT theories in healthcare programmes; key elements in knowledge translation; and a conceptual framework.

### 2.2 Literature review methodologies

This section offers a description of the methods and systems used to select literature with the aim of providing an objective view of concepts relevant to the subject area. Note was taken of the five-step method of systematic review suggested by Khan, Kunz, Kleijnen, and Antes (2003).

A systematic approach to the review of literature involves structuring the selection of documents and research. This approach is regarded as useful for organised research that studies clinical implementation (Cronin, Ryan, & Coughlan, 2008).

#### 2.2.1 Identifying relevant literature

A search for journals, articles, academic research and library books was conducted in the area of implementation science and KT. General searches were conducted on google scholar and ebso-host. In addition, grey literature about the implementation of the EHW

programme in GPG was sourced through consulting the policy and research team in the OoP.

The relevance of the literature was determined through the identification of key themes for the research questions. These were KT definitions and theory; KT concept development and methods; implementation science; KT principles; barriers to KT; and KT in Africa and developing countries.

The most used databases were the Center on Knowledge Translation for Disability and Rehabilitation Research (KTDRR); The Canadian Institute of Health Research (CIHR); BioMed central; Implementation Science.com; Knowledge Translation Unit, University of Cape Town; The Knowledge Translation Network Africa (KTNet) and Programme for Improving Mental Health Care (PRIME).

### 2.2.2 Assessing the quality of the material

The researcher excluded material that was not relevant to the study and those that did not detail data sources. The material used was from original authors, key researchers and endorsed review writings in practical implementation of the theories, models and frameworks.

The collected evidence was then summarised and interpreted to give a clear review in relation to the purpose of the study.

### 2.2.3 Limitations to the Review

The concept of implementation science and KT is relatively new; this presented a limitation for this review. Moreover, earlier research shows that there are still only a few contributors of knowledge in the subject area and their suggested concepts have not been largely reviewed by peers.

This limitation confined the researcher to focus on a few “credible” authors and institutions in developing the literature review chapter. The credibility of authors was

determined through reviewing the author's credentials and contributions to the organisations listed in section 2.2.1.

## 2.3 Knowledge translation and its establishment

As early as the 1960s, it became evident that healthcare institutions were not incorporating research findings into implementation. Some recent literature refers to earlier exploration of this concept in the 1950s (Jacobson, Butterill, & Goering, 2003). This challenge persisted, regardless of the availability of evaluation studies, that showed improved outcomes arising from research knowledge and where multi-disciplinary approaches were used to close existing gaps. This then gave Graham et al. (2006) an idea that perhaps implementers get confused when they have to translate and integrate research findings into implementation. It could be worsened by the fact that, in most cases, policy makers and researchers are often separate from implementers.

Graham et al.'s sentiments arose from the communities theory framework which emerged in the 1970s. This framework was meant to assist in translating research into policy and implementation. However, it was criticised for being too ambitious in its goals. Even so, it paved the way for researchers to add information to the KT concept (Caplan, 1979).

In addition to the new discoveries made, there were also a number of establishments that appeared in other parts of the world. In the late 1980s, the US expanded the National Centre for Healthcare and Research by establishing a department for translating research into practice, with the intention of developing and enhancing healthcare services and their methods of delivery. Today, this institution is known as the Agency for Healthcare Research and Quality and it continues to make an impact in the KT space (Baine, 2012). Its formation was followed by the establishment of other organisations such as the Campbell Collaboration and the Cochrane Collaboration in London with similar purposes (Tetroe, 2007).

Though there are a number of organisations that exist for KT purposes, current research seems to suggest that the CIHR has had a major influence on global institutions and research. It was founded on the principle that KT is the basis for linking research and

evidence-based knowledge with implementation programmes so as to improve outcomes. To drive this purpose, it became one of the major institutions which contributed extensively to the advancement of KT models from the late 1990s to date. This led other organisations, such as the WHO and the National Institute on Disability and Rehabilitation Research in America, to take lessons on the KT models, and develop approaches and manuals for healthcare institutions ((Smylie, Martin, Kaplan-Myrth, Steele, Tait, & Hogg, 2004; Sudsawad, 2007).

### 2.3.1 The definition and objective of knowledge translation

Much of the literature suggests that KT groups could not agree on a standard definition, since organisations define it according to their localised need. Variations in understanding its meaning ranged from *'knowledge transfer', 'knowledge dissemination' to 'knowledge utilisation'*. However, currently, there seems to be no noticeable difference in KT definitions.

Estabrooks, Thompson, Lovely and Hofmeyer (2006) and Graham et al. (2006) suggest that KT refers to ethically accepted approaches, technologies, assessments and systems in an organisation to convert research knowledge into practical applications and implementation processes. This definition gives an impression that organisations are at liberty to design contextual methods for translating research into practice.

The CIHR (2012, p. 1) defines KT as:

> *A dynamic and interactive process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of Canadians, provide more effective health services and products and strengthen the health care system.*

These two definitions are widely used in the KT context as they encompass a number of functions and procedures that are required in the KT execution. Fundamentally, KT includes processes to create understanding, disseminate information and to integrate research and evidence-based findings into the relevant programme implementation, with a condition that the methods used, must be agreed upon in the relevant field.

Additionally, Straus, Tetroe, and Graham (2011) state that, though the available definitions for this concept show integration of a number of processes, they are somehow limiting. They argue that KT should not simply be defined as the utilisation of approaches to transform knowledge into implementation, but should also include the concept of knowledge availability and its usage. This notion may be useful in highlighting the conceptual steps shown by the knowledge-to-action model, developed by Graham.

Though this model has been accepted by the CHIR and is commonly used in different sectors, the knowledge *use* part of it, is often left in the shadows (Straus et al. 2011). The limitation to this notion is that knowledge translators tend to be limited to monitoring the use of knowledge. They may not necessarily have control or influence to drive the relevant stakeholders to utilise the available knowledge.

Therefore the lack of control in the KT processes over what and how research is used, appears to be a potential challenge to the ultimate aim of the KT concept, i.e. to improve implementation processes and outcomes in healthcare through the *use* of information to close gaps between evidence-based findings and practice (Liebeskind, 1996; Straus et al., 2011).

KT objectives appear to be closely linked to its definitions and its origin. Generally, KT needs to inform decision-making by all relevant stakeholders, which includes healthcare workers, policy-makers, researchers, administrators, funders and patients (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012). The goals of KT highlight the need to create common understanding in the interpretation and practical usage of research by ensuring that easier and commonly agreed processes are used with the objective of closing the gaps from what is known, to what is practised (Graham & Logan, 2004).

This purpose gives an idea that, though knowledge translators cannot force knowledge, they can reduce possible resistance through creating common decisions at the onset of the KT project as suggested by Graham and Logan (2004).

### 2.3.2 Knowledge translation foundations in implementation science

KT is a concept founded in implementation science as a sub-objective. Implementation science originated from fields of psychology, sociology and organisational theory. The models explored in these fields seek to impart knowledge on understanding the influences of implementation outcomes (Nilsen, 2015). Similar to this study, exploring methods of KT in the EHW GPG programme may give ideas on the effects that translation methods have on the observed outcomes as discussed in section 1.1.

Cabassa and Baumann, (2013) and Helfrich, Damschroder, Hagedorn, Daggett, Sahay, Ritchie, Stetler (2010) argue that implementation science is not only about integrating research into programmes, but also the adaptation of innovation acquired through practice and translating knowledge into implementation. According to Nilsen (2015), implementation science is aimed at:

- Identifying guiding principles in KT from theory or concept into practice;
- Learning the influence of outcomes and identifying advanced ways of improving service delivery;
- Evaluating programme implementation processes;
- Encouraging research into policy and implementation; and
- Designing methodologies on how new improvements may be incorporated.

The implementation science concept involves the principle that outcomes in healthcare services may be improved by employing multi-disciplinary measures, adopting innovation, improving decision-making and creating knowledge understanding in implementation (Damschroder et al. 2009; Dobbins et al. 2009; Helfrich et al. 2010).

Internationally, health institutions put this concept to the test by employing strategies to improve outcomes. For instance, Titler et al. (2009) conducted a study to test if the outcomes would change favourably where the element of research translation with multi-disciplinary approaches was applied in a hospital setting. The results showed programme outcomes had improved better than expected.

Another study was conducted by Underhill, Operario, Mimiaga, Skeer, & Mayer, (2010) in a similar setting. The focus was placed on the outcomes resulting from translating stroke rehabilitation knowledge into implementation in three different

countries. Though the results of the study showed attributes of improvement, they also indicated that the local environment influences the success of the concept. Based on this, it cannot be assumed that the available implementation science models and methods are suitable or can be used in every environment.

Earlier research focused on healthcare programmes that were generally hospital-based. This showed that the uptake and/or adoption of implementation science in the EHWP field of practice is limited (Attridge, 2009; Nilsen, 2015). Yet, the EHW programme is also a healthcare programme that has a unique target market, who are normally employees in the organisation. Yet, focus seems to be shifting to healthcare programmes that have wider targets.

The minimal use and integration of research in workplace health programmes poses a risk to its development, as it can result in the concept losing sight of what is suitable to its audiences, as stated by Daniels, Teems, & Carroll (2005). This supports the multi-disciplinary approaches and the assimilation of research knowledge into EAP identified by Stokols et al. (1996). The limitation of these concepts is that they do not identify how progress can effectively be made through assimilating their findings into the programme.

Given the limitations of research assimilation in implementation, it can be concluded that implementation science principles need to be tested in different settings. This can be useful in suggesting practical methods on how to unify research on implementation in different contexts.

### 2.3.3 Knowledge translation in Africa

Similar to other KT programmes in the world, Africa has developed concepts that are aligned to the global understanding of KT. The KTNET seems to be better known on the continent. The network is able to support KT projects in sub-Saharan African nations and partners with learning institutions (Ekirapa-Kiracho, Walugembe, Tetui, Kisakye, Rutebemberwa, Sengooba, Kiwanuka, 2014).

The available literature offers limited information on the foundations of KT in Africa, but does present a pattern of related studies conducted. For instance Mbonye and Magnussen (2013) conducted a study focusing on translating health research into policy and implementation in Uganda. The study participants comprised policy makers, researchers, civil society members, university media graduates and governmental officials. They found that KT is possible, but it requires strategic decision making and dedicated implementers for it to work.

Moreover, they observed that participants showed increased interest in policy workshops and gained more technical knowledge. This gives an impression that physical interaction methods in knowledge sharing and dissemination may be effective.

Mugwagwa, Edwards, and de Haan (2015), building on Mbonye and Magnussen (2013), assessed if policies that allow and support innovation and research to be assimilated into implementation, were in existence. The study was conducted in three different countries: Senegal, Tanzania and Mozambique. It was found that policies that favoured strategies to convey research and innovation into integration did exist. However, they could not be executed due to lack of enforcement, capacity and resources.

The challenges observed in the African context are not unique and may be common to all developing countries. Simpson, Wittet, Bonilla, Gamazina, Cooley and Winkler, (2007) conducted a study in India, Indonesia, Thailand, Ukraine and Nicaragua to examine how research was used to develop strategies to translate rotavirus vaccine information into implementation. They found that though KT approaches were developed, limited resources made it difficult for them to be enforced, thus risking the achievement of their objectives.

The contribution made by these researchers in the field is acknowledged, however such studies merely give an analysis of gaps and barriers, but fall short in suggesting usable interventions. An example of such interventions could include a contextual process map that may direct the practice of KT in the African context.

Conducting a yardstick study, similar to Mugwagwa, is however admirable. Making recommendations that are uninformed by local norms and practices may be resisted by

information users, thus worsening the problem. Similar to this study, its results may give an idea of what local methods exist to support knowledge adoption and to counter existing barriers.

#### 2.3.3.1 Knowledge translation in South Africa

In the local context, previous research on implementation science has focused more on advocating for the integration of evidence-based knowledge into practice, yet is failing to give a practical framework for doing such. In an effort to close this gap, the programme for improving mental health care (PRIME) has been established to improve implementation by using implementation science methods (Programme for Improving Mental Health Care, 2013).

This institution has attempted to intensify research uptake activities to improve outcomes and translate knowledge into practice as an extension of the Monitoring and Evaluation (M&E) framework. The PRIME strategy is founded on the theory of change, which is complementary to the outcomes approach adopted for implementation by government locally. The strategy gives a process map that shows actions to be applied during the input and output stages; how to evaluate actions during the short and long term outcomes; and, ultimately how to measure impact (Department of Performance, Monitoring and Evaluation, 2010; Programme for Improving Mental Health Care, 2013).

This strategy is considered as progress towards adopting implementation science techniques in the local context, although there is limited evidence of its use, despite PRIME having facilitated capacity building workshops and provided training to the Human Sciences Research Council and the University of Cape Town Lung Institute (Programme for Improving Mental Health Care, 2013).

Other research houses in South Africa which also support evidence-based uptake of research in practice, through conducting research studies in healthcare, include the South African Medical Research Council (SAMRC) (SAMRC, Strategic Plan: 2015/16-2019/20).

In addition, the government has released guidelines for an outcomes-based approach, in an effort to direct the integration of evidence-based knowledge into implementation

so as to improve outcomes. These guidelines assume a process map framework, guided by the theory of change. However, there is a lack of knowledge on the extent to which both the MRC and governmental resources are utilised (Guide to outcomes approach, 2010)

Apart from knowledge imparted by formal institutions, there are independent studies that show aspects of implementation science. The examples include: The review of evidence-based interventions in the prevention and treatment of substance use disorders; and implementing social policies in South Africa (Madzivhandila, 2014; Myers, Harker, Fakier, Kader, & Mazok, 2008). These journals show a need for further exploration of this concept locally.

It appears that there is limited use of KT-related information provided to enhance implementation research by Titler et al. (2009) and Graham et al. (2006) could spread light on the matter. They posited that the low research uptake observed may be attributed to integration difficulties. This integration difficulty is also observed with information that is supposed to explain how to solve the challenge, namely knowledge translation research.

Programmes may benefit from the use of research information as mentioned by Daniels et al. (2005) and Govender and Terblanche (2009). They state that, opportunities for knowledge translation, particularly in an EHW programme, are unlimited, since employee assistance services should be continuously assessed through techniques such as client satisfaction surveys, information management system evaluations and measurement of utilisation rates. These methods of enquiry allow recommendations to be contextual and easier to adopt.

## 2.4 Knowledge translation guiding theories and models

The purpose of a theory is to provide insight in to the study's concepts, hypothetical assumptions, as well as the research strategy (Maxwell, 2005). Similar to the disagreements over definitions discussed in section 2.2.1, there seems to be no all-embracing theory that guides the concept of KT. Literature suggests that the most used

theory, is the diffusion of innovation, which to a certain extent can be regarded as the closest to being predominant (Estabrooks et al. 2006).

Seemingly, the agreement that most theorists share, is the ultimate goal of what KT should achieve (Estabrooks et al. 2006). This research paper also adopts the overarching perceived aim, which is to

> *describe and/or guide the process of translating research into practice; understanding and/or explaining what influences implementation outcomes and evaluating implementation. (Nilsen, 2015, p. 2).*

The theoretical approach to this concept shows a combination of frameworks, models and standard philosophies. According to Estabrooks et al. (2006) and Sibley and Salbach (2015), the principles used to decide on the type of theory or approach to utilise, is normally based on the:

- KT processes
- The goals of the exercise
- The context in which the exercise is to be assumed and
- The methods of assessments to be adopted

This section therefore gives an overview of theories, models and frameworks that are commonly referred to in the field.

### 2.4.1 Overview of Knowledge Translation KT theories, models and frameworks

#### 2.4.1.1 Theories

Schutz, (1962) defines a theory as a logical assumption and explanation of experimental certainties. Ideally theories are meant to explain why certain results may be observed from certain actions. According to Estabrooks et al. (2006, p. 29) KT theories are required "to guide developments and test various levels interventions such as for individual behavioural, team, and organizational levels".

As indicated by the literature and shown in table 1, the leading theories in KT include the Diffusion on Innovation; Organisational; and Social and Process theories.

#### 2.4.1.2 Models

Models are understood to be methods of execution, which give an arrangement of steps to be taken towards a certain goal. According to Nilsen (2005) in some instances, models can be understood as theories since they are closely related. Earlier research suggests that KT models are adopted and modified from pre-existing classic models and form the broader field of social sciences. Based on the readings, the observed modification of KT models gives reason behind the use of the combination of approaches to theories.

In this context, models are perceived to be guidance tools that specify action steps in the process of translating research into implementation (Graham & Tetroe, 2007; Sudsawad, 2007). Table 2 gives an outline of the models that exist and are commonly used in the field.

#### 2.4.1.3 Frameworks

Frameworks give a fundamental idea that influences implementation processes as well as describe systems of practice. Ideally, frameworks need to consider the context, information users, guidelines, policies and all other resources needed for successful project execution (Nilsen, 2015).

In the KT setting, there are evaluation and determinants frameworks which are divided by means of their purposes. According to Ward, House, & Hamer (2009), determinant frameworks can be useful in determining the cause-effect in the translation process, which may include difficulties in procedures and other hindrances, while evaluation frameworks give an outline to be followed in assessing implementation struggles. An overview of the frameworks is given in table 3.

**Table 1: Overview of Theories assumed in KT**

| THEORY | ORIGIN | OBJECTIVE | LIMITATION |
|---|---|---|---|
| (a) Diffusion of innovation theory (Kaminski, 2011; Wejnert, 2002) | Initiated by Gabriel Tarde in 1903; Amplified by Ryan and Gross in 1943 and adopted into practice by Rogers in 1957. | To give an explanation on why and how methods, technologies and innovation of new ideas can be utilised and how much time it takes for them to be adopted within a social organisation | Success is dependent on the availability of human capital and their persuasion and preferences towards certain decisions, which can be challenging, since it has the potential to inhibit objectivity. |
| (b) Organisational Readiness theories in KT (Denis & Lehoux, 2009; Weiner, 2009; Wood & Bandura, 1989) | Informed by the social and cognitive theory of organisational management by Wood & Bandura (1989) and adopted by Weiner (2009) as an organisational readiness theory | To convey methods of examining intellectual and organisational readiness and resources required to improve knowledge use, adaptation, innovations and ultimately outcomes | It is based on the assumption that organisations are effective and "can" take action towards making decisions, managing operations and integrating new knowledge. Yet research has shown that organisations are challenged in this regard, thus putting the theory at risk of failure. |
| (c) Social Theory (Comte, 1975; Estabrooks et al. 2006; Unger, 1983) | Stems from the positive philosophical concept by Comte in 1868 (as cited by Comte, 1975); adapted and modernised by Unger (1983) | To give acknowledgement to the societal practices, networks, cultures, behaviour and structures in which people learn, produce and share knowledge. | There is a possible inconsistency that may appear in dissemination and use of KT due to societal beliefs and traditions |
| (d) Planned action Theory (Chen, 1990; Graham & Tetroe, 2009; Greene, Caracelli, & Graham, 1989; Weiss, 2000) | This theory is perceived to be influenced by the Theory of change as shown by Chen, (1990 and (Weiss, 2000) | Gives a systematic method to infer changes in an environment | The plan cannot work independently; it requires continuous assessments, monitoring and evaluation, decisions and innovation to establish correct transition of the plan. |

**Table 2: Overview of the Models assumed in KT**

| MODEL | ORIGIN | OBJECTIVE | LIMITATION |
|---|---|---|---|
| (a) Ottawa Model for Research use (Canadian Institutes of Health Research, 2012; Logan & Graham, 2010; Logan, Harrison, Graham, Dunn, & Bissonnette, 1999) | Developed by Graham and Logan in 1998 following numerous exploration in barriers to research use by other researchers Logan et al. 1999) | To create inter-activeness in the process of research use between information users and information evaluators through continuous monitoring. | The success of this model is based on the assumption that there would be proper management of barriers in the implementation setting. In the absence of these strategies, the model may fail |
| (b) CIHR Model of KT (Canadian Institute of Health Research, 2012; Sudsawad, 2007) | Developed by the Canadian Institute of Health Research in 2005 (Sudsawad, 2007) | A research cycle process map that is aimed at creating an overarching guide to KT | Similar to other models, this model is also perceived to give little consideration to guiding KT in native communities. |
| (c) The Knowledge to action process model | This model was proposed by Graham et al. (2006) | This model is aimed at giving a process map for facilitating KT from process to implementation through a cyclical approach. | There is limited literature available that deals with the limitations of this model. |

**Table 3: Overview of frameworks assumed in KT**

| FRAMEWORK | ORIGIN | OBJECTIVE | LIMITATION |
|---|---|---|---|
| (a) Dissemination and utilisation of research framework (Dobbins, Ciliska, Cockerill, Barnsley, & DiCenso, 2002; Estabrooks et al. 2006; Havelock, 1974) | Developed by Havelock, (1974) as a build-up of the Diffusion of Innovations concept by Rogers | Aimed at promoting better methods of information distribution, institutionalisation and use | There is limited information that assesses the model in order to provide a sufficient and objective limitation. |
| (b) Understanding user context framework (Canadian Institute of Health Research, 2012; Jacobson et al. 2003) | Developed by researchers in the 1970s to promote knowledge use through contextualisation (Jacobson et al. 2003) | To promote consideration of individuality in knowledge-user settings during the process of disseminating and using knowledge | Its success is dependent on user-researcher "good" relations, thus risking objectivity of information selected for adoption by the user. |
| (c) Promoting Action on research implementation in Health Services (Helfrich et al. 2010; Kitson et al. 2008; Rycroft-Malone, 2004) | Came into existence in 1998, from experiential and collection effort in healthcare (Rycroft-Malone, 2004) | To facilitate the implementation of research given through evidence and aligning to contextual uniqueness | The framework is perceived to be complex and has limited evidence to support its claim in practice |

The overview of theories, models and frameworks is derived from original and key contributors in implementation science. There is limited literature available that analyses and assesses these concepts. Available knowledge is subjective since institutions and key researchers use and evaluate their own models in different settings. This raises a concern of objectivity in the information provided and creates a limitation in information for the possible use of that specific concept.

## 2.5 Planned Action Theory

The purpose of a theoretical framework is to provide a systematic approach to understanding the different aspects of KT that are relevant to this study (Black & Mendenhall, 1990; Crotty, 1998).

The study is founded on process models which are informed by classical theories within the planned actioned concepts. Planned action theory refers to the

*logical interrelated concepts that explain, in a systematic way, the means by which planned change occurs, that predict how various forces in an environment will react in a specified change situation, and that help planners or change agents control variables that increase or decrease the likelihood of the occurrences of change.* (Straus, Tetroe, & Graham, 2013, p. 185).

The objective of this research is to explore methods of translating knowledge into implementation in the GPG EHW programme. The reviewed theoretical viewpoints suggest that the planned action concepts give insight into the study's objective.

According to Straus et al. (2013) planned action theories in the field of KT are aimed at:

- Giving direction to implementation processes and resources in relation to the set objectives
- Creating common understanding through planned action steps that can be taken by participants involved
- Assisting participants to predict possible interferences in relation to the proposed change

Literature suggests that, this theory stems from classical theories of change which was originally the work of Rogers, under the diffusion theory which was later reiterated by researchers such as Chen and Weiss (Chen, 1990; Graham & Tetroe, 2007; Rogers, 1993). Theories of change give a description of how and why change takes place in an environment.

Though they serve their purpose, Straus et al. (2013) considered that there was a need for a concept that would give guidance on managing planned change for implementation. In this exploration, they considered a number of theories that exist in the field of social sciences, healthcare, education and management then made contributions to the planned action through the development of the Knowledge to action and Ottawa model (Logan & Graham, 2010), discussed in section 2.5.1.1 and 2.5.1.2

### 2.5.1 Classical approaches to Planned Action theory

In explaining implementation and change, Nilsen (2015) indicates that the classical approach is based on, but not limited to, the Theory of Diffusion, Social and Cognitive assumptions as well as Organizational Theories. This section discusses classical theories that are perceived to be relevant to the study.

#### 2.5.1.1 Diffusion of Innovation

The first classical approach discussed is the theory of diffusion of innovation, which simply explains why and how methods, skills, tools and innovation of new ideas are used and how much time it takes for them to be adopted within social structures (Wejnert, 2002). This theory emerged in the US around the 1920s and 1930s. It was used in the agricultural sector to assess farmers' dependence on agricultural technologies. Since then, the theory has been used in numerous sectors to manage the flow of innovation in growing areas such as the implementation science field (Nilsen, 2015; Rogers, 1993).

According to Rogers (1993), the flow of innovation is mostly dependent on communication channels and is facilitated through a five-step process, which he refers to as the innovation decision process. He proposes that the management of innovation requires information to be examined and filtered through reliable structures to ensure that validity and reliability are adhered to.

Success in implementing the theory of diffusion relies on availability of resources, namely human capital, in order for them to take on the desired actions required to adopt and convey innovations brought forward (Rogers, 1993). Healthcare sectors are complex and vast; therefore, more resources may be required to measure the success of the diffusion initiatives. This is perceived to be a challenge, particularly in sectors that already have capacity shortage issues.

Moreover, there is a possibility that some innovative ideas may be preferred over others, because of favouritism towards the innovating individuals. This may lead to adoption of incorrect information and a misguided focus on programme implementation (Abrahamson & Rosenkopf, 1993; Dearing, 2008; Sahin, 2006).

Given its perceived limitation in the healthcare sector, the theory of diffusion innovation decision process is perceived to be effective, provided that it is facilitated through a moral framework, placing the evidence-based and quality assurance instruments as a base for accepting innovation. The theory also fails to show how outcomes of the innovations adopted may be measured and redefined to inform new processes and directions.

#### 2.5.1.2 Theory of research utilization

Research utilization theory is assumed to be an idea that gives direction to the integration of evidence-based knowledge into implementation (Dobbins et al. 2002). The literature suggests that the major contributors to this theory are Knott and Wildavsky in 1980, through a knowledge stage scale. In their concept, knowledge goes through a seven stages model, namely: how knowledge is received; read and understood; contextualised in practice to suit the existing needs; applied through a contextual theory; influences decision making; modifies implementation; and, evaluates outcomes through policy change (Knott & Wildavsky, 1980).

Craik and Rappolt (2003) facilitated the research utilisation concept in an occupational therapy setting. For them, the success of the theory requires occupational therapists to be enthusiastic about finding the most accurate research available. In doing so, the practitioner needs to have the experience and skill required to critically assess the information found.

The findings shared by Craik and Rappolt may also serve as a limitation to the application of this theory. Particularly in the South African context, where practitioners are often different from researchers (Madzivhandila, 2014), it tends to be difficult to find practitioners who may hold both the implementation and the research skill.

Research utilisation challenges seem to have been a major stimulator to the advancement of the KT concept. Literature shows that research challenges gave rise to the two-community theory as discussed in section 2.2.

#### 2.5.1.3 Theory of planned behaviour

Straus et al. (2013) refer to the planned behaviour theory as another contributor to the planned action concept, since it is based on an assumption that human behaviour is directed by their belief, which is another force that reacts to or imposes change in an environment. Therefore consideration is given to this theory in explaining successful implementation influences in different environments.

This theory shows strong connections with the cognitive behavioural notion in psychology, which states that behaviour is controlled by individual cognitive patterns and activities (Hupp, Reitman, & Jewell, 2008). Similarly, the application of the planned behaviour theory, shows that intrinsic influences and attitudes, possibly have more power over the behaviour of the individual than external factors (Godin & Kok, 1996). This was perceived to be a limitation, particularly since behaviours are uncertain and difficult to predict in the implementation world which may hinder performance and progress (Ajzen, 1985).

As shown through literature, classical theories of planned action have contributed to the emerging information in research. There are a number of developments to these theories by researchers such as Graham et al (2006) and Landry, Amara, Pablos-Mendes, Shademani, and Gold, (2006). Moreover, institutions such as the CIHR have disseminated research and utilised methods from such theories.

### 2.5.2 Process model approaches to Planned Action theory

The process model approach to KT is used to explain and guide the method of converting research knowledge into implementation. Unlike implementation

frameworks, the process model approach does not merely provide structures to implementation but adds on action steps and practical guidance to facilitate implementation activities and plans (Graham et al. 2006; Nilsen, 2015). This segment gives an outline of the process models that are relevant to the study.

#### 2.5.2.1 The Ottawa Model of research use (OMRU)

The model adopts an interactive approach through assessing barriers and contextual strengths in KT, monitoring innovation and knowledge use and evaluating results. The implementation success of the model is dependent on continuous assessments, monitoring and evaluation of decisions and innovations incorporated in all its phases, as shown in figure 1. This is done to identify a possible need to modify the implementation plans adopted, in order to get the desired outcomes.

The Ottawa model for research use seems to be influenced by the theories for research utilisation, in that its primary purpose is to promote the use of research through systematic measures of monitoring and evaluation in the process of transferring innovation into implementation (Logan et al., 1999).

This model is considered to be more similar to the research uptake model for improving mental health, which is designed by the PRIME in South Africa. The PRIME's strategy is founded on a theory of change which complements the outcomes approach which has been adopted for implementation in the local public sector context. It further emphasises user involvement in the research cycle while adhering to monitoring and evaluation procedures (Guide to outcomes approach, 2010; PRIME, 2013).

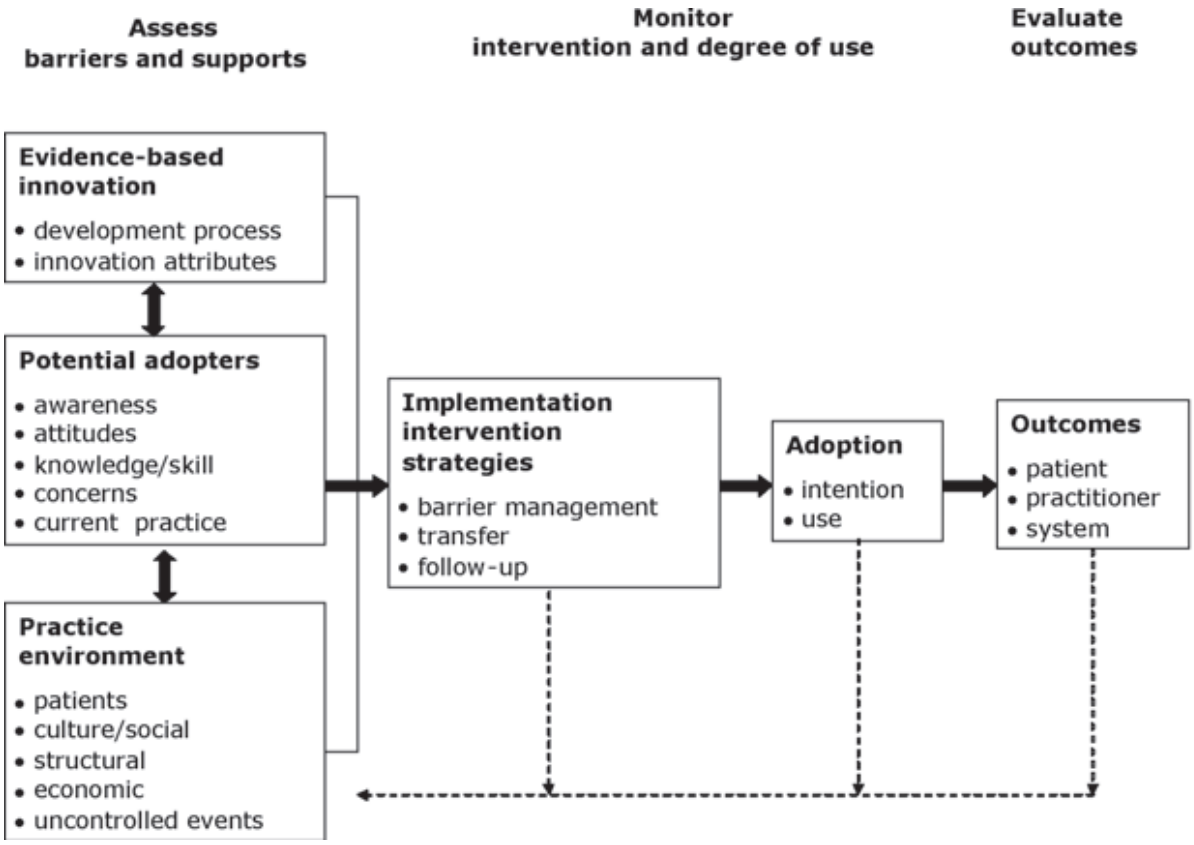



**Figure 1: The Ottawa Model of research use (OMRU)**

**Source: (Graham & Logan, 2004, p. 94)**

When applied in practice, this model presented strengths in assessing contextual barriers that exist in adopting evidence based information, yet showed limitations in providing consistent and reliable information in varying environments such as healthcare settings (Logan et al., 1999).

#### 2.5.2.2 Knowledge to Action model (KTA)

The knowledge to action model was suggested by Graham et al. (2006), with the aim of addressing gaps identified in classical approaches when guiding the process of KT. This model provides a conceptual framework to assist in converting information to implementable activities and assessing its use. This is done through the action and knowledge creation cycles (Graham et al. 2006).

As shown in figure 2, the knowledge creation cycle has three phases which are knowledge examination, knowledge assimilation, and knowledge concepts or tools. The action cycle comes after knowledge has been created and it is responsible for

facilitating knowledge use through seven stages. The seven stages are selection and tailoring of knowledge; monitoring the use of selected knowledge; evaluating outcomes; sustaining knowledge use; identifying challenges; adapting knowledge to local context; and assessing barriers to knowledge utilisation (Canadian Institute of Health Research, 2012; Sudsawad, 2007).

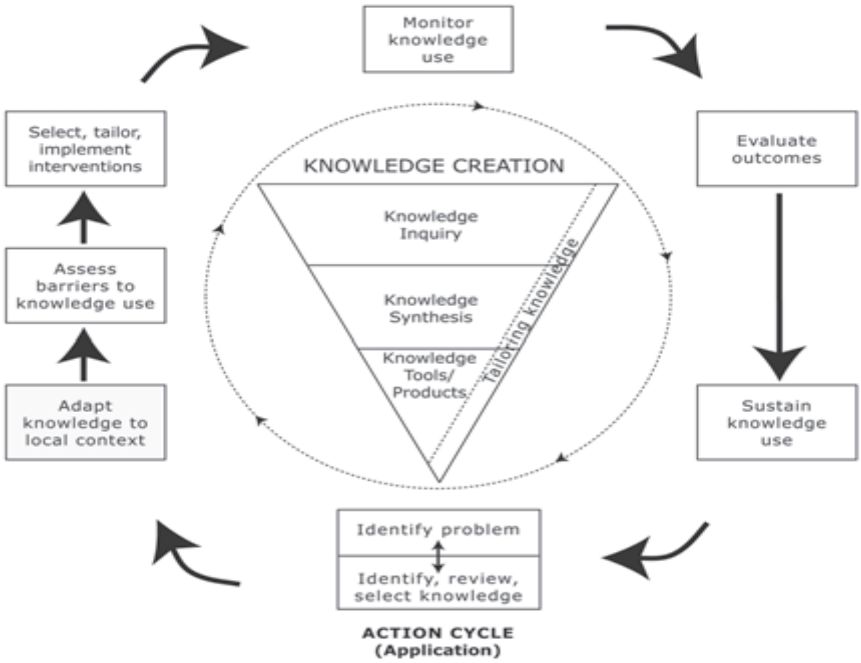



**Figure 2: The Knowledge-to-Action Model**

**Source: Sudsawad (2007, p. 9)**

The theoretical assumption of this model emphasizes the importance of acknowledging the urgent needs and priorities of the information users and adopters (Graham et al. 2006). The American physical therapy association has found this model to be effective in designing, planning and evaluating interventions that are orientated for their consumers (Tugwell, Santesso, O'Connor, & Wilson, 2007).

It has also been observed to be flexible when combined with other conceptual frameworks in rehabilitation settings for children with cerebral palsy as investigated by Russell et al. (2010). It showed similar results when paired with a skills performance model in nursing academic setting (Field, Booth, Ilott, & Gerrish, 2014)

and in clinic settings to promote health in relation to spina bifida (Claude, Juvenal, & Hawkes, 2012).

Another element that makes the KTA more suitable, is its consideration for first-hand experience to be incorporated in the knowledge innovation processes, which allows the model to be contextual to unique environments (Graham et al. 2006; Graham & Logan, 2004). Moreover the model has also taken the theory of change in its development, which is similar to the guiding principle of the South African government's outcomes approach to implementation, thus making it suitable to guide the research.

The KTA model has been observed to be useful in a number of settings however there is limited research on how the model has performed when incorporated in workplace health-related strategies. Therefore, this paper may also bring insight into its possible practicality in such programmes.

## 2.6 Knowledge Translation theories in healthcare programmes

KT approaches are primarily utilised in health care with the aim of upscaling the use of research evidence, in order to improve the quality of services rendered to patients, which can then be measured through outcomes (LaRocca, Yost, Dobbins, Ciliska, & Butt, 2012). These approaches look at methods used to intergrate evidence-based information into interventions including examining how the behaviour of healthcare workers can improve programme outcomes. o (Eccles & Mittman, 2006).

The value of KT concepts in health care is its potential to close gaps between research and practice. In doing so, a focus has been placed on a number of factors which include modifying the behaviour and attitudes of healthcare workers so that they become eager to learn about evidence-based information. To create a positive attitude, institutions attach continued professional development points to knowledge relevant to the subject area (Grimshaw et al., 2012). This was seen to be an incentive and it appeared to be a workable strategy in getting healthcare professionals enthusiastic about obtaining new knowledge.

However, Davis et al. (2003) suggests that the continued developmental approach needs to be combined with other holistic methods in imparting knowledge. He argues

that this approach has little impact on the ultimate purpose which is to improve implementation outcomes.

The second value of KT is its perceived ability to guide appropriate decision making and communication for policy developers, field specialists and implementers (Grimshaw et al., 2012). Straus et al. (2011) propose that the knowledge to action model should be used as a theoretical framework for translating knowledge that can be understood by both researchers and decision makers at organisational level. However, there is limited literature that suggests that this model is effective in imparting knowledge into decision making.

According to Lavis (2006), methods utilised to get information into decision making require high levels of interaction and prompt responses by policy making researchers, regardless of what framework one chooses.

The ultimate goal for KT in health care practices is the improvement of outcomes, as suggested by literature. According to LaRocca et al. (2012), effective KT strategies are the ones that convey knowledge on policy that has the potential to deliver the best outcomes. To achieve these outcomes, policy can advocate employing multi-disciplinary approaches, exploring perceptions and imparting experiential and practical methods to deliver services (Nilsen, Ståhl, Roback, & Cairney, 2013).

Opportunities for KT theories in healthcare-related programmes exist, possibly more than the literature has presented, though there are contrasting arguments as to their effectiveness, as shown by the literature. Some researchers have questioned their feasibility in less organised systems. The current theories seem to be relevant in communities that have recognised structures and are able to follow the process flows considered (Roy & Campbell, 2015).

According to Smylie et al. (2004) the CIHR-endorsed model, shows little room in accommodating communities that generate and transfer their knowledge through wisdom and stories. This criticism appears to be a reassertion made by Kirmayer, Brass, and Tait (2000). These authors suggest that western methods need to be combined with communal practices for the KT process to work.

The criticisms made by Smylie and Kirmayer, however, would require validation by another research study to test the application and effectiveness of these theories in communities such as rural dwellings in the local context.

## 2.7 Key elements for Knowledge Translation implementation

KT is perceived to be difficult and some of its models have also been viewed to be complex and time consuming (Armstrong et al., 2013). There is limited literature that suggests that there are generic principles for effective and efficient KT. This could be because the KT field is relatively new and a number of concepts are still being tested and reviewed. Even so, there are theoretical models and frameworks that are available with commonalities that authors seem to be agreeable about.

From the literature, it is evident that the key purpose of KT is the ability to convert concept, theories and research into policy and ultimately implementation, with the aim of improving outcomes. This has to be done in a systematic manner that guides both the researcher and implementer on the steps to take.

According to Choi (2005), the basic principle of KT is putting in place methods to integrate knowledge into practice and to put it in the most simplified format. Furthermore, there seems to be a common view from other authors and researchers in the subject area, that fundamental principles need to include: the process of planning; effective facilitation methods; evaluation of KT strategies; and the assessment of barriers. These common key aspects are discussed below and their sequence is organised at the discretion of the researcher based on the literature reviewed.

### 2.7.1 Planning

Wilson, Petticrew, Calnan, and Nazareth (2010) understand dissemination as a planned process that considers the methods of KT, targeted audiences, the settings in which research findings will be used as well as the techniques for assessing barriers. This process should also include interaction through communication with the wider policy community and decision makers, who will facilitate the research uptake processes into implementation. According to Grimshaw et al., (2012), planned KT is more likely to yield the desired results as it guides actions and resources to the set objectives.

The CIHR (2012) suggests that KT planning should assume project management techniques. Moreover, it needs to highlight: the objectives of the tasks; targeted audiences; models and strategies to be used; and, capacity and resources. This will be useful in identifying possible obstacles in carrying out the KT plan.

Planning is an important factor in successful KT as it is perceived to give guidance to the methods suitable to be imparted in the targeted setting.

### 2.7.2 Effective facilitation methods for KT

Facilitation recognises the importance of bringing together strategies and contextual improvement plans to influence change and outcomes (Davies, 2012). It requires tools, skills and capacity to guide the process of combining new and existing research. This can be achieved through determining effective methods for KT (Liyanage, Elhag, Ballal, & Li, 2009; Canadian Institute of Health Research, 2012; Sudsawad, 2007).

In facilitating KT, most authors and strategies emphasise the importance of user-involvement to help in putting together "effective" KT methods that are unique to the specific environment. There are variations on what is perceived to be "effective" methods. However, it appears that the most commonly agreed effective methods are interactive approaches such as educational outreach programmes and workshops; electronic or manual reminders or a combination of methods to deliver the same information. (Bero et al. 1998).

LaRocca et al. (2012) found similar results to Bero et al. (1998) after they conducted a systematic review to identify "effective" KT, specifically for the public health sector. They indicate that, though these interventions are not guaranteed to be consistent, they however seem to be favoured in this sector. In addition they found, tailored intervention with audits and feedback to also be "effective".

Grimshaw et al. (2001) and Yost et al. (2015) further include the importance of acknowledging organisational structures as well as leadership views and opinion as an important factor in assisting KT to achieve its goals. Grimshaw et al., go further to specify that the lack of agreement between users and researchers poses a risk in facilitating a successful project. Based on the readings, the user-researcher relationship is perceived to be paramount in eliminating barriers to knowledge use.

Lemire, Souffez, and Laurendeau (2013) designed a KT facilitation tool that was aimed at assisting researchers and implementers to translate knowledge into implementation. The tool gives suggestions and guidance on the aspects involved in KT, in an organised manner. However, there is limited evidence of the use and reviews of the tool, thus limiting insight on its effectiveness.

### 2.7.3 Evaluation of KT strategies

In discussing the evaluation concept in KT, Blake & Ottoson (2009) suggest that evaluators should not be biased towards positive outcomes, but rather embrace both. The evaluation process allows the translator to review their strategies and make adjustments if needed. In doing so, they may use simple evaluation methods to assess outcomes and impacts made by their efforts (Bhattacharyya, Estey, & Zwarenstein, 2011; CIHR, 2004).

Evaluation strategies in this subject field are considered as one of the key components required to achieve objectives, particularly, since it appears that there are variations in opinions of what works, where and how (Dobbins et al., 2009a; Dobbins, et al., 2009b). The drawback in this regard is that KT evaluation methods in literature are limited. In fact, a number of researchers make reference to the significance of assessing barriers a lot more than they refer to evaluating KT strategies.

### 2.7.4 Assessment of Barriers in KT

The assessment of barriers in KT seems to be a concept embedded in the translation theory. This theory is concerned with user engagement approaches and further emphasises the need to maintain acceptable standards in the quality of information as well as its accuracy (Liyanage et al., 2009). According to Azimi, Fattahi, and Asadi-Lari (2015), the assessment of barriers in KT is key, since KT was developed with the aim of responding to barriers that exist in the subject area.

According to Graham and Logan (2004), the assessment of barriers, when using the Ottawa model, needs to be conducted in the initial phases of the project. The assessment process needs to review potential hindrances in the process of acquiring evidence-based innovation, with the potential information use and user in mind.

These are similar to the Knowledge to Action model designed by Graham et al. (2006). It seems that there is a lack of reliable assessment tools of barriers. However, Straus et al. (2013) recommends the Clinical Practice Guidelines Framework as the most trusted tool. This assessment tool appears to be useful based on the reviews done by Straus et al., however, more research is required to ascertain these claims.

Graham appears to be the major contributor advocating for the assessment of barriers. His involvement in the development of the Ottawa Model for research use and the Knowledge to Action model as discussed in section 2.5.2.2 and 2.5.2.1, highlights that.

## 2.8 Conceptual framework

According to Maxwell (2005) a conceptual framework is a systematic tool that details logical variations in a simplified manner. Ideally, the framework should detail the study's assumptions, based on supporting theories in literature. The Framework outlines the basis of the study in relation to the context in which the study will be conducted.

In creating a conceptual map, Maxwell (2005) and Ravitch and Riggan (2016) suggest that one should consider:

- Experiential knowledge and themes that they refer to in the study
- Reviewing writing related to the subject area
- Cross-examining concepts in the subject area
- Conducting an experimental interview to get more information on your ideas

The conceptual design of the study is guided by the KT process model which provides a systematic approach to conveying knowledge into implementation (Sibley & Salbach, 2015). It is formulated with an exploratory idea in mind to show the phases on "how" knowledge moves from concept to implementation in the GPG context. Moreover, the outcomes approach and the DPSA EHWP implementation strategies have been considered since the study will be conducted in the public sector.

The conceptual framework assumed in the study is shown in figure 3, below.

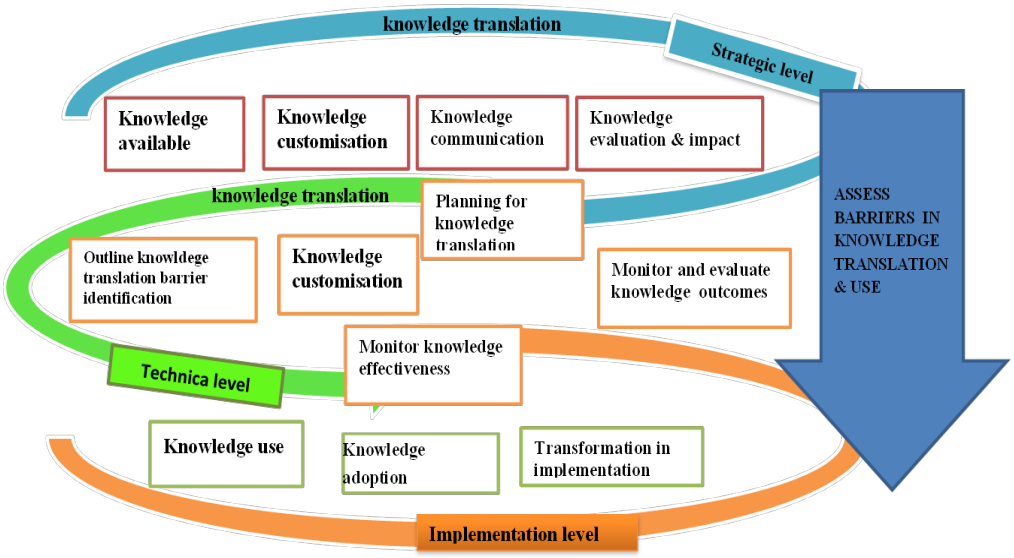



**Figure 3: Conceptual framework**

**Source: Own**

## 2.9 Conclusion

It is concluded that, knowledge is a valuable commodity when used accurately. It has the ability to effectively transform and drive programmes to achieve their intended goals. Yet there are a number of knowledge interpretation challenges that generally exist and should not be ignored, which include knowledge access, knowledge irregularities between knowledge producers and users, inefficient knowledge communication channels and knowledge mismatch.

The literature reviewed suggests that there is a growing need for implementation science in policy implementation, particularly in health, given the implementation gaps that exist. This concept would assist in minimising inconsistencies in policy and strategic concepts through adopting a "flexible" practical KT tool, since health care organisation can change rapidly.

It appears that researchers cannot come to a common conclusion about standard methods of KT. This could be perpetuated by the difference in ideas of what works in different communities, particularly, in non-western communities. However, they seem to agree on the key principles that should guide the implementation of the concept as well as the ultimate goal for KT projects.

The planned action theories have been reviewed comprehensively, as discussed in this segment. However, the knowledge to action model is perceived to be the major guiding approach to the study, since it is primarily concerned with explaining and guiding the method of converting research knowledge into implementation in a practical manner.

This review has demonstrated practical and theoretical concepts that guide the execution of KT through the outlined theories, models and frameworks that may add value to a health and wellness programme within the local context.

The next chapter brings to light the research methodology used in conducting the study.

# CHAPTER THREE

## 3. Research Methodology

### 3.1 Introduction

This chapter is aimed at providing a description of the research methodology used to conduct the study; details of the methods and techniques used to collect and analyse data; sampling designs and approaches; and, an outline of data sources and interpretations.

### 3.2 The study methodology

Research methodology refers to the approaches, methods, techniques and systematic processes used to collect, analyse and apply information for the purpose of validating theoretical assumptions (Kothari, 2004).

This study seeks to gain understanding of people's social and cultural experiences, based on the assumption that specific findings emerge from social perceptions (Ulin, Robinson, & Tolley, 2004). Therefore the qualitative approach was assumed to be appropriate as it seeks to gather in-depth insight and interpret different processes that shape behavioural patterns through exploratory and explanatory strategies (Wagner et al., 2012).

The literature review in chapter 2 illustrated that there are different opinions and experiences in applying the existing theoretical framework in KT. Therefore, the qualitative research methodology is considered suitable for this research, as it allows the study to gain:

- Detailed understanding of research participants and the practical methods they used to translate knowledge in the GPG context
- Comprehensive perspectives on the barriers that tend to hinder this process.

The research design assumed to be relevant in exploring the methods of KT in the EHW programme, is the phenomenological paradigm. According to Conroy (2003) and Wagner et al. (2012), this paradigm seeks to provide:

- insight on several people's experiences in a certain context to make sense of a given phenomenon, and
- in-depth evaluations of subjects and issues as they emerge.

However difficulties in data analysis and interpretation of results can arise from this research design, which in turn can question the credibility of the study outcomes (Easterby-Smith & Thorpe, 1991). Thus, Merriam (2002) indicates that the enquiry needs to follow four steps in the pursuit of the phenomenological paradigm, to minimise such disadvantages. These steps are:

- Bracketing: by remaining objective, by being aware of the beliefs and fixed ideas of the research subject (Crotty, 1996).
- Intuiting: by attempting to be empathetic with the participant's shared experiences (Gray, 1997).
- Analysing: by using appropriate research methods to make sense of the data: filtering information; creating meaning; categorising themes; cross-examining information; and, validating and presenting data (Colaizzi, 1978).
- Describing: articulating meanings and perceptions of the participants without adding in a non-given factor to their own interpretation (Giorgi, 2012).

### 3.2.1 Research Method

According to Kothari (2004), research methods refer to approaches and techniques used to collect data. The research methods applied in this study are detailed in Table 4.

**Table 4: Research Methods**

| Approaches | Research Method | Purpose |
|---|---|---|
| **Documentary research** | Documentary analysis | To gain insight on content used to guide KT from the existing documents |
| | Historical analysis | To review the existing notes, minutes and other historical records which may have been used for KT in the programme |
| **Field research** | Focus group sessions | To gain collective perspectives on the research question |
| | Individual interviews | To gain evidence from coordinating and policy making departments |

### 3.2.2 Implementation of the research methods

Documentary research involved the analysis of documents and recorded information that exist to guide implementation of the programme. In order to understand what documentation or records are available to guide KT in the programme.

These documents and recorded information were studied at a basic level, by merely observing what was in the documents. This was followed by a higher level review, which explored what the documents suggested in relation to effective KT methods and guiding frameworks in the public sector (Estabrooks et al., 2006; Graham et al., 2006; Wagner et al., 2012). This was done with the aim of attaining a more satisfactory enquiry on available data (Bowling, 2009).

Secondly, information was obtained by conducting focus groups as well as individual interviews at the institutions responsible for implementing the programme (Haycox & Noble, 2003; Jones & Hunter, 1995; Wagner et al., 2012) Through this process it was possible to listen to and learn from the experiences of the programme implementers and managers. Interviews were tape recorded with process notes captured manually.

Participants were invited using emails that outlined the objective of the study, the date and time of the focus groups or individual interviews. The focus groups allowed the researcher to gain different perspectives and opinions simultaneously. Moreover, it gave the participants an opportunity to engage on the KT methods and challenges that exist in the programme (Wagner et al., 2012). One drawback of this was that in some instances the group members used the platform to vent their frustrations, thus prolonging the allocated time for the session.

Individual interviews, on the other hand, were more controllable, allowing time to probe further and with better time management. The challenge experienced was the extensive travelling and, on one occasion, the interview environment was not favourable.

With both types of interviews, semi-structured questionnaires were administered, which none of the participants had viewed prior to the sessions. The questionnaire explored a framework of themes, to allow the respondents to bring in their contextual ideas, which may have been unknown to the researcher (Ritchie, Lewis, Nicholls, & Ormston, 2013).

The questionnaire consisted of five key questions which covered issues of available knowledge; customisation and knowledge-user involvement; knowledge communication methods; strategies used to monitor and evaluate knowledge use and barriers and methods used to measure the success of KT techniques.

The questions were designed to ensure that participants and the researcher shared common understanding of what "knowledge" referred to as well as translation practices in the GPG EHWP context. This was done to provide clarity and minimise possible confusion in responses given.

### 3.2.3 Sampling design and methods

Research participants were chosen using the non-probability sample method. Purposive sampling was considered appropriate since this allowed participants to be chosen based on their area of wprk and their knowledge of the particular theme that was being investigated.

Selected participants had to show characteristics that related directly to the research so as to be able to obtain the central theme and data required (Lewis & Ritchie, 2003; Wagner et al., 2012). This sampling style is complementary to the phenomenological approach, adopted by the study, in that participants have experience in the subject examined (Creswell, 2013)

The study participants consisted of:

- Two national departments which were the DPME: Human Resources MPAT unit; as well as DPSA: EHWP, Policy and Research Directorate.
- The Provincial coordinating departments, which were the GPG: Transversal EHWP and
- Nine implementing GPG departments.

The research had initially targeted two focus groups with ten implementing GPG departments. However, after invitations were sent, one department was not available. Individual interviews reached all targeted departments and participants. Data was collected in the manner shown in table 5.

**Table 5: Sampled population**

| Research method | Department | Number of participants |
|---|---|---|
| **Individual interviews** | Department of Performance, Monitoring and Evaluation (DPME) | 1 |
| | Department of Public Administration (DPSA) | 2 |
| | GPG Office of the Premier | 2 |
| **Focus group 1** | Department of Health | 2 |
| | Department of Social Development | 1 |
| | Department of Human Settlement | 1 |
| | Cooperative Governance and Traditional Affairs | 1 |
| | Department of Education | 1 |
| **Focus group 2** | Department of e-Government | 1 |
| | Department of Infrastructure Development | 1 |
| | Provincial Treasury | 1 |
| | Department of Roads and Transport | 1 |

Data was collected between the June 14 and November 2, 2016 from three groups in the KT value chain of the employee health and wellness programme in the public sector.

Interviews and discussions were conducted in English, however, respondents were allowed to use alternative languages that they felt comfortable with, which included isiZulu and seTswana.

### 3.2.4 Data Sources and Analysis

The data sources utilised to gather information for the studies were documents, focus groups and individual interviews.

#### 3.2.4.1 Documentary sources and analysis

Documents were analysed to see how relevant and useful they were in guiding knowledge translation. Documents consisted of reports on official statistics and government prescripts that were perceived to be relevant to the programme. These included: the GPG EHWP annual implementation report for 2013/14 and 2014/15; Systematic monitoring tool; DPSA EHWP strategic framework; Management Performance Assessment Tool; and, the DPME outcomes approach.

The documents were first assessed for representativeness, objectives, and limitations on their ability to conceptually communicate knowledge translation methods and techniques. This process involved viewing the document producers, where they fitted in the public sector hierarchy and their possible intentions with the documents, in relation to their responsibilities. It also included examining the availability of specific translation guides and plans in the document (Wagner et al., 2012).

The second step entailed an examination of the documents to determine their ability to be specific, contextual, and understandable in their objectives to their audiences. In addition, the documents were critically assessed to determine the extent of reforms, additions and modifications compared to their historical versions (Ritchie, Lewis, Nicholls, & Ormston, 2013).

#### 3.2.4.2 Focus groups and individual interviews data analysis

The second method of data collection involved conducting focus group discussions with programme implementers at departmental level in the Gauteng provincial government. These groups included key personnel from different departments who were involved in concept development, implementation, as well as monitoring and evaluation.

In addition, in-depth, one-on-one interviews were conducted with the provincial coordinators at the Office of the Premier and the national departments that developed the concepts, namely DPSA as well as the DPME.

The obtained data was transcribed manually in a word document and was later transferred to an excel spreadsheet. Each response was grouped with its question. This was followed by a colour coding exercise to identify and compare contrasting and possible correlations in information provided. The data was then organised to draw out the emerging themes in order to respond to the research question.

The level of analysis further engaged a descriptive approach through observing and documenting key feelings of participants together with significant issues in KT, that were not expected (Ritchie et al., 2013; Wagner et al., 2012). This gave insight on the underlying gaps in policy implementation and interpretations; the level of autonomy and resistance; as well as conceptualisation and assumptions in the KT processes.

The responses and views of the implementers and concept developers were further compared and contrasted to determine the level of shared understanding in KT processes in the programme at the different execution levels. This was done to identify the possible gaps and contrasting ideas in the implemented KT methods.

### 3.3 Ethical consideration

There are three main ethical issues that qualitative researchers need to be cognisant of according to Ramos (1989). They are the researcher's objectivity in data interpretation, the research design as well as the relationship between researchers and participants. Therefore, the information shared by participants was acknowledged to be specific to their view and was obtained on a voluntary basis (Orb, Eisenhauer, & Wynaden, 2001; Ramos, 1989).

Participants were made aware of the purpose of the study and that information was only going to be used for this study. In addition, the importance of confidentiality and privacy during the focus group sessions was emphasized and informed consent from each research participant was obtained, which indicated how privacy, confidentiality and anonymity would be maintained (Lewis & Ritchie, 2003). This was done to ensure that the research's validity was not compromised.

Lastly, approval to conduct the study was obtained from the sampled institutions by writing requests to the directors general and heads of departments. The requests detailed the purpose of the study and the proposed sampled population. This was done

to uphold ethical practice as well as to inform the institutions of possible suggestions and implications that may be unearthed by the study.

### 3.3.1 Credibility and trustworthiness

The credibility of the research methods and instruments was maintained so as to ensure that readers perceive the data obtained to be trustworthy. As supported by Shenton (2004), credibility in the research study was done through:

- Getting familiar with programme implementation principles by reviewing documents and engaging participants
- Utilising methods and instruments that are accepted in qualitative research
- Collecting data from different sources to obtain different viewpoints, and
- Describing the findings in their truest form without the researcher's interpretation, as shown in chapter 4.

## 3.4 Conclusion

The advantage of this homogeneous sample is that it is contextual to the study and provided views of the programme from different levels. Both the DPME, as the custodian of the outcomes approach, and MPAT, gave a view on how these tools could be used to enhance performance and improve outcomes. The EHWP unit from DPSA also shared insight on the developed concepts and how they are meant to be translated to guide programme implementation in national and provincial departments.

The provincial transversal EHWP gave an interpretation on the provincial coordinating, monitoring and evaluating functions of the programme in accordance with its set objectives. Moreover, the implementing departments provided the implementation level point of view with regards to knowledge use and contextualisation. The diversity ensured that a full range of knowledge was acquired (GPG EHWP Trends report 2012/13; DPSA, 2008; Lewis & Ritchie, 2003).

This chapter has described the principles assumed in qualitative methodology and methods utilised in phenomenological approaches to research.

The next chapter presents data in a thematic format in relation to the objectives of the study.

# CHAPTER FOUR

## 4. Data Presentation

### 4.1 Introduction

This chapter is a presentation of the data collected for the study within the GPG EHW programme. The results are conveyed in themes and categories as determined by the study's objectives.

In the data representation, verbatim quotes captured during the interviews are included to allow the audience to understand and create links to the data analysed (Corden & Sainsbury, 2006).

### 4.2 Objectives of the research study

The objective of the study was to explore KT methods of the EHWP in the Gauteng provincial government, through:

- Presenting the knowledge available for the programme's implementation process and how it is used;
- Identifying methods and processes utilised to translate knowledge in the programme; and
- Identifying and defining barriers that exist in the KT process of the EHW programme.

### 4.3 Profile of participants

The sample was chosen from employees who possessed a minimum of three years' experience in the EHW programme. Nine participants were GPG programme implementers from different departments and were divided into two focus groups. The employment rank classifications were namely: EHWP practitioners and managers.

Two participants from the provincial coordinating department were interviewed individually and were classified as EHWP managers. Lastly, three participants from national departments were classified as EHWP managers and MPAT administration manager.

Their work responsibilities as mentioned by the respondents included: the Management of EHWP implementation; EHWP Advisory services; coordination and implementation; EHWP monitoring and evaluation, policy coordination and implementation support; occupational health and safety and hygiene services; and EHWP policy development and implementation support

All 14 GPG departments were invited to partake in the study, however, only nine participated. The participants comprised three males and twelve (12) females, with thirteen (13) black and two white people. The table below shows an analysis of the participating group, which was made up of 15 participants.

Certain occupations were grouped so as to minimise the risks of breaching confidentiality as some participants may be easily identified.

**Table 6: Participant profile**

| **Participants profile** | | **Total** |
|---|---|---|
| **Participations** | Implementers | 10 |
| | Provincial Coordinators | 2 |
| | Non-implementers | 3 |
| **Gender** | Males | 3 |
| | Females | 12 |
| **Race** | Black | 13 |
| | White | 2 |
| **Employment rank of respondents** | EHWP Managers | 6 |
| | EHWP Practitioners | 8 |
| | MPAT administration manager | 1 |
| **Work responsibilities of respondents** | Management of EHWP implementation | 3 |
| | EHWP Advisory services | 1 |
| | Coordination and implementation | 4 |
| | EHWP monitoring and evaluation, policy coordination and implementation support | 2 |

| | | |
|---|---|---|
| | Occupational Health and Safety and Hygiene services | 2 |
| | EHWP Policy development and implementation support | 2 |
| | Management of the performance assessment tool | 1 |

### 4.4 Key result findings

The following result findings from participants are grouped in terms of common responses, as per the themes identified.

#### 4.4.1 Document findings

The documents were reviewed based on availability and they included the GPG EHWP annual implementation report, which is sometimes referred to as the business intelligence report, DPSA EHWP strategic framework, DPME outcomes approach guide and the GPG EHWP policies. This was done to gain insight on available content used to guide KT.

The DPSA EHWP strategic framework introduced in 2008, contained a twelve step-by-step guide to implement the programme. This guide resembles some of the key elements for KT implementation, discussed in section 2.7, which are: planning for implementation; user involvement; and monitoring and evaluation. Though these elements were identified, they were merely describing plans for action activities and not methods to be used in assimilating new discoveries into implementation.

Moreover, the plan was more inclined toward monitoring and evaluating implementation of policies and outcomes of interventions, but did not emphasize the need to monitor the creation and use of knowledge to improve the planned interventions.

The GPG EHWP implementation report consisted of a review of the presenting health related risk trends and their impact in the workplace. Moreover, there was a description of recommendations that can be undertaken to improve the status quo, which were also supported by research studies. However, this document did not give guidance on how its recommendations can be facilitated in the workplace. This is

viewed as a gap, particularly, when, as shown in the literature, the role of KT is predominantly the responsibility of the knowledge generator.

The EHWP polices described ways in which the programme can be implemented in departments. This outline was also observed in the outcomes approach guide, which is rooted in the theory of change guided by the logical framework for monitoring and evaluation.

### 4.4.2 Presentation of Themes from interviews and focus groups

The responses were categorised in themes and sub-themes, showing similarities and dissimilarities among respondents to enable the reader to create relations.

The category of themes and sub-themes that seek to respond to the objectives of the study are provided in table 7.

**Table 7: Results themes**

| Themes | Sub-themes identified |
|---|---|
| Knowledge available for the programme's implementation process and how it is applied | Legislation |
| | Policy |
| | Research |
| | Other available knowledge |
| Methods and processes available for KT (*from concept or theory to implementation)* | Communication channels and tools |
| | Knowledge contextualisation |
| | Knowledge implementation guides |
| The role of DPSA, DPME and OOP in KT | KT support |
| | Measuring the success of KT |
| | Knowledge user involvement |
| Barriers that exist in the KT process of the EHW programme | Monitoring and Evaluation processes |
| | Feedback on policy implementation from concept developers |
| | Lack of management support |
| | Skills and Capacity |

### 4.4.3 Presentation of results

The results discussion will be split into four primary ideas which emanate from the aims of the study as pre-identified. The discussions will further be broken down into sub-themes, which stemmed from the research response, to provide more clarity and understanding to the content. The results further incorporate direct quotes to allow the reader to create links between the results and the data.

#### 4.4.3.1 Knowledge available for the programme's implementation process and how it is applied

This theme showed a general agreement with regards to the available knowledge for implementation among the three levels of practice in the programme. The implementers, provincial coordinators as well as the non-implementers (national departments), shared a common understanding in terms of knowledge available to give direction and standardization to the programme implementation.

**(a) Legislative Framework**

The research findings showed that one of the main knowledge contributors in the EHW programme was the legislative documents within the public service. Participants indicated that guidance for implementing the programme is mainly given by Acts, which are watched over by the DPSA and the Department of Labour. The Acts were the Occupational Health and Safety Act, No. 181 of 1993; Compensation for Occupational Injuries and Diseases Act, No 61 of 1997; Labour Relations Act, No. 66 of 1995; Basic Conditions of Employment Act, No. 75 of 1997 and the Public Service Regulations 2015. It was also pointed out that, section 24 of the constitution generally gives guidance to health and wellness implementation in the province. Some of the responses that shed light on the legislative framework were:

*I would say that the national or the legislation is most important. The acts that we have, the occupational health and safety act, especially act 85 of 1993, that protects the employees in the workplace, you know and giving you the duties of each and every stakeholders that we having in the department. And we've got another act that is important, the COIDA or the compensation of occupational injuries and diseases Act, the act actually protects the employers now, in terms of if should anything happen.* [Implementer: EHWP Advisory services]

*We've got another, the labour relation act which tells you about the labour issues and conflicts in the workplace. And the basic employee (pause) Basic conditions of employee's Act "you know" tells you about the fairness of what to do, what not to do. Those are the (pause) and the constitution* [Implementer - Occupational Health and Safety and Hygiene services]

*Yes, there are other documents cause the Strategy framework is.constructed out of consultation of other legislation with which would be your occupational Health and Safety Act* [Provincial coordinator: EHWP monitoring and evaluation, policy coordination and implementation]

*And then the other document that we get a mandate from, is public service regulations 2001, they have just now being repealed by 2016. And those public service regulations also provide for the heads of the department to provide employee health and wellness and the good work (pause) working environment for the employees* [Non-implementer: support EHWP Policy development and implementation support]

**(b) Policy**

The participants indicated that the available legislation is used to give guidance to the development of the policies to be implemented in the programme. The policies mentioned were four EHWP policies namely: Safety, Health, Environmental Risk and Quality Management; Health and Productivity; Wellness Management; and HIV, AIDS and TB management policy. The participants also mentioned that, beyond these policies, there is an ill-health retirement policy used to manage ill-health cases in the workplace. Some of the views on policy knowledge were;

*So your policies will be customised to suit your environment so it will differ from one environment to another, but we are guided by the same act*. [Implementer: Occupational Health and Safety and Hygiene services]

*Legislation that (pause) would guide the formation of a policies in the realisation thereof, in terms of implementation.* [Provincial Coordinator: EHWP monitoring and evaluation, policy coordination and implementation support]

*Four policies of the program, which is the HIV, AIDS, STI and TB policy management policy; and the second one is the Wellness management policy; and the third one is the SHERQ policy, which is safety, health, environment and risk management. So all these policies, they are derived from the legislative of the country, from the constitution and from there public (pause) regulations act. And as well as the OHS act.* [Non-implementer: EHWP Policy development and implementation support]

From the responses it was evident that, legislation knowledge is translated into policies to guide implementation. \

**(c) Research**

All participants mentioned research and its use in the knowledge pool of EHWP. However, though there is general agreement about the use of research and its importance, there seem to be different opinions regarding the meaning of research and its source. Non-implementers referred to research studies conducted by some of their partners, namely the Human Sciences Research Council (HSRC), even though at times, they are perceived to give irrelevant information.

There was also a view from non-implementers that research execution is a responsibility of a different directorate within the DPSA. They indicated that:

*You know the problem with the research that is that you have seen, is that we rely mostly on HSRC, the HSRC is a population-based study and you are not able to pick up out of out of that population which population (pause) it belongs to the public service.* [Non-implementer- EHWP Policy development and implementation support]

*That research unit is actually look on the development and the implementations of the policies across the country. Now if there are any changes, they will be tried to do a research on the implementation of that particular policy and if there are gaps they will find it. There is a research committee for the public service whereby, these committee or task team committee, it has been approved by the department.* [Non-implementer- EHWP Policy development and implementation support]

Departmental implementers and provincial coordinators were of the opinion that research knowledge in the programme had its foundation in the above studies commissioned by entities such as the HSRC and international organisations, while

their experiential knowledge obtained from implementation reports added to this. They perceive these knowledge sources as informants on new developments and how to adjust certain actions in implementation. Some of the views of implementers and provincial coordinators were;

*With your own research and and your own knowledge to say this is how you should be done. Well I've doing it like that. I don't know if there is any document that will be (pause) that is guiding the implementation of any of the acts.* [Implementer- Occupational Health and Safety and Hygiene services]

*But mainly the (pause) like research studies like "Zinakekele" at one point I (pause) like it, used to do like a BMI report [cross talk] BRM reports yha ey…So we will use that information to input, in terms of the activities because th (pause) like operational plans I mean they are very generic, so we would speak of activities across the board.* [Implementer- Coordination and implementation]

*The transversal Team will formulate that and it will also advise departments to say that on your departments out of our analysis, out of our research, we have seen that on this particular area, that's where your risk area, so as a means of advising them and guiding departments.* [Provincial Coordinator- EHWP monitoring and evaluation, policy coordination and implementation support]

*I think as a as a province and this is also attested in the recent HSRC survey, that we have it that we commissioned as a Province, to look at knowledge levels of our employees, with regards to HIV AIDS information, education.* [Provincial Coordinator, EHWP monitoring and evaluation, policy coordination and implementation support]

From the responses gathered, it was evident that there was no commonality between the three ranks on the nature of research availability to guide implementation and new developments in the programme. The key dissimilarity is that, non-implementers seem not to recognise the knowledge acquired through implementation and the extent to which implementers have used it.

### (d) Other available knowledge

Respondents also mentioned information documents that appeared to be commonly utilised and useful in the implementation of the programme. These documents do not necessarily fall within the categories discussed above, in this theme. Respondents revealed that there is an EHWP strategic framework, developed by the DPSA to guide the implementation of the programme as well as a National Strategic Plan on HIV, STIs and TB, developed by the national department of health. The programme implementers need to adhere to the latter, when implementing the HIV, AIDS and TB management pillar. Furthermore, there was also an indication that certain professional statutory bodies, would also add ethical knowledge on the conduct of its members in implementing. Participants indicated that:

*So in addition to that employee health and wellness strategic framework, we also (pause) we are also guided by the national strategic framework for HIV, AIDS and TB and STI. So as a result [clears throat] when we implement that a pillar of HIV and AIDS. We make sure we align it according to then the the the the key priority areas that have been identified by the country for that particular year.* [Non-Implementer-EHWP Policy development and implementation support]

*In terms of implementation, we follow the (pause) the framework of employee health and wellness strategic framework. Which was consulted and launched in 2008. And in 2009 eh all government provincial and national departments eh received a circular to implement and integrated employee health and wellness (pause) framework eh guided by numerous research.* [Provincial Coordinator- EHWP monitoring and evaluation, policy coordination and implementation support]

*That is governing all that EAP activities and their code of principles and ethics that guide you and give you an indication of exactly what's supposed to be in (pause) EAP programme and that then help you to implement those activities that is important part of the EAP programme. And this is where you need to start to make ensure that adhere to those ethical codes and processes before you think about governmental legislation and policy cause that is the beginning of everything.* [Implementer-Management of EHWP implementation]

Overall, all the study participants had a common understanding and awareness of the knowledge available to guide the implementation process of the programme. Experiential knowledge was seen to be useful in balancing prescribed implementation knowledge and the problem trends that are presented on the ground.

#### 4.4.3.2 Methods and processes available for knowledge translation (from concept or theory to implementation)

This theme seeks to respond to the primary objective of the study, which is to explore the methods of translating knowledge from concept to implementation in the programme. Three major and sub-themes were identified as discussed below.

**(a) Communication Channels and Tools**

For knowledge to be translated, the programme has adopted communication approaches between the non-implementers, provincial coordinators, and implementers. All interview respondents mentioned that the information is carried from the concept to implementation using different approaches.

These approaches are alleged to be part of the GPG EHWP communication strategy. They consist of: national and provincial newsletters; workshops; posters; meetings; client relations management meetings; national and provincial circulars; conference calls; and national department websites.

Though there was general agreement in terms of the type of communication channels and tools used, there was a noticeable difference in opinion about the effectiveness and the preferences of the identified channels and tools. Non-implementers believed that communicating through the departmental heads, OoP as well as websites was functional.

Implementers preferred physical and direct communication techniques. This is because according to their experience, indirect communication has numerous challenges, which included delays in receiving correspondence which tend to result in challenges in seeking and responding timeously. Some of the differences in opinion were:

*It's published on our website, on the DPME website we've got about 34 case studies on our website. Yha (pause) because our system is electronic, people are supposed to*

*(pause) I mean we are living in such an advanced age. We can't not to be seen to send electronically, so everything is basically electronic.* [Non-Implementer- Management of the performance assessment tool

*We (clears throat) have a communication strategy which was developed by transversal employee health and wellness as a means of (pause) of the guide in terms of how do you go about in in communicating. And also that will advise us in terms of yabona what (pause) what information actually is to be communicated. You would use our (pause) premier's office (pause) quarterly newsletter; there's Gauteng online, we could use .sometimes we use posters; we sometimes use our ehhh communi-care in disseminating. Those are some of the communication channels are available for now.* [Provincial Coordinator- EHWP monitoring and evaluation, policy coordination and implementation support]

*We communicate anything that affects us through our meetings, through our workshops, that for example we have an interdepartmental committee meetings that we, we hold.* [Non-implementer, EHWP Policy development and implementation support]

*DPSA and the circulars "nhe" they are very good in circulars informing the (pause) the (clears throat) that there is still here. It goes through the HOD who would say (pause) you know (pause) this area. So the HOD would say they DDG, (clears throat) did you give us (pause) give the directorates that are mandated on whatever the changes is that policy that they are having. And if it changes in terms of HR side then the DDG will call the HR directorate.* [Implementer- Occupational Health and Safety and Hygiene services]

*But mina, my challenge is we usually get the, (pause) it maybe two days late…like is and you get and let me say they will say they will want the response by today. You get it today in the morning and they say before 10h00 you should have answered on this. And you look at the date when it was received from the HOD to when it reaches us. It's a bit of a challenge.* [Implementer-EHWP Advisory services]

Generally, all tiers of the programme, are in agreement about the existence and use of communication channels and tools. However, implementers consider some of the

techniques mentioned above as ineffective, since indirect communication tends to hinder knowledge transference.

**(b) Knowledge contextualisation**

After knowledge has been communicated to provincial coordinators and implementers, the responsibility to contextualise and adapt it to the unique environments follows. Implementers and provincial coordinators showed consensus on the use of the provincial health trends report gathered by the provincial coordinating team. They also referred to DPSA strategies to assist in the tailoring of knowledge into their environments. These included the consultative forum and policy measures. Some opinions indicated that:

*That's where as a province, we look at where we are, what will be our key priorities for the coming financial year or coming up with a strategic framework for a period of five years to say as a province*. [Implementer- Management of EHWP implementation]

*Yha like the transversal reports that have been done. Then will take that that information and then customise it to what our department. We will also go to our partners such as GEMS and any other service providers that we have used in the previous financial year, in terms of reports that we have received, to better understand the trends of the issues that have been ongoing within the department. And if sometimes maybe there's been a research study that has been done maybe commissioned by the GPG*. [Implementer, EHWP Coordination and Implementation].

*Processes of what will happen is that after that generic strategic framework has been developed, as Gauteng, We look at yabona, our specific needs as a province, in terms of how can we customise this framework to suit yabona our (pause) our unique needs within the province. Then we would develop your generic GPG operational plan yabona, your generic policies, ehhh generic strategy for the province. And after that has been done the processes that yabona departments will be informed to say, this is the generic yabona strategy that we have as at the Department this is what…this is the generic ehhh strategy that we have as a Province.* [EHWP monitoring and evaluation, policy coordination and implementation support]

National department have only referred to strategies that they have designed to support departments. However, they have also mentioned that departments have the liberty to use their own methods to contextualise information. Some of the views were;

*The generic indicators, they are just to guide (pause) just to give guidance to the practitioners on implementation of the program. But it is not limited on the additions, ehh with it with what it might be existing into their department. Because they need to I customise their policies in line with the national policy.* [Non-implementer - EHWP Policy development and implementation support]

*And then within each objective we've got what we call sub-objectives or sometimes referred to it as a (pause) as policy measures. So those policy measures there are, they are outlining under each pillar what (pause) strategic outcome you need to get; the sub-strategic outcome that you need to do to achieve, when you implement each of those 4 pillars.* [Non-implementer - EHWP Policy development and implementation support]

From the responses gathered, the GPG EHW programme seemed to have adopted a strategy that suits their context. The respondents at these two levels mentioned that after knowledge has been received from the national departments, it follows the following path:

- Firstly, to ensure that departmental implementers are aware of the correspondence, the provincial coordinators will host a forum for all implementers;
- Secondly, each department focuses implementation efforts on presenting departmental risk trends gathered in a provincial annual implementation review report. The collective would decide on how to go about introducing and adapting the new information in context. This process also includes the selection of priorities based on the DPSA's generic policies and operational plans as well as the consulted provincial operational plan.

### (c) Knowledge implementation guides

Reponses on this theme showed that contextualisation and the use of implementation guides takes place around the same time. The provincial coordinators and non-implementers indicated that there are implementation guides that seek to standardise implementation of the programme.

It was gathered that some of these guides serve a dual purpose for both the implementation guidance and contextualisation. These included: policy measures; DPSA's generic operational plans; provincial operational plans; inspection reports; step-by-step implementation guide and the SHERQ checklist tool, as shown by some views below:

*So those implementation guides are aligned to individual policy measures and also gives you the examples of the activities, that you have to put in place in order to add to implement that particular policy*. [Non-Implementer, EHWP Policy development and implementation support].

*Looking at step-by-step guide for departments to implement the very policies that were were eh developed and launched for departments. To make it easier for the program to have a legal framework, guiding it and a legal document in terms of a policy.* [Provincial coordinator, EHWP M&E, policy coordination and implementation support]

*So the departments have been guided on what activities should they put under each policy measure. And then to do that, we developed what we call implementation guide.* [National Department, EHWP Policy development and implementation support].

In addition, the implementing team in the department went further and mentioned the use of inspection reports made available by the Department of Labour and certain legislation, such as schedule 8 of the labour relations policy, also serves as a guide in managing ill-health related cases in the workplace. Some of the respondents mentioned that:

*I don't know if there is any document that will be (pause) that is guiding the implementation of any of the acts.* [Implementer, Occupational Health and Safety and Hygiene services].

*The labour relations act, which tells you about the labour issues and conflicts in the workplace you know. And especially when you look at the pillar HPM, HPM on incapacity. Schedule 8 it's sort of a guideline, telling you on how to deal with incapacity until the end.* [Implementer- EHWP Advisory services]

*Especially with the SHERQ ehh programme, especially on our department (pause) department of labour is actually (pause) we are (pause) we do have workshops with them and currently we even (clears throat) we even had to [inaudible segment] section seven for department of Health only. Which was written by chief inspector that informs that we need to have a policy, yha because of how they have done their evaluations and monitoring.* [Implementer - Occupational Health and Safety and Hygiene services].

Although, implementers mentioned the availability and use of some implementation guides mentioned by provincial coordinators and non-implementers, there were some observed inconsistencies. The majority of implementers seemed to have no knowledge of the existence of an implementation guide, namely the step-by-step guide. Some also mentioned that they depend on their own professional knowledge to adapt knowledge to their context.

#### 4.4.3.3 The role of DPSA, DPME and OoP in knowledge translation.

The purpose of discussing the role of these departments is to:

- Outline roles that they carry out in ensuring that departments understand the knowledge and mandates that they convey
- To understand procedures that are put in place to measure the success of KT and
- To find the degree to which knowledge users are involved in the process.

Three sub-themes were identified which give a view of the role played by the mentioned departments in this area.

### (a) Knowledge translation support

As identified by respondents, there is support that is offered by the provincial coordinators and concept developers to implementing departments. From the interviews, a well-founded consultative forum and policy workshops are offered at national level. These gatherings appear to be favoured by implementers. Though this is the case, there was variance in perceptions, regarding the level of support offered and received at provincial and implementation level.

A majority of respondents at provincial and implementation level felt that the supportive workshops could be up scaled and be made more frequent. Some of the opinions were:

*So beyond that then then DPSA would have those annual policy workshops. I think the last one we had was in in 2014, wherein we had such a workshop and uh DPSA would take the departments through a process of impl (pause) being able to implement.* [Provincial coordinator, EHWP M&E, policy coordination and implementation support]

*(inclusion) for DPSA it's not enough what with their providing us with, because they are focusing us on high level type of (pause) to say ok (pause) with HIV and AIDS blah blah blah, this is what you need to focus on. They don't actually zoom in into what is the purpose of the HIV and AIDS pillar, you understand? What do you focus on? What are you educating on?* [Implementer, EHWP Coordination and Implementation].

In addition to the decline in support offered by national departments, implementers felt that the provincial coordinating team is also limited in its attempt to find a solution to implementation challenges. This was due to the reason that concepts are designed at national level, thus there is not much decision making done at the provincial level.

However, a significant number of implementers sounded satisfied with the provincial support structure offered by the OoP. Those structures included a provincial forum, strategic planning session, departmental client relationship management meetings and programme trainings. Implementers indicated that:

*Provincial workshops and forums which (pause) where it's more like a peer support from my fellow coordinators, in terms of how they to implement the program.* [Implementer- Coordination and implementation]

*So we can now vent our frustrations and they can now forward the frustrations to the DPSA but nothing is happening, to use MPAT as an example. I know for a fact that the transversal team wrote a letter to the DPSA saying (pause) clarifying that whole submission date thing, which made no difference then one cannot help wondering what ...what are the purpose then? S .to concur with what she is saying, yes they are doing the best that they can, like they really try to help us.* [Implementer- Management of EHWP implementation]

Gathered from the responses, the programme has established supportive platforms at all levels of the programme execution. However, it is also evident that the level of support from the national level to the province is regarded as not being enough. Furthermore, the limitation in training becomes a barrier in KT since some respondents felt that the knowledge available tends to be at a high level and does not necessarily zoom into tangible action points.

**(b) Knowledge user involvement**

Another role of the DPSA, DPME and OoP as identified by respondents, was the action of user involvement. Knowledge users in this regard, would be the implementers and provincial coordinators. Under this sub-theme, there was an indication that information users are involved through workshops and consultative forums. These platforms are often used to collectively discuss priorities for implementation. Implementers stated that:

*Where all the departments in the province are consulted during the strategic ehh planning, a meeting that normally takes place over two days. That's where as a province we look at where we are (pause) what will be our key priorities for the coming financial year or coming up with a strategic framework for a period of five years to say as a province.* [Implementer - Management of EHWP implementation].

However, from some of the responses given, it was recognised that there are issues that exist with the identified user involvement methods. Some of the respondents

implied that these fora merely exist for compliance and rarely achieve their intended purpose. Some of the views were:

*It's it's it's much better and it is easier but the thing is whether you agree with it or not it's another thing.* [Implementer- coordination and implementation support]

*We need to review that because we found that there are short falls, there are things that don't work for us as GPG and for us as departments. We really need to, but then there is a resistance somewhere when you start to say let's review the the policy. You will be told about the cabinet.* [Implementer, Occupational Health and Safety and Hygiene services]

Feelings of frustration experienced by implementers were also observed. A majority of interviewees stated that the national department also does not provide feedback on submitted reports. Yet, they felt that feedback information would be valuable in improving programme implementation. This shortfall may compromise the KT process in the programme.

**(c) Measuring the success of knowledge translation**

The importance of measuring the achievements in KT is to ensure that concepts are understood by the targeted audiences and are interpreted in a relatively similar way in order for the policy to reach its intended goals. This is an important phase towards standardising implementation and identifying where the blockages may be.

Under this sub-theme, there were noticeable differences in opinion and experiences of the type of translation measures that exist and the manner in which they are implemented.

Non-implementers seemed to rely more on observation which was the impression given by the submitted annual and quarterly departmental repots. They also admitted that because of the absence of an evaluation study, it is challenging to know if departments actually do understand what is in the existing pool of knowledge for the programme. Non-implementers stated that;

*No one ever evaluated the extent to which the knowledge is translated into implementation. It is just indirectly by (pause) may be observing the submission of the operational plans. And then, again submitting an operational plan does not actually*

*translate into the actual implementation.* [Non-implementer- EHWP Policy development and implementation support]

*Yes, they are received well, because if you do the, if you assess the annual implementation of the program from each department, you will see that the program is actually well run, because that is the only way you monitor, through the quarterly reporting and the annual reporting.* [Non-implementer- EHWP Policy development and implementation support]

Provincial coordinators and implementers gave an impression that the province has developed a strategy to measure if information is translated into operations as desired or not. From the interviews, they indicated that departmental reports would be quality assured by the provincial team prior to submitting them to the DPSA. Furthermore, there is an annual risk report which gives an implementation review for all departments in the province. This report is perceived to be of assistance in assessing the extent to which implementation has taken place against the problem areas in the province. Some of the responses were:

*And the transversal one of its functions is to monitor implementation and compliance to what we have agreed upon at a strategic level. Looking at the operational plans, if they come and we have omitted some of the information, then they will return it back to say, this was what was agreed upon, is it not going to be applicable in your department? And there is that two way engagement, it's more close now.* [Implementer- Management of EHWP implementation]

*We use those priorities that come out from the business intelligence implementation report. We do it on an annual basis and similar departments are also… as a way of monitoring the program they're supposed to. They are expected in fact to do (pause) to comply with the department of monitoring and evaluation; MPAT compliance on an annual basis.* [Provincial coordinator-EHWP monitoring and evaluation, policy coordination and implementation support]

It can be concluded that national departments seem not to have a reliable measure in place, to be able to distinguish if their methods of translation initiatives are yielding the desired results or not. This poses a threat to the quality of implementation and the

resources put in place to translate knowledge, since there is no evaluation of its success in the KT process.

#### 4.4.3.4 Barriers that exist in the knowledge translation process of the EHW programme

Essentially, this theme is meant to identify difficulties that may exist in the execution of KT processes of the programme. According to the responses given by participants, four potential hindrances that may pose as barriers in the identified process were identified. The purpose of identifying barriers is to: create insight for concept developers on possible limitations in KT; identify possible blockages to knowledge use and review the current approaches used. Respondents identified barriers that hinder KT and implementation in the programme from their own experiences.

These barriers are discussed under the following sub-themes: monitoring and evaluation methods; feedback on policy implementation; managerial support; and skills and capacity in programme implementation.

**(a) Monitoring and evaluation (M&E) methods**

Monitoring and evaluation practices tend to be useful as they may assist with problem identification in implementation; assessing practical solutions and ascertaining interventions to be revised and used.

Methods of M&E identified in the programme were those that appeared on departmental quarterly and annual reports. Tools specified were the provincial implementation review report, DPSA audits, SMT and MPAT.

In this sub-theme, there were significant inconsistencies about the existence and effectiveness of M&E tools or methods. These inconsistencies seem to be a result of misinterpretations between implementer and non-implementers. For instance, a significant number of implementers were under the impression that the SMT tool requires DPSA to monitor its results and give opinions on how the departmental heads can mitigate against the identified issues. Yet, the non-implementers are certain this is a self-assessment tool that is meant to allow implementers to reflect on what systems need to be improved upon in order for the programme implementation to flourish. These are some of the views that give insight on these contradictions:

*Why we call it systems monitoring, is to monitor the systems that are in place, that are put in place in the Department to make sure that the programme employee health and wellness programme is implemented. Now the system monitoring tool sort of puts in the criteria that has to be there, for the program to be easily implemented.* [Non-implementer- EHWP Policy development and implementation support]

*It's like the SMT like we did our SMT last year and we submitted it, we indicated for OHS that we don't have someone who has expertise in OHS. It and SMT zooms into it eh that is or is this SHERQ being implemented up according to 1 2 3? We indicate" no no no" we write there, challenges we send it up, it's signed by the HOD, but does anyone ever come back it.* [Implementer- EHWP Advisory services]

*The SMT report has been the same since the last 3 (pause) 4 years, it's just the same document. Now if my policy is implemented in 2013, my policy is implemented in 2014, in 2015, in 2016. Now what the hell is now the difference? We don't get any feedback from DPSA, it's almost as if a faceless something that is forcing all these things on us and force us to do all these things that takes a lot of time* [Implementer- Coordination and implementation]

Provincial coordinators were under the impression that the annual implementation review they produce, also serves as an M&E tool.

**(b) Feedback on policy implementation from concept developers**

This sub-theme showed a difference in experiences and perceptions of implementers and provincial coordinators from that of non-implementers at national departments. Similar to the expectation of feedback from the SMT tool discussed above, implementers believe that after every implementation review conducted through MPAT, DPSA audits and observations of departmental reports, there should be a feedback process that gives clarity on what is done right and what requires improvement. These are views of some that felt there was no feedback:

*We (pause) we are not involved. It's more about submitting "you know" and reaching the deadlines you know. When you look at the compliance indicators that they want in order for you to be compliant "you know"and achieving high score. They look at the date, they look at the signatures on the HODs, they look at (pause) if you've all four policies [cross talk] you know and budget and "you know" (pause) If they sit*

*somewhere, we don't know where, they look at the department and say and say if the department of health they've submitted all this. Therefore, you are compliant and you've got your 4.* [Implementer- EHWP Advisory services]

*As long as you do that and submit on time you get out acknowledgement from transversal that's it end of the story. You focus on the future, there is no one coming back and saying 'hey you have not made this and this according to the review that you have done'. No one comes back.* [Implementer- Coordination and implementation]

Yet, there was a minority of implementers that felt that there was feedback that they receive at the provincial level as part of the consultative forums. The respondents stated that:

*Yes, we have the transversal employee health and wellness unit to assist us and guide us It goes back to SMT, it's the workshop and trainings 'you know' yha, and the feedbacks that they are giving us as a (pause) and the forum. [*Implementer- Occupational Health and Safety and Hygiene services]

Feedback on implementation is meant to improve the quality of implementation and knowledge use. Yet, from the interviews, it was realised that the feedback process is rather slow moving and does not give proper information. This poses a risk to possible improvements in the quality of implementation and outcomes thereof.

**(c) Lack of management support**

Gathered from the responses, it was deduced that managers were part of the key stakeholders in supporting KT in departments. However, departments often indicated that they lack support in this regard, which tends to result in a lack of budget allocation and resistance in adapting knowledge. Despite continued engagement with management, mentioned at all tiers of the programme, managers simply defer. These are some of the views:

*And then managers (pause) I mean this thing can be received at a normal church, where the pastor can provide that kind of service to the like ehh the congregants. So now when you bring that service internally? Yes it's a service, because you must remember that, now you are providing a holistic service to the all (pause) all of these employees I mean like this framework and this programme of EHWP at some*

*instances it works in silos it works alone.* [Implementer- Coordination and implementation].

*So if you come and you start saying things about cost then that thing is not going to get approved and it's going to take forever because everyone needs to think about the cost. So for us it's quite different, I try to focus more on the things that will have no cost implications ...* [Implementer- Coordination and implementation].

*And those people at a high level are the people that are far from the problem is it. For example at an implementation level I wrote a comprehensive report that was showing the non-compliance of the departments. And just to get it, just to get the letter of non-compliance signed by the head of the department, it became a hassle.* [Non-implementer, EHWP Policy development and implementation support]

Generally, interviewed groups seemed to agree about the lack of managerial support and how it has resulted in resistance, low quality in implementation and poor KT outcomes. This barrier gives an impression that due to resistance and lack of resources, departmental implementers may not use the knowledge provided.

**(d) Skills and Capacity**

Having the relevant skills and capacity is necessary to enable the programme to provide quality services. This perspective was given by respondents at all tiers of programme execution. In this case, capacity seemed to be understood as a relevant qualification and experience in programme. Respondents specified that:

*I think it can be both, the skill to implement in terms of what kind of competencies are required to implement the program. And coupled with that it's not only the (pause) the competency also also is informed by if (pause) I think the other challenge with employee health and wellness is that there no (pause) like a regulated eh qualification, that would make it easier for (clears throat) even when we are recruiting at recruiting stage, to get the right type of competencies and qualification.* [Provincial coordinator, EHWP monitoring and evaluation, policy coordination and implementation support]

*I think there's a lot of capacity issues, that's why even (pause) like the communication will always be a barrier. Cause I mean you'll find that you don't have a like*

*environmental… like the ehh specialist that is going to talk to and like in terms of OHS, I don't know how in terms of the qualifications you would find that mainly is training that happens post appointment.* [Implementer, Coordination and implementation]

*So you see that, you like you need that knowledge that that someone can actually see the picture bigger picture from a distance and… if in the field or in the employee of a GPG as a whole we do not have those professionals. It becomes comes a risk.* [Implementer, Coordination and implementation]

Professional inputs in KT are required to provide an overall assessment of information conveyed by non-implementers and also innovation on how such data can be assimilated in implementation. It is evident that the lack of capacity and relevant skill in the programme may pose hindrances to KT.

### 4.5 Conclusion

In essence, what emerged from the results is that translation methods of knowledge from concept to implementation are in existence. Yet, there is a need for adequate planning to go into the management and arrangement of the methods and techniques identified. The planning and arrangement needs to suit the context of GPG EHW programme.

Ideally, the knowledge-to-action technique, assumes that KT may be in a systematic format, with identified steps and techniques. However, from the research responses, it was realized that certain steps do not necessarily adapt to the conceptual theory guiding this study. Moreover, respondents specified that the process of translating concepts into implementation does not necessarily have a clear path that is practised in the programme.

Table 8 below, highlights the findings from interviews and focus groups based on KT phases, methods and challenges as described in the Knowledge to Action model, in a summary format. It further gives an overview of the knowledge available, its translation methods as well as the challenges identified, as shown through the collected data.

**Table 8: Summary of findings from interviews and focus groups**

| Knowledge translation phase (As identified in the KTA model) | Knowledge/Methods used in translation Phase | Tools/ techniques used in knowledge translation | Challenges identified |
|---|---|---|---|
| Knowledge available | Legislation | Occupational Health and Safety act, No. 181 of 1993; Compensation for Occupational Injuries and Diseases Act, No 61 of 1997; Labour Relation Act, No. 66 of 1995; Basic Conditions of Employment Act, No. 75 of 1997; and the Public Service Regulations 2015 | No challenge identified by respondent |
| | Policy | Safety, Health, Environmental Risk and Quality Management; Health and Productivity; Wellness Management; and HIV, AIDS and TB management policy ill-health retirement policy | No challenges identified by responded |
| | Research | Human Social Research Council; International organisation standards; experiential knowledge; and implementation reports | • Research execution is a responsibility of a different directorate within the DPSA<br>• Non-implementers seem to not recognise the knowledge acquired through implementation |
| | Other | DPSA to guide the implementation; National Strategic Plan on HIV, STIs and TB; and Professional statutory bodies | |
| Adapt knowledge to local context | Communication techniques | GPG EHWP communication strategy;<br>• Workshops; Meetings | Disjuncture in communication effectiveness and preferences between |

| | | | |
|---|---|---|---|
| | | • Client relations management meetings<br>• Posters<br>National and Provincial Circulars<br>Conference calls<br>Websites | implementers and non-implementers. |
| | Knowledge contextualisation | Consultative forum; Policy measures; GPG EHWP implementation review | There is lack of awareness by National Departments on contextualization methods used in the province |
| Existing barriers to KT | Feedback on policy implementation from concept developers | No evaluation study conducted | Implementation reviews may not necessarily be informed by evidence-based studies since there is no feedback |
| | Lack of management support | | No budget allocation; resistance to knowledge adoption |
| | Skills and capacity | "Relevant" professional for programme implementation | Hinders quality and innovation in implementation |
| | Knowledge implementation guides | National and Provincial generic OPS plans; Step-by-step implementation guide; SHERQ checklist tool; and Inspection Reports | Lack of awareness of some of these existing guides at implementation level |
| | Knowledge translation support | DPSA Policy workshop; GPG EHWP consultative forum; Strategic planning session; Departmental client relationship management meetings; and programme trainings | Perceived minimal support offered by concept developers to implementers |
| Selection, tailoring and implementation of knowledge | Knowledge user involvement | DPSA policy workshops and GPG consultative forums | Implementers' inputs tend to not be considered in creation or review of knowledge |
| | Measuring the success of KT | Observations; Annual and quarterly departmental reports; Provincial quality assurance and EHWP Annual implementation reviews | Implementers lack of awareness on what and how is M&E conducted in the programme.<br>The reliability of the observation method in M&E cannot be |

| | | | |
|---|---|---|---|
| | | | substantiated given the challenges identified at implementation level |
| Monitor KT and use | Monitoring and evaluation of knowledge use through implementation | Systems monitoring tools; Management, performance, assessment tool; Annual risk trends report; and DPSA audits | Lack of awareness or misinterpretation of the actual purpose of the tools; and<br>Lack of oversight on the self-assessment tools |

The purpose of the study was to explore the methods of KT and in the process to also identify barriers that may exist in this process. The study achieved its objectives and provided details of findings, responding to the objectives of the study.

Chapter five gives an analysis of the research results outlined in this chapter, comparing them to the documents that exist for the GPG EHW programme implementation and the assumed theoretical and conceptual framework in KT.

# CHAPTER FIVE

## 5. Results interpretation and discussions

### 5.1 Introduction

This chapter is aimed at providing a comprehensive analysis and interpretation of the results described in chapter four. The analysis is based on global theories and African and South African practices in KT, which are also described in chapter two, in the literature review. Secondly, the analysis places emphasis on public sector perspectives.

The main objective of the study was to explore the KT methods of the employee health and wellness programme in the Gauteng provincial government. Moreover, the study was to identify barriers that exist in the process. This objective was achieved by using the phenomenological approach to qualitative research with a purposive population sample. This sample comprised EHWP practitioners and managers as well as the MPAT administration, who have been involved in the programme for a minimum of three years.

The hypothesis of the study was that there are possible barriers that exist in translating and converting knowledge into implementable activities. These obstacles may then result in minimal integration of research and evidence-based and experiential knowledge into the programme. This was informed by the observed discouraging outcomes in the programme's health trends between 2009 and 2015. Numerous writers, Titler et al. (2009) and Walker et al. (2013), have indicated that effective integration of knowledge and its use in programmes, tend to result in positive effects on implementation and addressing gaps that may exist towards policy objectives, thus improving outcomes.

The key findings of the study are discussed in section 5.2 and 5.3. They are arranged in accordance with the themes identified in chapter four, so as to not confuse the reader.

## 5.2 Discussions of results

### 5.2.1 Knowledge available for the programme implementation process and how it is used

The legislative framework and policies that exist in the programme result from parliamentary considerations, which are then inferred into a policy and disseminated to the public for further opinions and ideas. Following this process, the frameworks and policies are transferred into a strategic framework and implementation plans for execution as documented by Cloete et al. (2006) and Cloete, Thornhill and Cloete (2012).

This suggests that knowledge available to guide implementation in the GPG EHW programme, seems valid as stated by Wehrens (2014). He argues that knowledge can be regarded as valid and scientific when it is shaped by social, economic, cultural, and political factors in its foundation.

Moreover, from a global perspective, the existence of research and experiential knowledge is regarded as useful in designing and implementing relevant interventions for users. This is because this type of knowledge is derived more from cultural practices and communal experiences, particularly in qualitative studies (Ritchie et al., 2013a).

Further, it was recognised that there was a shared understanding of knowledge available to guide the implementation of the programme. However, its use appeared to be centred on what actors, at each level of programme implementation, preferred. For instance, implementers preferred to use the implementation results combined with policies, legislation and guidelines provided by statutory bodies. The combined information was perceived to be insightful in crafting and tailoring interventions to the GPG EHWP trends.

The issue that emerges is that there seems to be no clear path as to how the implementation results and experiential knowledge is considered and assimilated in the EHWP concepts. This idea is derived from the responses given by implementing departments, which suggested that concept developing departments seem not to consider implementation data as evidence-based or research knowledge. Moreover, their inputs seem to have little to no influence on the concepts developed to ensure that they respond to the presenting GPG trends. This was also confirmed by the concept developers' responses as they merely referred to research institutions as their main source of research knowledge.

The dependence on reliable research hubs by concept developing departments is observed to be important in enlightening the programme's implementation with valid and reliable facts. The dependency on research hubs is not unique to GPG as stated by Wehrens (2014). He argues that this dependency is often caused by uncertainty of reliability in the knowledge given.

Though that may be the case, the perceived disregard of implementation data is considered disadvantageous to the programmes' advancement and potential improvement. This is because implementation outcomes have been discovered to be useful in determining the effectiveness of implementation plans. Outcomes can also measure whether policy objectives have been attained and what possible adjustments are needed as identified by Nilsen et al (2013) and Sudsawad (2007).

Moreover, the DPME's guide to the outcomes approach, emphasizes the need to monitor and evaluate implementation outputs to provide insight on which interventions work and which ones do not. This is done to create discussions on what alternatives can be adopted and how they may influence the results (Guide to outcomes approach, 2010). Yet the results seem to suggest that knowledge application in the programme is not compliant with the outcomes approach.

The perceived lack of standardization in the application of knowledge in the levels of programme execution has a potential to influence consistencies in outcomes (Matland, 1995). According to Grimshaw et al. (2001), these differences may pose challenges for KT objectives in the programme.

### 5.2.2 Methods and processes available for KT (from concept or theory to implementation)

The data obtained in GPG, suggested that methods of KT consist of communication channels and tools, knowledge contextualisation techniques and implementation guides. However, there were noticeable differences in perceptions on the effectiveness of these techniques. These difference are challenges, since Grimshaw (2012) argues that the impactful meaning of knowledge needs to be translated in a manner that is understandable and desirable by its users. That includes ways and means of informing implementers on the approaches and systems to adopt information into programme implementation.

In the EHWP, communication channels used include electronic and manual systems. These consist of emails and hard copy documents, however, implementers in GPG mostly preferred physical interaction methods which comprised client relations management meetings, GPG consultation forums and policy workshops. This is similar to findings made by Bero et al. (1998); LaRocca et al. (2012) and Mbonye and Magnussen (2013).

The second approach of KT in GPG was the contextualisation of concepts. This was achieved through the use of implementation guides which comprised policy measures, DPSA generic operational plans, provincial operational plans and the SHERQ checklist tool. Respondents referred to implementation guides as having a dual purpose. Firstly, it was to create a common understanding of the national and provincial priorities of the programme and then to assist implementers to adapt information to suit their context. According to Myburgh (2013) and Schwartz and Evans (2007), the use of implementation guides is a common practice in guiding programme operations and maintaining uniformity in the public sector

The communication methods, knowledge contextualisation, and implementation guides seem to be nationally prescribed practice. Provincially, the programme seems to have adopted KT approaches that are suited to their context. In GPG, the knowledge is customised through monitoring provincial and departmental health trends among employees. This practice is important in helping to tailor and prioritize interventions as supported by Graham et al. (2006) and Logan and Graham (1998). The respondents at departmental and provincial levels mentioned that after knowledge has been received from the national departments, it follows a certain path, which can be summarised as follows:

- Firstly, to ensure that departmental implementers are aware of the correspondence, the provincial coordinators will host a forum for all implementers.

- Secondly, based on the departmental risk trends gathered in a provincial annual implementation review report and the Department of Labour inspection reports, the collective would decide on how to go about introducing and adapting the new information into their context. This process also includes the selection of priorities based on the DPSA's generic policies and operational plans as well as the consulted provincial operational plan.

The methods employed by the GPG EHW programme give an impression that the use of knowledge is based on the presenting health trends that are unique to GPG. When viewed

holistically, the data shows that the GPG EHW programme seems to have adopted an interactive strategy that suits their context.

However, the key challenge that emerged from a majority of implementing departments, was the ineffectiveness of written communication in communicating knowledge. Communication consisted of posters, circulars, electronic mail, memos and intranet posts. The ineffectiveness of the communication seems to be caused by undesirable organisational factors wherein correspondence is sent to departmental heads and their seconds-in-command. Following this, communication is directed to senior managers then to their deputies before it reaches the actual implementer.

Though the involvement and acknowledgement of organisational structures are regarded as important in accordance with Grimshaw et al. (2001) and Yost et al. (2015) in this instance, this process is seen as causing unnecessary delays in communication and increases communication touch points which may limit interaction between concept developers and users, and thus threatens the achievement of KT objectives.

Secondly, there seems to be unequal understanding of knowledge and its use by concept developers and knowledge users in implementing departments. This was observed, particularly when concept developers mentioned an existence of a step-by-step guide for implementing the programme, which implementers seemed to be unaware of.

The inconsistencies and misunderstanding of knowledge in the EHW programme, was one of the specific hindrances identified with regard to the KT concept. Graham et al. (2006) and Grimshaw et al. (2012) argue that a major indication of effective KT is a common interpretation on the purpose and use of knowledge. Based on literature and data obtained, the usefulness of the identified methods of KT, particularly those used by concept developers, needs further assessment.

The results have identified the processes and methods of KT in the programme. However, there were a number of observed risks in the methods used to translate knowledge in the EHW progamme. These include the minimal level of engagements, confusion and feelings of frustrations by implementers. Since this is not an evaluative study, the observed risks would require another study to substantiate them.

#### 5.2.2.1 The Role of DPSA, DPME and OoP in knowledge translation

In the GPG context, the responsibility to convert information into implementation was not clearly defined. Perceptions on the roles of the DPSA, DPME and OoP in KT varied among respondents. Firstly, they mentioned that the DPSA and the OoP played a supportive role in knowledge creation and modification to suit the relevant environment. Other respondents felt that there is minimal support given, particularly from the DPSA, in fact the national department was seen as merely taking decisions on their behalf and seldom considered implementers' inputs. This tends to result in challenges for implementers to adapt knowledge to the local context.

Moreover, there was minimal reference made by implementers to the existence of researchers in formulating and translating knowledge into the programme. This may be ascribable to the fact that the research and policy unit in DPSA does not fall within the EHWP directorate, as mentioned by DPSA respondents. This is viewed as an additional barrier for KT in the programme, particularly since Wilson et al. (2010) argue that the role of KT lies with the researchers. They need to translate knowledge for policy makers and administrators. While this is the ideal practice in KT methods based on the readings, some researchers may lack the skill to conduct KT, since the CIHR (2012) defines KT as a dynamic process that requires certain abilities and resources to be effected effectively.

The second role of the knowledge developers was to coordinate consultative engagements and policy workshops to involve knowledge users in KT processes. However, it appeared that these processes merely took place for compliance purposes, in that, irrespective of the inputs made by implementers, there were minimal changes made to that particular document. Therefore, this leaves implementers with no opportunity to influence drafted concepts with their experiential knowledge. Therefore, this practice may render the methods of KT in GPG as ineffective, and may further tarnish the user-researcher relationship, which is seen to be paramount for KT facilitation as identified by Grimshaw et al. (2001).

The lack of influence of knowledge by users during knowledge creation stages is not unique to the EHW programme in GPG. Myburgh (2013) identified this tendency in the South African public health sector context. She states that knowledge in the public sector healthcare context is usually assimilated into implementation through mandatory guidelines for health care workers. This practice has not achieved desirable results, since health care workers approach these guidelines with resistance.

The third role of the provincial and national departments was the responsibility to measure the extent to which knowledge had been successfully translated and implemented. The methods of measuring knowledge-use varied between the provincial and national departments. National departments employed methods of observation on self-administered implementation reports. The self-reporting method appears to be commonly used in collecting data, as shown in the literature. However, the issue that emerges is the reliability of information provided through this technique. This issue is also identified by Martinez, Lewis, and Weiner (2014). They argue that this technique poses weaknesses, since it is prone to the individual's bias.

Measuring knowledge use is perceived to be an important aspect in determining the effectiveness of KT methods. According to Logan and Graham (2010) and Menon and Varadarajan (1992), this practice can further assist in identifying barriers that tend to hinder knowledge utilization.

Unlike their counterparts, the provincial coordinating team has adopted a different strategy. This involves the process of quality assuring departmental implementation plans and reports before they are submitted to the DPSA. This is done to ensure that the content in these documents responds to the health risks identified by the annual implementation report. The knowledge measurement approach observed in this case shows similarities to content analysis approaches as identified by Dunn (1983).

According to Dunn (1983), content analysis involves the act of examining research reports, study material and any other kind of document that contains experiential information. This method has also been considered useful in comparing short-term implementation approaches amongst selected research groups.

The identified roles and responsibilities spell out the ideal in practice. . Yet, practically, they probably need to be evaluated to study their effectiveness. Roles in the KT process need to be clearly defined to minimise barriers.

### 5.2.3 Barriers that exist in the KT process of the EHW Programme

Respondents stated that there are four major barriers that exist in the KT process for the programme. These are: differing views on methods used to monitor and evaluate information; poor feedback on policy implementation from concept developers; lack of managerial support in adopting knowledge as well as the inadequate skill and capacity to perform KT duties.

Liyanage et al. (2009) define barriers in KT as constraints and hindrances that may disturb a well-ordered process of KT. This implies that barriers in KT are based on the opinion of the knowledge creators and users and they may vary from one environment to the other.

Firstly, respondents identified the SMT, DPSA's MPAT as methods to monitor and evaluate knowledge in the programme. However, there was an observed misconception about the purpose of the SMT, wherein implementers thought the tool was meant to monitor implementation systems and evaluate the programme. However, the DPSA clearly defined it as a self-assessment tool to provide reflection for the implementer.

Another misconception in monitoring methods was around experiential knowledge made available by the provincial and departmental implementers. Respondents at these levels perceived the annual implementation review report as a document that enlightens knowledge creators to the extent to which national concepts have been implemented and their outcomes. However, the national department made no reference to this booklet.

Moreover, the interviewed groups seemed to differ on the purposes of MPAT. National departments believe MPAT is used as a monitoring and evaluation tool, while implementers perceive it as a compliance measure, since it was merely concerned with checking the existence of implementation documents such as policies and operational plans, yet it fell short in assessing the quality of the content presented.

Though techniques to monitor and possibly evaluate the implementation of the programme seem to exist, the responses gathered did not show that there is a clear path known by all tiers of the programme. This raises concerns on how concept developers identify the need to review certain practices and existing limitations in the programme. This concern is echoed by Azimi et al. (2015) and Davison (2009). They argue that monitoring knowledge use may provide an opportunity for knowledge translators to assess practical solutions to the identified problems.

The second identified barrier was the lack of feedback on policy implementation from concept developers to implementers. The research gathered indicated that EHWP implementers expected that information collected through the DPSA audits, SMT and MPAT would be given back to them. This information needs to detail shortfalls and recommendations, to offer an opportunity to redirect implementation by making the

necessary adjustment. Yet, an observation made was that the feedback process in the programme was sluggish to non-existent.

Literature shows various important uses of feedback to improve implementation outcomes. According to Lang, Wyer, and Haynes (2007) feedback information is useful in promoting interaction between researchers and users as well as changing implementation patterns and patient outcomes. In a systematic review conducted by Field et al. (2014) feedback activities were perceived to be an important part of KT methods, to upscale knowledge use. Feedback information is also viewed as an educative act, as it gives insight into implementation modifications to get the desired results (Lang et al., 2007; Straus et al., 2011).

The third barrier identified by respondents was the lack of managerial support in adopting knowledge. The interviewed groups at all levels of programme execution identified the lack of managerial support as a major KT barrier. They viewed managers as an important stakeholder who through their power to direct budget allocation and other resources into implementation, could improve programme outcomes.

Along with lack of support, respondents also identified a level of resistance by managers in adopting reforms specified by the national and provincial departments. The major concern with this challenge was the observed minimal efforts made by concept developers to close this gap by providing insight to managers on their role and its importance to KT. Challenges with managerial support in the programme have also been identified by Madikologa (2014). She argues that managers often do not consult the EHW programme implementers, nor provide implementation direction.

Yet, Straus et al. (2011) state that the role of leadership and management is crucial as the power to influence decisions in the organisation lies with them. In addition, Grimshaw et al. (2012) argue that involvement of leadership in KT projects often produces the desired results.

The fourth KT barrier in the programme included skills and capacity that are required to understand, contextualise, and adopt the available knowledge into implementation. The interviewed groups indicated that the capacity challenges included limited staff members available for programme execution as well as the appointment of random personnel to implement the programme.

These included persons who either did not have a post-matric qualification or did not possess a health, occupational, behavioural and social sciences related qualification registered with

the relevant statutory body. Respondents viewed this as a challenge since KT requires professional inputs to advise how to assimilate research into implementation. It further tends to create high work burdens on other employees.

This challenge noted by respondents has also been identified in literature as a concern for successful KT projects. According to Grimshaw et al. (2012), the lack of skills to evaluate and understand research information can obstruct knowledge management and translation. However, Liyanage et al. (2009) and Straus et al. (2011) suggest that organisations can curb this, through teaching research literacy to healthcare professionals. However this suggestion seems to be unusable because of the inadequate skills of some of the employees.

The analysed results indicate that the barriers identified are not necessarily unique to the EHW Programme. Dobbins et al. (2009b) states that, KT organisations across the world are often faced with environmental dynamics and knowledge mismanagement amongst other issues. However, there are available, workable solutions which the programme may initiate in order to enable managers, concept developers and implementers to minimise hindrances and facilitate KT plans better.

### 5.3 Content analysis of EHWP implementation documents

In order to gain insight into the level of support for KT practice in the programme, it was necessary to analyse the content of documents that guide implementation. These documents included the DPSA EHWP strategic framework, GPG EHWP implementation reviews reports, EHWP policies, as well as the DPME's outcomes approach.

Generally, the documents analysed provided implementers with information and guidance on programme practice. They have not instituted a systematic framework that clearly outlines how the information can be used and when. This may also substantiate the confusion exhibited by implementers on the purpose and use of each document, which also suggests a possible communication gap between knowledge developers and implementers.

### 5.4 Summary of findings

The detailed analysis and discussion of the results have shown and critically discussed the methods and barriers of KT in the Gauteng provincial government. This section provides insight on the key aspects suggested by the data and its interpretation in response to the research question.

### 5.4.1 Knowledge adequacy

The findings showed that there is adequate knowledge to implement and give direction to the programme. In the GPG EHWP, knowledge did not only consist of legislative frameworks, but included experiential information, implementation outcomes as discussed in section 4.4.2.1.

However, the data also indicated a possible risk to the application of the knowledge provided. The concept developers of the programme did not recognise and use experiential knowledge to inform policy and other legislative documents. Yet, this practice can provide relevant contextual responses to the presenting problems, thus encouraging utilisation by implementers (Sudsawad, 2007).

### 5.4.2 KT methods, processes and tools

The methods utilised to translate concepts into implementation consisted of communication techniques and implementation guides, used to contextualise interventions. Though the methods exist, they seem to be faced with a number of challenges. These approaches seemed to mismatch the users' needs and failed to generate understanding of the content. This challenge can be reduced through refining KT techniques to adopt a more clear and systematic approach.

### 5.4.3 KT barriers in the GPG EHWP

It was identified that KT is hindered by the limitation in budget allocation, personnel, and skill to manage as well as implement the knowledge created. The programme managers can curb this through engaging the human resources department to attract the desired skills and to initiate KT training.

### 5.4.4 KT roles in GPG EHWP

It seems that roles in KT are not clearly defined. Moreover, there is an uncommunicated assumption that implementers understand the information given and can integrate it into their environment to respond to their needs. Based on the data provided, this assumption has resulted in confusion and feelings of frustration among the three tiers in the programme execution.

It appears that the initial hypothesis made by the research is somewhat correct. It was assumed that, the unfavourable outcomes observed in the programme may be caused by, among other things, flawed KT methods. This challenge renders policy objectives and concepts not to be realised, especially when the personnel responsible to follow them through, do not understand their content.

# CHAPTER SIX

## 6. Conclusion

### 6.1 Introduction

The importance of KT seems to be a growing practice globally, as its effectiveness is associated with improved implementation and outcomes thereof. Though this insight exists, it has not minimised the KT issues that occur in the process of assimilating research into implementation.

Likewise, the study was based on the assumption that, among other factors, the observed poor outcomes in the GPG EHWP can also be attributed to flawed KT methods. Therefore, semi-structured research questions were designed and implemented to obtain views on the KT methods used in the programme, their existing barriers, and role differentiations in the departments involved. This exploration was channelled in accordance with the available literature and theoretical framework discussed in chapter 2.

This chapter, therefore, provides a summary of the essence of the study and an overview of insight on the findings. It also provides reflections, and limitations of the project as well as future areas of research.

#### 4.1 Overview of the study

The exploration of the KT methods in GPG EHWP shows that KT methods are in existence, as presented in chapter four and five. The methods included communication techniques and knowledge contextualisation approaches, mainly executed through training, consultative forums and policy workshops. These methods were used by national and provincial departments to translate policy, research, national mandates and South African legislative framework in the form of Acts into implementable activities.

The data analysed showed that, while these methods exist, they are presented with information and execution gaps. This was reflected by the disagreements in the level of understanding, awareness and use of the existing knowledge in the programme as well as an unclear KT execution process and sequence.

The mix-up can be attributed to the absence of a systematic framework to guide KT in the programme. This has resulted in programme implementers developing their own process

maps to integrate newly discovered knowledge into implementation. The level of independence given to departments is viewed as a challenge, particularly when the shortage of relevant skills has been identified as a barrier to effective KT in the programme. Moreover, this practice has been proven to be ineffective in policy execution, as it results in inconsistencies in interpretation and implementation.

Secondly, the methods used to monitor knowledge use were perceived to be time wasting and merely conducted for compliance. This was also reflected in the lack of commitment to the role of monitoring knowledge use shown by knowledge developers. They consistently referred to the concept of 'self-monitoring' while shifting the responsibility to monitor knowledge use to implementers. This was perceived to be a significant risk, particularly when the role of the concept developers in monitoring knowledge is seen to be an integral part of identifying gaps and producing practical solutions to support programme practice.

Moreover, the identified KT barriers in the programme, shown in chapter 4, highlight a need to assess the implemented KT methods, organizational culture and management styles. These factors are perceived to be key to effective KT in the programme as they assist organisations to plan better, identify hindrances, and clarify roles in the project.

Generally, the results show that KT methods and processes in the programme, are still at a developmental stage. Regardless of which KT theory is used, there are three basic principles identified to be fundamental to the success of the KT in GPG EHWP.

First, the KT process needs to be implemented in a circular motion, where concept developers provide knowledge for implementation, then monitor its use. Second, outcomes, results, and experiential knowledge need to be included in the evaluation of concept documents. Third, feedback must be presented to the relevant audiences to improve implementation so that monitoring can begin again. Throughout these stages, roles and barriers need to be clearly identified, to minimise misunderstanding in the KT project.

The conclusion presented in this chapter needs to be interpreted and understood in relation to the other chapters in this study.

### 6.2 Strengths and Limitations

The provided information is adequate to give an understanding of the knowledge that exists in the programme, its uses and translation hindrances. This information will provoke discussion among policy developers, researchers and implementers on the importance of KT and assess practical solutions to the identified barriers.

The major strength of the study, is the significance in adding knowledge to EHWP for possible improved practice through the provision of in-depth contextual experiences.

One of the identified limitations was that study participants were employees within the EHWP national and provincial departments. Therefore, study findings and conclusions can only be applicable to EHWP within the sampled departments. Moreover, the findings of this paper are limited to personal experiences and opinions of the participants, and conclusions made were based on past events.

### 6.3 Future research

This study explored the methods of knowledge translation methods in the GPG EHWP and contextual hindrances that are in existence. It would therefore be useful to identify the applicability of the KT theories in an environment with limited resources similar to that of the GPG EHWP.

Moreover, a longitudinal study is desirable, in order to assess whether changes in KT methods in the programme would minimise hindrances and have an effect on desirable outcomes.

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APPENDIX A




Participant Code:……

**Consent form for Participation in the research study entitled:**

Exploring the knowledge translation methods of the Gauteng Provincial Government Employee Health and Wellness.

I ……, hereby consent to participate in the research study conducted by Vuyolwethu Mtshengu. The purpose and procedures of the study have been explained to me. I understand that my participation is voluntary and that I may refuse to answer any particular items or withdraw from the study at any time without any negative consequences. I understand that my responses will be kept confidential.

Name…….

Date……

Signature……

APPENDIX B




Participant Code……

**Consent form for audio taping of the interview for the research study entitled:**

Exploring knowledge translation methods of the Gauteng Provincial Government Employee Health and Wellness programme.

I ……, hereby consent to the tape recording of the research interview conducted by Vuyolwethu Mtshengu. I understand confidentiality will be maintained at all times and that tapes will be destroyed two years after the publication arising from the study or six years after completion of the study if there are no publications. I also agree to allow for direct quotes to be incorporated into the study.

Name of Department…….

Date……

Signature……

# APPENDIX C

Appendix: C
Participant Information Sheet

University of Witwatersrand
Faculty of Humanities
School of Human and Community Development
Private bag 3
WITS
2050
Email: Alex.vandenheever@wits.ac.za
939511@students.wits.ac.za

Good day

My name is Vuyolwethu Mtshengu and I am a Masters of Management in Public Policy at the University of Witwatersrand for the academic year 2016. As part of the requirements for the degree, I am conducting a research study entitled: Knowledge translation methods of the Gauteng Provincial Government Employee Health and Wellness programme.

It is hoped that the research study will enhance EHWP implementation process by exploring barriers that hinder policy translation and develop appropriate intervention and methods in the implementation process thereof.

I therefore wish to invite you to participate in the study. Your participation is entirely voluntary and refusal to participate will not be held against you in any way. Your identity will be treated with anonymity and all the information gathered through the interview will be treated with confidentiality. If you agree to participate, I shall arrange to interview you at a time and place suitable for you. The interview will last approximately one hour. You may withdraw from the study at any time and you may refuse to answer any questions that you feel uncomfortable with.

With your permission, the interview will be tape-recorded. No one other than my supervisor will have access to the tapes. The tapes and interview schedules will be kept confidential and locked in a cabinet for a period of two years following any publications or for six years if no publications emanate from the study. Please be assured that your name and personal details will be kept confidential and no identifying information will be included in the final research report.

Please contact me on 0848738685 or my supervisor, Prof. Alex van den Heever on 011 717 – 3944 if you have any questions regarding the study. We shall answer them to the best of our ability. Should you wish to receive a summary of the results of the study; an abstract will be made available on request.
Thank you for taking the time to consider participating in the study.

Yours sincerely

Ms Vuyolwethu Mtshengu
Master of Management of Public Policy Student
Witwatersrand School of Governance

Prof. Alex van de Heever
Student Supervisor
Wits School of Governance

**APPENDIX D**

**Semi-Structured interviews for Departmental implementers**

1. What Knowledge available?

(a) What guides the implementation of the EHWP in GPG?

(b) Is there guiding method or tool to support in knowledge translation?

2. How is knowledge customised?

   (a) Which other platforms are available to ensure guidance and support in knowledge translation?

   (b) How do these platforms assist you to translate knowledge into implementation?

   (c) Do you feel that you are involved well in the knowledge translation processes?

   2.1 What processes are used to contextualise the knowledge?

   (a) Who and how do you select priorities for implementation?

   (b) Are there any challenges in the identified process?

   (c) How useful are these guidance/tool/process in assisting you to achieve the EHWP objectives or implementation.

   (d) Does the governing departments mentioned provide knowledge that suits your departmental priorities?

   (e) If it does not, what do you do? How do you ensure that Knowledge (e.g. policies) are aligned to departmental needs?

3. What knowledge communication tools are available?

   (a) What type of methods is used to convey knowledge to you?

   (b) What knowledge communication tools are available?

(c) How are implementation processes communicated with you?

(d) Do you understand e,g policy and how it needs to be implemented in your departments?

(e) Is there any guidance material offered to provide support and guidance?

(f) Is it understandable to you?

4. How is knowledge monitored and evaluated?

(a) Who monitors if programme implementation is in line with the knowledge prescribed (as answered in question 1)?

(b) Who evaluates if knowledge implemented as desired by DPSA?

(c) Is the knowledge available useful towards the programme objectives?

(d) How do you measure the usefulness of the implementation?

(e) What do you do with the implementation results?

(f) How do you synthesize implementation results to knowledge (policy, strategic plan etc)

5. Knowledge translation outcomes

(a) Are there any structures available to measure success in outcomes of knowledge translation?

(b) Are the knowledge translation methods yielding the desired results?

(c) What gives you an indication that the translation methods used yield the desired results?

**APPENDIX E**

**Semi-Structured interviews for Provincial and National Departments**

1. What Knowledge available?

   (a) What guides the implementation of the EHWP in GPG?

   (b) Is there guiding method or tool to support in knowledge translation?

2. How is knowledge customised?

(a) Which other platforms are available to ensure guidance and support in knowledge translation?

(b) How do these platforms assist departments to translate knowledge into implementation?

(c) How do you ensure that departments are well involved in the knowledge translation processes?

(d) What processes are used to contextualise knowledge?

(f) Who and how do you select priorities for implementation?

(g) Are there any challenges in the identified process?

(h) How useful are these guidance/tool/process in assisting you to achieve the EHWP objectives or implementation.

(i) Do you provide knowledge that suits departmental priorities?

(j) If it does not, how do implementers ensure that Knowledge (e.g. policies) are aligned to departmental needs?

3. What knowledge, communication tools are available?

(a) What type of methods are used to convey knowledge to implementers?

(b) What knowledge communication tools are available?

(c) How are implementation processes communicated with implementers?

(g) Do they understand e,g policy and how it needs to be implemented in their respoctive departments?

(h) Is there any guidance material offered to provide support and guidance? Is it understandable to you?

4. How is knowledge monitored and evaluated?

(a) Who monitors if programme implementation is in line with the knowledge prescribed (as answered in question 1)?

(b) Who evaluates if knowledge implemented as desired by national departments?

(c) Is the knowledge available useful towards the programme objectives?

(d) How do you measure the usefulness of the implementation?

(e) What do you do with the implementation results?

(g) How do you synthesize implementation results to knowledge (policy, strategic plan etc)

5. Knowledge translation outcomes

(a) Are there any structures available to measure success in outcomes of knowledge translation?

(b) Are the knowledge translation methods yielding the desired results?

(c) What gives you an indication that the translation methods used yield the desired results?

## APPENDIX F

## Research approval for DPME

WITS SCHOOL OF GOVERNANCE
UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Enquiries: Vuyolwethu Mtshengu
Student: Master of Management in Public Policy
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| | | |
|---|---|---|
| **TO** | : | **Tshediso Matona (Mr)**<br>**Acting Director General: DPME** |
| **Cc** | : | **Nomlala Ntabozuko (Mr)**<br>**Director: Human Resources Management** |
| **Cc** | : | **Ian Goldman ( Dr)**<br>**Head: Evaluation and Research** |
| **FROM** | : | **Alex van Den Heever (Prof)**<br>**Wits School of Governance: Social Security Systems Administration and Management studies** |
| **DATE** | : | **22 July 2016** |
| **SUBJECT** | : | **Request for approval to conduct an academic research within the DPME evaluations and research unit** |

1. **PURPOSE**

The purpose of this memorandum is to request the Director General's approval for Ms. Vuyolwethu Mtshengu to conduct an academic research in DPME within the Employee Health and Wellness Programme, as partial fulfillment towards a degree for Master of Management Public Policy for which she is registered for, at the Witwatersrand University for 2016.

2. **BACKGROUND**

Ms. Vuyolwethu Mtshengu is currently studying Masters of Management in Public Policy with the Witwatersrand University. She is also an employee for the Gauteng Provincial Transversal EHWP programme. Her study will enhance knowledge and skills in strategic support and advisory services within the GPG departments and may improve policy design that will benefit the province and enhance service delivery in the following areas of EHWP:

Advanced quantitative and qualitative methodological knowledge in policy issues, knowledge management, decision formulation skills in key areas of EHWP policy formulation, strategic decision making, process and institutional design for the management of EHWP policy, policy implementation, monitoring and evaluation, and policy review.

## 3. MOTIVATION TO CONDUCT THE STUDY

The Gauteng Director General approved four GPG transversal EHWP policies in 2015 in line with the DPSA employee health and wellness strategic framework. However, the public sector lacks frameworks that would give direction on how policies, new developments, innovation and research knowledge within the field can be managed and adapted into the programme's implementable activities. This then gives programme implementer's independence to develop their own process maps that are meant to assist them in incorporating newly discovered knowledge into the programme practice. However, there are consequences with this level of autonomy, which may include inconsistencies in policy implementation and outcomes thereof.

As part of this study, the researcher wishes to explore the DPME's methods in assisting the public sector translate performance results, research and policy from knowledge to a technical and implementation level, since DPME is the custodian of the outcomes approach aimed at enhancing governmental performance. This may also be an opportunity for DPME and GPG to discover gaps that may exist in incorporating performance results to improve performance. It will further assist in improving the programme's implementation and lessen the predominant health risks once recommendations of the study have been inferred.

### 3.1 The proposed research topic will focus on:

Exploring knowledge translation methods of the Gauteng Provincial Government Employee Health and Wellness programme

#### 3.1.1 Secondary Objectives

- Raising awareness to policy makers, research and implementers on the importance of knowledge and how its translation may be a benefit towards improved implementation.
- The study may add value in the implementation practice of the EHWP through imparting understanding on how research and evidence based knowledge can be adopted in practice.
- Contributing knowledge to the implementation science field of study with the South African context.

It is envisaged that the study may improve the quality of service delivery implementation through learning best approaches from evidence based and experiential knowledge. It will also assist the EHW programme to align to M&E's outcomes approach as administered by the Department of Performance, Monitoring and evaluation as well as the DPSA's EHWP requirements.

**4. Deliberations**

The research study will be conducted during 2016 academic year. This a qualitative study which will employ a non-probability sampling method. Using a case study method to explore the in-depth experiences of EHWP Coordinators in the context of study, which will include 14 departments within GPG, the DPSA EHWP directorate and the DPME evaluations and research unit. The sample criteria are as follows:

- Participants to have been employed as an EHWP Coordinator since 2012
- Participants to at least have 3-5 years' experience in the wellness field
- Policy specialist with 3-5 years' experience in DPME

The method of data collection will include focus groups and individual interviews which will be conducted through a standardised questionnaire and will be analysed through noting quality and identifying patterns and themes relevant to the research.

**5. Financial Implications**

Ms. Mtshengu is a recipient of a bursary from the Gauteng Department of e-Government to study Masters of Management in Public Policy and there will be no further financial implications for the Province for granting her permission to conduct an academic research study.

**6. Recommendations**

In light of the above motivation, it is therefore recommended that the Director General in DPME grant Ms. Mtshengu permission to conduct research study within the research and evaluations unit as part fulfillment towards a Master's of Management in Public Policy for 2016 academic year.

www.wits.ac.za/wsg

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**Alex van Den Heever (Prof)**
**Wits School of Governance: Social Security Systems Administration and Management studies**
**Date:**

Support/ ~~not supported / supported as amended~~

**Ntabozuko Nomlala (Mr)**
**Director: Human Resources Management**
**Date:** 12-08-2016

Comment: 12-08-2016. Students research topic is related to evaluation and research branch

Support/ not supported / supported as amended

**Ian Goldman (Dr)**
**Head: Evaluation and Research**
**Date:**

Comment: Supported

Approved/ not approved/ approved as amended

**Tshediso Matona (Mr)**
**Acting Director General: DPME**
**Date:** 21/8/2016

Comment:

www.wits.ac.za/wsg

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## APPENDIX G

## Research approval for DPSA

the dpsa
Department:
Public Service and Administration
REPUBLIC OF SOUTH AFRICA

Private Bag X916, Pretoria, 0001 Tel: (012) 336 1000, Fax: (012) 326 7802
Private Bag X9148, Cape Town, 8000 Tel: (021) 467 5120, Fax: (021) 465 5484

Inquiry : Ms Brenda J Hendricks
Telephone : 012-336 1570
Email address : Brenda@dpsa.gov.za

Dear Ms Vuyolwethu Mtshengu

Your letter requesting permission to use the Department to conduct research has reference.

The Department has considered your application and grants approval to your request on the following conditions:

a) You shall not use or refer to any information classified as confidential, secret or top secret; and that
b) You will not use or refer to any information of a personal nature without the consent of the affected individual, to comply with the provisions of all laws which regulate the protection of personal data, in terms of the of Personal Information Act 2013 as well as the Electronic Communications and Transaction Act 2002.

You are also required to submit the final research paper to DPSA before it is submitted to the University.

The Department takes this opportunity to wish you well in your studies. Please contact Ms. Brenda J Hendricks, brenda@dpsa.gov.za for any further assistance required.

Kind regards

Mr Mashwahle Diphofa

**DIRECTOR – GENERAL**

**DATE:** 08/08/2016

## APPENDIX H

## Research Approval for GPG Provincial departments

GAUTENG PROVINCE
e-GOVERNMENT
REPUBLIC OF SOUTH AFRICA

# INTERNAL MEMO

Enquiries: Menyezwa Menze
Directorate: Human Resources Services
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**TO** : **Phindile Baleni (Ms)**
**Director General: Gauteng Office of the Premier**

**Cc** : **Boy Ngobeni (Mr)**
**HoD: Department of e-Government**

**FROM** : **Menyezwa Menze (Ms)**
**Acting Chief Director: Human Resources Services**

**DATE** : **12 April 2016**

**SUBJECT** : **Request for approval to conduct an academic research in GPG Departmental EHWP units**

**1. PURPOSE**

The purpose of this memorandum is to request the Director General's approval for Ms. Vuyolwethu Mtshengu to conduct an academic research in GPG within the Employee Health and Wellness Programme, as partial fulfilment towards a degree for Master of Management Public Policy for which she is registered for, at the Witwatersrand University for 2016.

**2. BACKGROUND**

The Gauteng Department of e-Governance granted Ms. Vuyolwethu Mtshengu a bursary. She is currently studying Masters of Management in Public Policy with the Witwatersrand University. The course is in line with the job functions of the specialist and her Performance Development Plan. It also has core technologies on Policy design that will benefit the province and enhance service delivery in the following areas of EHWP: Advanced quantitative and qualitative methodological knowledge in policy issues, knowledge management, decision formulation skills in key areas of EHWP policy formulation, strategic decision making, process and institutional design for the management of EHWP policy, policy implementation, monitoring and evaluation, and policy review. These are highly

required to render strategic support and advisory services within the GPG departments.

## 3. MOTIVATION TO CONDUCT THE STUDY

The Director General approved four GPG transversal EHWP policies in 2015 in line with the DPSA employee health and wellness strategic framework. However, the DPSA framework does not give direction on how new developments, innovation and research knowledge within the field can be managed and adapted into the programme's implementation framework. This then gives programme implementer's independence to develop their own process maps that are meant to assist them in incorporating newly discovered knowledge into the programme practice. However, there are consequences with this level of autonomy, which may include inconsistencies in policy implementation and outcomes thereof.

This study will afford an opportunity for the province to discover gaps that may exist in the implementation of the GPG EHW policies by GPG departments. It will further assist in improving the programme's implementation and lessen the predominant health risks once recommendations of the study have been inferred.

### 3.1 The proposed research topic will focus on:

Knowledge translation methods of the Gauteng Provincial Government Employee Health and Wellness programme

#### 3.1.1 Secondary Objectives

- Raising awareness to policy makers, research and implementers on the importance of knowledge and how its translation may be a benefit towards improved implementation.
- The study may add value in the implementation practice of the EHWP through imparting understanding on how research and evidence based knowledge can be adopted in practice.
- Contributing knowledge to the implementation science field of study with the South African context.

It is envisaged that the study may improve the quality of service delivery implementation through learning best approaches from evidence based and experiential knowledge. It will also assist the EHW programme to align to M&E's outcomes approach as administered by the Department of Performance, Monitoring and evaluation.

## 4. Deliberations

The research study will be conducted during 2016 academic year. This a qualitative study which will employ a non-probability sampling method. Using a case study method to explore the in-depth experiences of EHWP Coordinators in the context of study, 14 departments with 29 EHWP coordinators will be invited to participate. The sample criteria are as follows:

- Participants to have been employed as an EHWP Coordinator within GPG since 2012
- Participants to at least have 3-5 years' experience in the wellness field