INTERSECTORAL COLLABORATION DURING POLICY FORMULATION AND EARLY IMPLEMENTATION: THE CASE OF THE FIRST 1,000 DAYS INITIATIVE IN THE WESTERN CAPE PROVINCE, SOUTH AFRICA

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KEYWORDS

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Intersectoral collaboration

Interests

First 1,000 Days

Western Cape Province

Policy adoption

Implementation

DECLARATION

I declare that *Intersectoral collaboration during policy formulation and early implementation: The case of the First 1000 Days Initiative in the Western Cape Province, South Africa* is my own work, that it has not been submitted before for any degree or examination in any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

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ABSTRACT

Background

Intersectoral collaboration for health is widely recognised as a critical component of interventions to address complex public health issues. However, there is limited research that has examined how intersectoral approaches are formulated and implemented, especially in low- and middle-income countries. As a result, although the literature is populated with calls for action, little exists that can inform the evidence on how to sustain intersectoral action for health.

This thesis is a case study of intersectoral action in the Western Cape Province of South Africa, examining the unfolding policy formulation and implementation processes of an initiative referred to as First 1,000 Days, in the period 2016 to 2019. Within early childhood, the First 1,000 Days (FTD) period presents a favourable window for intersectoral interventions that can ensure positive outcomes from early years of life to adulthood. The FTD initiative emerged in the Western Cape Province of South Africa in response to the growing number of children exposed to the social challenges of violence and of alcohol and drug abuse. The FTD focuses on improving outcomes for children holistically, in terms of nutrition, health, education, caregiver support and protection and safety. Through the case of the FTD, and drawing on policy analysis theory and collaborative governance constructs, the thesis analyses the possibilities and constraints of intersectoral collaboration during phases of the policy process.

Methods

The case of the FTD initiative was constructed through a triangulated qualitative analysis of policy documents, and in-depth interviews and observations of the actors involved in policy formulation at the provincial level and in implementation in two sub-districts. A number of conceptual frames guided the analysis. Challenges related to the FTD policy development were analysed using Schmidt's typology of 'ideas' and their associated frames in order to examine varying discourses within policy text. Further, analysis of the different experiences of policy adoption and implementation drew on Hall's framework of 3I's – ideas, interests and institutions – and on the collaborative governance model of Ansell and Gash, in order to understand the shift from political agendas to implementation of the FTD initiative.

Results

The study findings document a fluctuating policy trajectory. This started with agenda setting and political prioritisation of the FTD initiative prior to 2016, followed by a period of policy 'thinning' and a loss of intersectoral goals in 2017; and finally a later re-emergence of intersectoral FTD goals in selected sub-districts in 2018. The analysis of how the FTD transitioned between these stages showed that agenda-setting processes, catalysed by the increasing global evidence on brain development during early years, led to a favourable provincial context for child programmes, and a window of opportunity for active lobbying by policy entrepreneurs. However, during implementation, the intersectoral goal of the FTD got lost, with limited bureaucratic support from service delivery actors and minimal evidence of cross-sector involvement. Actors in the health sector, operating in an overwhelmingly siloed bureaucratic context and with decision-making power over the FTD, reformulated it as a traditional maternal and child health mandate. Ambiguity and contestation regarding FTD ideas and interventions between key actors from both provincial and sub-district levels and non-governmental organisations (NGOs) contributed to this narrowing of focus.

In contrast to these earlier processes, the re-emergence of intersectoral FTD goals within sub-districts that were experimenting with 'joined-up' government, referred to as the Whole of Society Approach (WoSA), offered insights into governance contexts and factors that enable intersectoral action. These included adequate starting conditions that triggered the need to collaborate, assisted by policies that provided the mandate to collaborate. Moreover, facilitative leadership ensured valuable engagement spaces, assisted by boundary spanning actors and the use of appropriate problem framing and definitions. These factors coupled with clear governance structures and trust-building processes significantly shaped the collaboration process, ensuring a commitment to intersectoral approaches for the FTD initiative in WoSA sites.

Conclusion

This thesis provides insights into both the constraints and enablers of effective intersectoral action on health. It highlights the importance of conditions that should be considered for the effective implementation of intersectoral action, including engaging cross-sector players from the start of agenda-setting processes and creating spaces that allow consideration of actors' different interests, especially at service delivery level. Engagement processes that ensure the deliberation and negotiation of policy options can lead to shared goals amongst collaborative

partners, especially if these processes prioritise relationship building and trust. Further, the framing of policy problems and solutions can be vital for ensuring buy-in of cross-sector actors and is assisted by the facilitative role of leaders who drive collaborative processes. However, such collaborative processes are neither self-generating nor self-sustaining and require investment of time, effort and adequate resources, all of which should be addressed when initiating intersectoral collaboration for health.

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DEDICATION

This thesis is dedicated to many of us who have pondered where policies that look and sound good, end up.

ACRONYMS

3I's	Ideas, Interests, Institutions
CBS	Community-Based Services
CHW	Community Health Worker
COPC	Community-Oriented Primary Health Care
DHS	District Health Services
ECD	Early Childhood Development
EXCO	Executive Committee
FTD	First 1,000 Days
HiAP	Health in All Policies
LMICs	Low- and Middle-Income Countries
MDGs	Millennium Development Goals
MEAP	Management Efficiency Alignment Project
MURP	Mayoral Urban Renewal Programme
NDP	National Development Plan
NGO	Non-Governmental Organisation
NIECD	National Integrated Early Childhood Development Policy
NPO	Non-Profit Organisation
PICH	Parent, Infant and Child Health (and Wellness group)
PSG 3	Provincial Strategic Goal 3
PSP	Provincial Strategic Plan
SBM	Saldanha Bay Municipality
SDGs	Sustainable Development Goals
SDH	Social Determinants of Health
ToC	Theory of Change
WCED	Western Cape Education Department
WHO	World Health Organization
WoSA	Whole of Society Approach

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CHAPTER 1:
INTRODUCTION

This chapter presents the background of the research by introducing the First 1,000 Days (FTD) initiative as a lens on intersectoral collaboration, the premise of the research. This is followed by an overview of intersectoral collaboration for health, locating its origins in the global landscape. Thereafter, the problem statement, research purpose and setting and accompanying aims and objectives of the research are outlined. The last section of the chapter provides the outline of the remaining thesis chapters.

1.1 BACKGROUND

The FTD, the period between conception and when a child is two years old, has received increasing attention due to the development that occurs in all domains (sensory, motor and cognitive) in this period. The FTD therefore presents a window of opportunity for early childhood interventions that ensure a conducive environment for adequate child development. An intersectoral approach to FTD, referred to as 'nurturing care', is crucial for this period when evidence shows that integrated health, nutrition and stimulation interventions promote positive outcomes that impact the whole life course (Britto *et al.*, 2016).

In South Africa, early childhood development (ECD) and the FTD period have been prioritised in the National Development Plan (NDP) (National Planning Commission, 2011) and the National Integrated Early Childhood Development Policy (NIECD) (Republic of South Africa, 2015), both of which have highlighted action in ECD as crucial to ensuring national development and growth. Actors within the Western Cape Province recognised the significance of the FTD period in ensuring wellness and enabling children to thrive and reach their full potential (Western Cape Government, 2014). In 2016, the FTD initiative was launched in the Province as an intersectoral initiative to improve outcomes for children in terms of nutrition, health, education, caregiver support and protection and safety. The intersectoral focus on the FTD was viewed as crucial within the Western Cape Province as a response to various socio-economic challenges related to the high rates of violence, alcohol and substance abuse, being the main factors that affect family structures and child development (Western Cape Government, 2014).

Following high profile political prioritisation of FTD in 2016, I became interested in tracking the development of the FTD initiative within the Province and, in particular, to examine the

implementation of intersectoral intentions. Since the FTD initiative was only launched in the Western Cape Province, I could only focus on the developments of the initiative and intersectoral plans in one provincial context. By the end of 2017, however, it was already clear that the intersectoral goals of the FTD initiative were being shed, resulting in a predominantly biomedical, health sector specific approach to the FTD. This study began as an effort to understand why an intersectoral FTD initiative was not implemented, despite what appeared to be a successful agenda-setting process.

Then, during the course of 2018, selected sub-districts within the Province began experimenting with approaches to joined-up government known as the Whole of Society Approach – or WoSA. Within two of the sub-districts involved with the WoSA, the FTD initiative re-emerged with clear intersectoral collaboration, in contrast to the earlier and narrower biomedical focus of the initiative. The re-emergence of intersectoral agendas therefore offered an additional empirical example that could be studied to understand factors that enabled commitment to the FTD initiative in the two WoSA sub-districts.

Using the FTD experience in the Western Cape Province, this thesis therefore examines the policy process of the FTD initiative to understand the trajectory of intersectoral initiatives from agenda setting to implementation. The goal of the overall study is to provide insights into what conditions may enable or inhibit the implementation of intersectoral collaboration for health, a concept that has had a long history in the global landscape.

1.2 DIVERSE ORIGINS OF INTERSECTORAL COLLABORATION FOR HEALTH

Intersectoral collaboration as a concept is based on the premise that health outcomes are largely dependent on the social determinants of health (SDH) which, in turn, reach beyond the terrain of the health sector. As such, collaborative action within and between sectors has been advocated to influence the social and economic conditions that contribute to health and wellbeing (Kickbusch & Buckett, 2010). The idea of collaboration to positively influence health outcomes can be traced to the Alma Ata Declaration (1978) and has been reiterated at several other moments since then. Some of the global agenda-setting moments related to intersectoral action for health include the Ottawa Charter for Health Promotion (1986), the Commission on the Social Determinants of Health (2006), the Health in All Policies Approach (2007), the Helsinki Statement on Health in All Policies (2013), the Agenda 2030 for Sustainable Development Goals (2015) and, most recently, in the Operational Framework

for Primary Health Care (2020) (World Health Organization, 1978, 1986, 2014; Commission on the Social Determinants of Health, 2006; World Health Organization and the Government of South Australia, 2010; United Nations, 2015; World Health Organization and the United Nations Children's Fund, 2020).

These global processes have deployed a range of terminologies used synonymously in reference to intersectoral action for health[1], including 'intersectoral' or 'multi-sectoral collaboration', 'intersectoral policies', 'healthy public policies', the 'Health in All Policies'(HiAP) Approach, and 'cross-sector collaboration' (Shankardass *et al.*, 2012; Chircop, Bassett & Taylor, 2015; World Health Organization and the Government of South Australia, 2017).

To locate the various shifts of intersectoral action for health within the international landscape, Kickbusch and Buckett (2010) provide a useful typology of developments, referred to as the 'three waves of horizontal governance'. These represent policy waves that promoted working across sectoral boundaries to address determinants of health (Kickbusch & Buckett, 2010). As shown in Table 1, the first wave of horizontal governance was the Alma Ata Declaration on Primary Health Care that proposed addressing underlying socio-economic and political causes of ill health as a core principle of primary health care (World Health Organization, 1978). Although the impact of social determinants was documented as early as the 1950s, the Alma Ata Declaration was the first systematic attempt to highlight the relevance of intersectoral action as part of primary health care (World Health Organization, 1978).

The second wave of horizontal governance following Alma Ata was the 'healthy public policies' movement, that included new thinking on health promotion. The Ottawa Charter for Health Promotion argued that health was a function of where people live and work and expanded the concept of health determinants to include promotion of healthy lifestyles and a consideration of supportive environments (World Health Organization, 1986). The health promotion movement also proposed complementary approaches such as taxation or legislation that would favour the creation of enabling environments for wellbeing (World Health Organization, 1986). Other related ideas that emerged during this wave included the

[1] The term 'intersectoral action for health' is used interchangeably in this thesis with 'intersectoral collaboration for health' as they are both concerned with addressing elements of the same phenomenon.

concepts of healthy cities, healthy workplaces and health-promoting schools (Kickbusch & Buckett, 2010). Since then, the health promotion literature has continued to contribute to the evidence on intersectoral approaches across various contexts (Weiss, Lillefjell & Magnus, 2016; Corbin, 2017).

Table 1: Waves of horizontal governance adapted from Kickbush and Buckett (Kickbusch &Buckett, 2010)

Waves of horizontal governance	The main changes accompanying declarations
First wave: Alma Ata and primary health care	**1978: Alma Ata Declaration on Primary Health Care** - Comprehensive health strategy beyond health services to address the underlying social, economic and political causes of poor health. - Primary health care involves all sectors and aspects of national and community development – in particular agriculture, animal husbandry, food, industry, education, housing, public works, communications and other sectors; and demands the co-ordinated efforts of all those sectors.
Second wave: Healthy public policies	**1986: Ottawa Charter for Health Promotion** - Health is created in the context of everyday life where people live, love, work and play. The focus on supportive environments introduced implementation of a common health purpose through 'settings' approaches such as the Healthy Cities Project, health-promoting schools and healthy workplaces. **1988: Healthy Public Policy conference (Adelaide)** - Introduced notion of being accountable for health impact contributing to the development of health impact statements as a policy tool to measure impact.
Third wave: Health in All Policies (HiAP) Approach	**2007: Health in All Policies Approach adopted as a health strategy of the European Union** - Introduced better health (improved population health outcomes) as a key dimension of wellbeing and defined the closing of the health gap as a shared goal across all parts of government. - Addressed complex health challenges through an integrated and dynamic policy response across portfolio boundaries. Health was no longer in the centre but incorporated a concern with health impacts into the policy development process of all sectors and agencies. - Allowed government to address the key determinants of health in a more systematic manner as well as to take into account the benefit of improved population health for the goals of other sectors.

The third wave of horizontal governance was the HiAP Approach that centred the health impacts of policies across all sectors and provided a roadmap for governments to address key determinants of health through a systemic approach (World Health Organization, 2014).

Although not included in the typology of waves as above, the 2008 report of the Commission on SDH was also an important global milestone. This described the various social determinants that shape health outcomes and the range of social and political actions required to effect a change, linking the intersectoral debate with a commitment to health equity (Commission on the Social Determinants of Health, 2006). The 2030 Agenda for Sustainable Development, released in 2015, offers yet another reinforcement of the need for horizontal forms of governance through its 17 Sustainable Development Goals (SDGs) and 169 targets across aspects of society. The Agenda was ambitious in asserting the need for integrated and sustained action across society to address complex challenges of poverty, inequality and tackling climate change (United Nations, 2015).

The term 'collaboration' describes a number of arrangements and levels of integration across a range of contexts (Warmington *et al*., 2004; Percy-Smith, 2006; Adeleye & Ofili, 2010; Chircop, Bassett & Taylor, 2015; Burgess *et al.*, 2017). Collaboration is interchangeably referred to as 'partnerships', 'teamwork', 'networking' and 'co-operation' (Chircop, Bassett & Taylor, 2015). It can be both horizontal between sectors or vertical between different governmental levels such as provinces and municipalities (Public Health Agency of Canada, 2007); and it can involve different degrees of collaborative action.

Some have framed collaboration as being on a continuum or as having levels of convergence (Axelsson & Axelsson, 2006; Bryson, Crosby & Stone, 2006; Kim *et al.*, 2017). The levels of convergence describe the intensity of collaborative arrangements ranging from integration, to collaboration, co-ordination and co-operation. Integration in this typology refers to the highest level of relationship where there is joint planning of policies with little individual autonomy of partners or sectors. Co-operation on the other hand would be a basic relationship between sectors, where partners work on their own goals but communicate with others. The in-between levels of collaboration and co-ordination would involve sharing personnel or resources to achieve a common purpose while maintaining sectoral independence (Axelsson & Axelsson, 2006). Due to the variety of terms and fuzzy definitional boundaries, research on intersectoral collaboration covers a wide range of activities and issues, approached in a number of ways (Public Health Agency of Canada, 2007; Chircop, Bassett &Taylor, 2015).

The most commonly cited definition of intersectoral collaboration for health is that by the World Health Organization (WHO):

> *'a recognised relationship between part or parts of the health sector with part or parts of another sector which has been formed to take action on an issue to achieve health outcomes (or intermediate health outcomes) in a way that is more effective, efficient or sustainable than could be achieved by the health sector acting alone.'* (Kriesel, 1998, page 3)

This definition recognises that intersectoral collaboration can be between different government sectors or between actors within and outside government.

There has been an acknowledgement of the limitations of the above definition, however, as it reflects a health-sector biased definition which can fail to explicitly address the contributions to health originating from outside the health sector (Adeleye & Ofili, 2010; Shankardass *et al.*, 2012). As such, I recognise that intersectoral approaches have been advocated in relation to broader factors beyond health-specific outcomes including in efforts to address environmental issues, forestry, education, among others (Tikkanen, Glück & Pajuoja, 2002; Meijers & Stead, 2004; Briassoulis, 2005; Percy-Smith, 2006). Therefore, for this thesis which examines policy making on the FTD, I draw on studies that have examined intersectoral collaboration related to the three horizontal waves and those beyond health-specific agendas.

1.3 PROBLEM STATEMENT

Collaborative action is based on the notion of synergy where combining the skills, resources and perspectives of a group of people or organisations can lead to outcomes that are greater than the sum of individual efforts. This particular feature is hypothesised as the means by which collaborations gain an advantage over individual action (Thomson & Perry, 2006). However, in the range of literature sources that consider intersectoral action for health, there is an uncontested understanding that the desired levels of collaboration are difficult to achieve (Chircop, Bassett & Taylor, 2015; Khayatzadeh-Mahani *et al.*, 2016; Baum *et al.*, 2017; Rasanathan *et al.*, 2017). In addition, there is limited evidence on how to initiate intersectoral collaboration and implement such approaches successfully (Exworthy, 2008). More research is needed on the numerous challenges to collaboration and on the practices of collaboration (Exworthy, 2008; Shankardass *et al.*, 2012; Embrett & Randall, 2014; Chircop, Bassett & Taylor, 2015; Glandon *et al.*, 2019).

A scoping review by Shankardass et al (2012) to identify the role of government in intersectoral collaboration, concluded that the literature in this field remains at a descriptive and superficial level. The authors further suggest that the key documents promoted by global agencies are not based on systematic, scholarly research and lack critical reflection about the initiation and implementation processes of intersectoral collaboration (Shankardass *et al.*, 2012). Moreover, Glandon et al (2019), in their reflection on the current methodological gaps and opportunities for advancing research on intersectoral action, highlight the types of research designs and methods that can best generate that evidence on intersectoral collaboration.

Few studies have assessed how intersectoral approaches have been adopted in different settings, especially in low- and middle-income countries (LMICs) (Bennett, Glandon & Rasanathan, 2018). Further, despite the growing interest in addressing the SDH, there is limited understanding of the particular demands that this presents in the various stages of the policy process, from formulation to implementation. Existing research in the field of intersectoral action to address the SDH rarely uses theoretical frameworks that have a political and policy analysis perspective (Exworthy, 2008; Embrett & Randall, 2014). Policy analysis methodologies and theory are relevant as they focus on the process of policy-making which is often contested involving complex interactions between actors and influenced by socio-economic and political contexts, and the content of the policy, including the influence of ideas (Gilson, Agyepong & Shiffman, 2018). The impact of politics, power and contexts provides a vital lens to understanding intersectoral policy processes (Embrett & Randall, 2014).

There is increasing recognition of the need to study the barriers and enablers of intersectoral policy adoption and implementation. Policy adoption, used interchangeably with policy formulation, refers to the stage of policy making where policy alternatives are considered, including the allocation of responsibilities and resources (Berlan *et al.*, 2014). Implementation involves the translation of policy intentions into effective policy and practices, a common policy challenge (Nilsen *et al.*, 2013) but particularly so for intersectoral policies addressing the SDH (Exworthy, 2008; Pelletier *et al.*, 2012; Khayatzadeh-Mahani *et al.*, 2016). A systematic examination of these policy processes can inform future efforts to implement intersectoral action for health.

1.4 RESEARCH PURPOSE

Through examining the policy processes associated with the FTD, this research seeks to highlight the dynamics and nuances of intersectoral policy processes. It contributes to the evidence base on how to develop intersectoral policy initiatives by identifying factors that can enable or hinder such processes. This could be relevant for both LMICs and high-income countries undertaking similar initiatives. A systematic analysis of factors that consider political contexts, the role of actors, interests and ideas can also inform the further development of the FTD initiative in the Western Cape Province.

Beyond the provincial FTD process, insights from this study can also inform policy makers and practitioners embarking on intersectoral collaboration to address complex policy issues in similar settings.

1.5 RESEARCH AIM AND OBJECTIVES

The aim of the research was to explore the possibilities and constraints of intersectoral collaboration through the lens of the unfolding policy process on the First 1,000 Days of Childhood Initiative in the Western Cape Province, in the period 2016 to 2019.

The specific research objectives were to:

1. describe how the FTD evolved from an intersectoral policy idea to policy content and processes of implementation;
2. identify which FTD interventions and intersectoral coordination strategies were prioritised and why;
3. map and describe actors (as individuals, policy communities, institutions, networks) involved in the formulation of the FTD policy, their inter-relationships and the roles they played;
4. examine how the intersectoral FTD initiative unfolded in the initial implementation phases; and
5. analyse the factors constraining and enabling FTD as an intersectoral initiative.

1.6 RESEARCH SETTING

The Western Cape Province is one of nine provinces in South Africa and has a population of 6,844,272 (Statistics South Africa, 2020). The Western Cape experienced rapid urbanisation and population growth from 4.5 million in 2001 to over 6 million in 2017, mainly due to the fact that the province has one of the better performing regional economies, education outcomes and health indicators in South Africa. The increasing rates of migration have contributed to a number of interrelated challenges including unemployment, poverty, poor social cohesion, and constraints of natural resources, housing and infrastructure (Western Cape Government, 2019b). Although noted as performing better than other provinces in South Africa in terms of child health indicators, child poverty rates are still high, estimated at 23% in 2019 (Hall, 2019). According to the 2018 General Household Survey, 14.7% of households in the Western Cape have inadequate access to food, placing many children at risk of underdevelopment due to stunting (Statistics South Africa, 2018).

Although children in the mostly urbanised settings of the Western Cape have better access to infrastructure than other provinces, they experience a series of other challenges. The province has the highest number of informally housed children (shacks or informal settlements), which exposes them to shack fires and paraffin poisoning, amongst many other risks (Hall, 2019). The provincial context is also shaped by some of the highest rates of violence and alcohol use in the country, impacting families with children (Western Cape Government, 2014). The abuse of alcohol has received increasing attention due to the high rates of foetal alcohol syndrome among young children (Adebiyi *et al.*, 2019). In 2016, the top three causes of premature mortality in the province were interpersonal violence (11.3%), HIV/AIDS (10.9%), and diabetes mellitus (7.6%) (Statistics South Africa, 2018). The province continues to record increases in murder, attempted murder, and sexual assault (Western Cape Government, 2019a).

South Africa is ranked as one of the most unequal countries in the world, and the Western Cape Province, and Cape Town as its metropole, have the highest levels of inequality in the country (Statistics South Africa, 2019). Geographical spaces of wealth and wellbeing exist alongside large-scale marginalisation, unemployment and poverty. These inequalities continue to fuel the social challenges of substance abuse, crime and violence. The resulting impact of these multiple socio-economic challenges triggered the need for initiatives such as the FTD to protect children and ensure effective child development outcomes.

Chapter 3 details the specific socio-economic profiles of the two sub-districts where the study was conducted.

1.7 OUTLINE OF THE THESIS

This thesis is organised into eight chapters and structured in the following manner:

Chapter 2 describes the literature on intersectoral collaboration, beginning with the idea of 'wicked problems', followed by an overview of ECD approaches both globally and locally. It then explores the evidence on the challenges facing intersectoral approaches and some of the suggested enablers of collaboration. The chapter concludes with a description of the theories and conceptual frameworks used to analyse the FTD policy process.

Chapter 3 addresses the methodology of the study. It provides the research design and specific data collection methods used to explore the FTD initiative, along with reflections on my positionality and ethical considerations.

Chapters 4 to 7 outline the findings of the thesis. Chapter 4 serves as an introduction to the findings by providing the overarching story and timeline of the FTD initiative, focusing on key moments that shaped the FTD policy process. Based on an analysis of policy documents, Chapter 5 describes the different sectoral understandings of problems and solutions for the FTD and how this created challenges in the early phases of the FTD policy process. Chapter 6 analyses the factors related to ideas, interest and institutions that shaped how the FTD initiative was adopted and implemented as a health sector specific initiative in the Province between 2016 and 2019. Chapter 7 then examines the re-formulation and re-emergence of the FTD as an intersectoral approach in two sub-districts and how this was achieved in these settings through an initiative called the Whole of Society Approach.

In Chapter 8, the last chapter of the thesis, I discuss what the findings offer for understanding the constraints and enablers of intersectoral policy processes. I also outline the main conclusions and limitations of the research and offer recommendations for practice and further research.

CHAPTER 2:
LITERATURE REVIEW

2.1 INTRODUCTION

In this chapter, I discuss the literature in relation to intersectoral collaboration for improving health outcomes. I do this in five sections.

The first section introduces the idea of 'wicked problems' and provides an overview of the ECD literature as a response to 'wicked problems', both globally and locally in South Africa.

The chapter then explores the challenges that face intersectoral collaboration efforts broadly in the field and outlines specific experiences of collaboration in LMICs. This is followed by a summary of the enablers of intersectoral collaboration, and the chapter concludes with a discussion of the concepts and theories employed in this research.

This literature review addresses the phenomenon of intersectoral collaboration to address health outcomes and, in doing so, focuses largely on policy processes. I do not review the in-depth financing aspects related to intersectoral policies such as specific budgeting details or taxation processes, which are beyond the boundaries of this research. Chapter 5 offers a comprehensive documentary analysis of strategies and interventions for the FTD and the ECD period, and these are therefore not extensively reviewed in this chapter.

2.2 THE IDEA OF 'WICKED PROBLEMS'

A significant hindrance to efforts to collaborate is the nature of 'wicked problems' typically targeted for intersectoral action (Chircop, Bassett & Taylor, 2015; Bilodeau *et al.*, 2018). 'Wicked problems' are characterised as being difficult to define, as multi-dimensional with no clear solutions, and as going beyond the responsibility of one government sector or organisation – examples of which are the causes of non-communicable diseases, poverty or health inequalities (Kickbusch & Buckett, 2010). It is also clear that many 'wicked problems' have existed for a long time and it is uncertain when they will end. Consequently, they are hard to analyse and solve with ready-made solutions (Kickbusch & Buckett, 2010; De Leeuw, 2017). Addressing 'wicked problems' is thus institutionally complex involving a range of actors, organisations and resources that interact in various ways (Briassoulis, 2005).

The WHO's Commission on the Social Determinants of Heath (2006) described the 'causes of the causes', which are the conditions in which people live as the consequence of underlying structural conditions which shape how societies are organised. These structural conditions are driven by social, economic and political environments that include poor social policies and unequal economic arrangements (Commission on the Social Determinants of Health, 2006). Beyond the WHO's Commission on the SDH, there has been wide acknowledgement that the structural inequalities shaping societies are globally unsustainable (Kickbusch & Buckett, 2010). Moreover, what happens in one part of the world affects other parts – like financial crises, diseases, wars and conflicts, population movement, trade and labour, food production. The interlinked nature of 'wicked problems', along with the new challenges of climate change, have prompted the need to act differently (Kickbusch & Buckett, 2010).

An additional characterisation of 'wicked problems' is that efforts to address one part of the problem may have unintended consequences, affecting the problem as a whole or revealing a new set of challenges (Kickbusch & Buckett, 2010; Bradford, 2016). Due to the changing boundaries of the problem over time, the resolution of 'wicked problems' requires innovative and continuous solutions that have proved difficult to achieve (Briassoulis, 2005; Chircop, Bassett & Taylor, 2015; De Leeuw, 2017).

2.2.1 'Wicked problems' and intersectoral action on early childhood

Evidence from around the world has shown that the SDH have their most profound impacts in early childhood (Dua *et al.*, 2016; World Health Organization, 2018b). The recent renewed interest in ECD has been propelled by the finding that every year, six million child deaths in developing countries are preventable; and that more than 250 million children under five years old fail to reach their development potential because of poor nutrition and extreme poverty (Grantham-Mcgregor *et al.*, 2007; Lu, Black & Richter, 2016). In addition, evidence on the fast-developing brain has emphasised the significance of this early period where foundational skills are established that have multiple impacts in later life (Black *et al.*, 2016; Britto *et al.*, 2016).

As a result, intersectoral interventions early in the life course are viewed as essential, anchored in what is now referred to as a 'nurturing care' approach (Britto *et al.*, 2016). The Nurturing Care Framework (NCF) proposes that effective child development requires a focus on health, nutrition, security and safety, responsive caregiving and early learning (World

Health Organization, 2018b). Global interest in ECD has been further secured by the presence of SDG targets on improving access to ECD and associating ECD with other SDGs targets that aim to reduce poverty and hunger (United Nations, 2015).

However, despite the increasing interest and progress in ECD-related research and programming, the field of ECD continues to struggle to ensure equitable access to nurturing care, particularly for children younger than three years of age (Black *et al.*, 2016). Also, some of the promising multi-sectoral interventions or projects, such as parental support, have proved difficult to scale up to large segments of the population, as they do not seem to find a fit with institutional environments in low-resource settings (Cavallera *et al.*, 2019). Other related properties of ECD services – such as the difficulties of measuring outcomes and the lack of a single sectoral home for ECD – contribute to implementation challenges (Cavallera *et al.*, 2019).

Another factor hindering efforts towards advancing ECD as a global priority has been the fragmentation of the global ECD community. This stems from the lack of a common vision or agreement on priorities, including which governance strategies are optimal (Shawar & Shiffman, 2017). Related to the level of fragmentation is the absence of clear global leadership, including among global agencies, which affects the ability to build effective institutional networks to achieve collective ECD agendas. Fragmentation also occurs at national levels as the responsibilities for ECD services are shared by a number of ministries and non-governmental organisations (NGOs) without clear roles (Shawar & Shiffman, 2017). This is exacerbated by the inadequate vertical co-ordination from national to local levels and by the duplication of services across sectors (Shawar & Shiffman, 2017).

2.2.2 The early childhood development landscape in low- and middle-income settings and South Africa

Recent work has examined evidence that can inform the design and implementation of ECD interventions at national and sub-national levels in LMIC settings (Pérez-Escamilla *et al.*, 2018; Cavallera *et al.*, 2019; Milner *et al.*, 2019). An analysis of four ECD programmes – in Chile, India, South Africa and Bangladesh – highlighted the importance of creating an enabling environment for intersectoral collaboration for successful scaling up of ECD interventions. The scaled-up ECD programmes in these four countries were enabled by strong political will, securing budgets and resources, relying on national laws mandating the programme, flexibility for local adaptation and maintaining quality through resource

investments in ECD providers and infrastructure (Pérez-Escamilla *et al.*, 2018). This research also reiterates the need to develop monitoring and indicators to track progress on ECD across sectors (Cavallera *et al.*, 2019).

Despite the documented successes in the scale-up of ECD, numerous challenges remain in South Africa. Although the release in 2015 of the NIECD (Republic of South Africa, 2015) signified commitment to ECD, the majority of young children are still impacted by a range of socio-economic inequalities related to poverty, poor nutrition and violence (Atmore, 2013; Republic of South Africa, 2015; Hall, 2019). Of the 19.7 million children in the South African population, 59% live below the upper poverty line – that is, in households whose monthly income is less than R1,183 (USD77.49) per capita which is the minimum requirement for basic needs such as nutrition, clothing and shelter. This indicates that South Africa has high rates of child poverty (Hall, 2019). Children living in poverty also bear the greatest burden of disease due to undernutrition and poor access to water and sanitation (Atmore, 2013; Hall, 2019).

Moreover, although the national child mortality rate has decreased over time, many children in South Africa still die from preventable causes. Stunting, caused by poor nutrition, affects 27% of children under five years of age, with higher rates in children under two years compared to those aged three years and older (Sambu, 2019). In addition, HIV prevalence affects one in four pregnant women and violence against children continues to shape the South African landscape (Hall, 2019). Beyond these causes of childhood mortality, climate change and non-communicable diseases are emerging challenges in the South African context (Azzi-Lessing & Schmidt, 2019).

According to the NIECD, the scope of ECD in South Africa refers to the period of human development from birth until the year before a child enters formal school. As a result of the ECD scope in South Africa, , the infrastructure of ECD services, including delivery of services, monitoring and evaluation, is a function of three main government departments: Health, Education and Social Development. Early learning programmes for children who are not of school-going age are provided mainly by NGOs and the private sector (Aubrey, 2017), with the role of government being to regulate and fund these ECD programmes (Republic of South Africa, 2015).

ECD service provision in South Africa is hampered by insufficient funding and governance, including institutional arrangements, leadership and co-ordination, and poor cross-sector implementation of available programmes (Republic of South Africa, 2015). In addition, ECD programmes and accompanying infrastructure are not equal across the country, especially disadvantaging those catering for children in under-resourced areas. Low-cost ECD centres often have poor infrastructure and inadequate conditions, which compromise the quality of services they provide. Many ECD practitioners also lack educational qualifications and the necessary skills to promote optimal child development in these centres (Aubrey, 2017). Further, children with disabilities are largely excluded from a number of ECD programmes (Republic of South Africa, 2015).

In summary, while there is increasing global attention to ECD, this is coupled with remaining questions around fragmentation, the low scale-up of evidence-based interventions and the need for appropriate monitoring indicators. Ensuring optimal development for young children in South Africa remains a daunting task due to related challenges of poverty and inequitable ECD services. In addition, the renewed interest in ECD and nurturing care highlights the value of the health sector as an entry point for ECD interventions, especially for intersectoral interventions in early life. As a result, the next section will examine the challenges of intersectoral collaboration for health which many of the proposed nurturing care and ECD interventions will encounter.

2.3 CHALLENGES OF INTERSECTORAL COLLABORATION FOR HEALTH

The range of obstacles that face intersectoral collaboration for health include the vertical organisation of sectors. Moreover, the multi-faceted nature of socio-economic factors rarely offers clear policy solutions and often results in the lack of consensus on appropriate interventions. In addition, the use of a long-term life course approach in addressing the SDH often does not align with the timelines of policy makers. Efforts to intervene are also hindered by the dominance of biomedical perspectives that have established patterns of interests and power that determine the allocation of resources. The logistics surrounding collaboration, such as time and divergent interests of stakeholders, further complicates these processes. I discuss each of these factors below.

At the heart of difficulties in intersectoral collaboration is the vertical organisation of sectors that deters efforts to collaborate (Chircop, Bassett & Taylor, 2015; De Andrade *et al.*, 2015; De Leeuw, 2017). The organisation of government bureaucracies according to areas of

specialisation promotes siloed functioning; and accompanying legislation and professional training further maintains the boundaries between areas of specialisation (Kickbusch & Buckett, 2010). Even within one government sector, inter-organisational collaboration is difficult to execute (Exworthy, 2008; Lencucha, Magati & Drope, 2016). Multiple actors or agencies within one ministry and across levels of government can be responsible for one mandate which creates a complex organisational environment for ensuring collaboration (Lencucha, Magati & Drope, 2016; De Leeuw, 2017). Intersectoral approaches therefore directly contradict or compete against established organisational systems within one organisation and sector and across sectors (De Andrade *et al.*, 2015; De Leeuw & Peters, 2015).

The other set of challenges facing intersectoral approaches for health is related to the complex nature of the SDH and the difficulties this poses for the policy-making process. The multi-faceted nature of SDH rarely offers clear policy solutions and results in the lack of consensus on appropriate interventions (Exworthy, 2008). This can be particularly challenging during the policy formulation or adoption stages of policy making, when concrete decisions regarding interventions for implementation have to be made (Howlett & Ramesh, 1995).

Multi-sector networks have often found it difficult to develop common objectives amongst multiple actors from different backgrounds and interests. This can include a lack of agreement on the choice, priority and sequencing of interventions. The lack of agreement on interventions either perpetuates sectoral programmes or causes delays that affect political commitments towards addressing the SDH (Pelletier *et al.*, 2012; Bilodeau *et al.*, 2018).

The life course approach considers the long-term effects on health and wellbeing from exposures during particular life stages (Kuh *et al.*, 2003). However, this approach to addressing the SDH does not align with the electoral cycles and timelines of policy makers (Exworthy, 2008), as their elections every four or five years do not support multi-sector plans which need a long period of time for the effects to be visible (Aarts *et al.*, 2011; Hoey & Pelletier, 2011). Moreover, even within networks or coalitions of policy advocates who support action on the SDH, it is difficult to sustain commitment over the extended periods of time required for effective intersectoral collaboration (Exworthy, 2008).

Efforts to address the SDH are also hindered by the dominance of biomedical perspectives that have established patterns of interests and power that determine the allocation of resources in health and other sectors (Phillips *et al.*, 2016). The predominant allocation of finances to the development of health service delivery for disease care, rather than prevention and promotion, may leave 'SDH to be over-shadowed in the policy process by healthcare itself' (Exworthy, 2008). Indeed, studies have shown how the rhetoric within health sector policy documents proposes health service provision or access and an individualised focus on health, rather than a broader focus on addressing the SDH (Carter, Hooker & Davey, 2009; Phillips *et al.*, 2016; Fisher *et al.*, 2017).

Moreover, some issues related to the SDH may command less attention from political leaders. An example is malnutrition which affects a group within the population – namely women, children and the poor – who may be invisible and silent to political leaders (Hoey & Pelletier, 2011).

2.3.1 Evidence on intersectoral collaboration for health

Beyond the range of challenges described above is the fact that not many studies have examined the everyday reality and practice of intersectoral collaboration. Literature in the field remains largely prescriptive and concentrates on 'calls for action' (Shankardass *et al.*, 2012; Embrett & Randall, 2014; Weiss, Lillefjell & Magnus, 2016).

While the evidence of improvements in the SDH at population level would be the best measures of collaborative effectiveness, outcomes from collaborative endeavours are hard to measure due to limited implementation experiences and the time needed to detect changes. It is also difficult to attribute changes to particular interventions, as improvements in the SDH typically have no linear cause and effect associations (Exworthy, 2008; Anaf *et al.*, 2014). The extent to which various types of intersectoral approaches contribute to reductions in health inequalities therefore remains a central question in the field (Barr *et al.*, 2008; De Andrade *et al.*, 2015).

Research on intersectoral collaboration for health in low- and middle-income countries

Few case studies have examined the experiences of intersectoral collaboration in LMICs. Of the studies that exist, most experiences have focused on understanding barriers to addressing malnutrition and ECD (Hoey & Pelletier, 2011; Pelletier *et al.*, 2012; Kim *et al.*, 2017; Zaidi *et al.*, 2018; Harris, 2019); examining the formulation and implementation of the HiAP

Approach, (Khayatzadeh-Mahani *et al.*, 2016; Mauti *et al.*, 2019); and exploring efforts to integrate mental health services (Sumner, Lund & Petersen, 2016). More recently, various authors have tried to understand the governance of intersectoral collaboration in LMICs (Bennett, Glandon & Rasanathan, 2018; Rasanathan *et al.*, 2018). Key themes emerging from these studies are discussed below.

There is a consensus that although many challenges experienced by high-income countries could be similar in LMICs, the governance environments in LMICs hinder the capacity for effective governance of intersectoral action (Bennett, Glandon & Rasanathan, 2018). Scholars who have examined the governance of health systems in LMICs, have characterised LMICs as having weak institutions (referring to the rules of engagement between stakeholders), unpredictable and limited funding, low levels of skilled staff and low salaries amongst government staff. Other key barriers for effective governance include the poor enforcement of laws and guidelines, rapid changes in government policy (with unpredictable effects), low levels of transparency and accountability and corruption (Brinkerhoff & Bossert, 2013; Swanson *et al.*, 2015; Gilson, Lehmann & Schneider, 2017).

The reliance on donor funding is one of the main hindrances to intersectoral collaboration in LMICs (Swanson *et al.*, 2015; Bennett, Glandon & Rasanathan, 2018). Donor funding promotes the focus on short-term disease specific interventions, which affects the sustainability of efforts required to act on the SDH. There is limited investment in long-term initiatives and building institutional capacity, and in ensuring the necessary incentives to collaborate. Donor funding can also lead to fragmented activities (Swanson *et al.*, 2015), skewed priorities and a lack of national ownership of intersectoral efforts. For example, research on the implementation of the HiAP Approach in Kenya and Iran showed how the approach was viewed as an external agenda, which contributed to a lack of interest from local stakeholders (Khayatzadeh-Mahani *et al.*, 2016; Mauti *et al.*, 2019). In certain cases, funding has been provided for policy formulation activities but not for the duration of the implementation process, which cripples intersectoral initiatives (Khayatzadeh-Mahani *et al.*, 2016).

As with high-income countries, government ministries in LMICs may emphasise hierarchical bureaucratic structures over promoting partnerships and communication across sectors (Bennett, Glandon & Rasanathan, 2018). Therefore, initiatives to co-ordinate across sectors at the frontline may be hampered by unsupportive bureaucracies. For example, in efforts to

address psycho-social rehabilitative services in South Africa, there was evidence of frontline service providers approaching intersectoral work individually. However, these individual efforts were not supported by their organisational structures, which made collaboration difficult to sustain (Sumner, Lund & Petersen, 2016). Both this and the Kenyan HiAP collaborative endeavours have shown how the lack of communication and poor knowledge of the work of other sectors contributes to the challenge of identifying roles and responsibilities of various sectors (Sumner, Lund & Petersen, 2016; Mauti *et al.*, 2019).

There is also the fact that some departments and sectors may not have the necessary capacity to fulfil intersectoral roles (Sumner, Lund &Petersen, 2016). It has been especially difficult to identify the roles of non-health sectors, as formal mandates, rules and guidelines for cross-sector work are rarely available (Skeen *et al.*, 2010; Sumner, Lund & Petersen, 2016; Mahlangu, Vearey & Goudge, 2018). In some instances, where platforms were created for multiple stakeholders to work together, the absence of particular sectors and the perceived lack of support for collaborative endeavours rendered these platforms ineffective (Manandhar *et al.*, 2009; Sumner, Lund & Petersen, 2016; Mahlangu, Vearey & Goudge, 2018).

Others have commented on how overburdened health systems in LMIC contexts remain predominantly focused on addressing communicable diseases rather than the underlying social determinants of both communicable and non-communicable diseases (Manandhar *et al.*, 2009). Related to this is the dominance of the health sector which can dilute efforts to address holistic approaches, as shown in efforts to address nutrition in India (Kim *et al.*, 2017). This can result in policy issues being perceived as the business of the health sector as opposed to a whole of government concern (Mahlangu, Vearey & Goudge, 2018; Mauti *et al.*, 2019).

Overall, the evidence on intersectoral collaboration in LMICs tends to report failure rather than success. Despite this grim picture, however, there have been a few examples of success. They include the establishment of the large-scale conditional cash transfer programme in Brazil which reduced under-five mortality rates; health system reform in Latin America; and a range of road traffic injury prevention initiatives in LMICs (Rasella *et al.*, 2013; Atun *et al.*, 2015; Staton *et al.*, 2016). These initiatives provide evidence that large-scale efforts to address the SDH in LMICs through intersectoral approaches have been possible.

The conditional cash transfer programme in Brazil was shown to be effective in reducing child mortality linked to poverty-related factors, although more research is needed to explore which governance factors enabled the widespread implementation of the programme (Rasella *et al.*, 2013). For some Latin American countries, the introduction of public policies that integrated health, social, and economic actions to alleviate poverty, reduce inequalities and improve health outcomes, effectively addressed the SDH through re-organisation of health systems and were underpinned by collective action. Positive outcomes in these countries have been attributed to the investment in managerial and political capacity, political commitment, the improvement of regulatory functions and legislation to ensure enforcement of various initiatives. One of the core distinguishing factors in ensuring the re-organisation of health systems in Latin American countries was the role of civil society social movements and community organisations in holding the government accountable for poor performance. (Atun *et al.*, 2015; De Andrade *et al.*, 2015). The systematic review of road traffic injury prevention initiatives in LMICs, on the other hand, showed how public awareness interventions to prevent traffic accidents were only effective when combined with the necessary legislation to ensure enforcement of various initiatives (Staton *et al.*, 2016).

I briefly review some of the general enablers for collaborative work in the section below.

2.4 ENABLERS OF INTERSECTORAL COLLABORATION FOR HEALTH

Although there is no correct way of carrying out intersectoral collaboration, a number of principles to promote successful collaboration have been proposed (Public Health Agency of Canada, 2007; Johns, 2010). Many of these are aimed at avoiding and preventing the challenges discussed earlier. These include engaging key sectors from the very beginning; clarifying individual sector responsibilities and joint goals; emphasising shared values and interests; and ensuring organisations have the capacity to take action and have sustained leadership, accountability and shared rewards. This requires that initiatives are well planned, that there is a strong rationale behind the intersectoral approach, and implementation processes that are monitored and evaluated (Public Health Agency of Canada, 2007; Barr *et al.*, 2008; Burgess *et al.*, 2017).

The critical role of political leaders and policies in promoting intersectoral action has also been emphasised (Public Health Agency of Canada, 2007; Johns, 2010). Policies have been described as acting as a 'driver, legitimiser and supporter of intersectoral collaboration' (Johns, 2010) as legislation can be used to provide the mandate for intersectoral work. High-

level political commitment can also provide motivation to sustain long-term investment in intersectoral collaboration (Johns, 2010).

For LMIC experiences, attention to local contexts, flexible approaches and an improvement of the organisation of health systems, as well as regulatory and legislative frameworks, have proved to be contributors to effective intersectorality (Rasella *et al.*, 2013; Atun *et al.*, 2015). In Latin American countries, civil society has also played a role in shaping a number of health reforms (Atun *et al.*, 2015).

In addition, a number of recommendations consider the importance of sustaining collaborative networks through relationships, ongoing communication, trust and adequate leadership (Johns, 2010; Emerson, 2018). These draw on the public administration literature of collaborative governance, which offers a useful lens for considering which enablers promote effective collaboration between stakeholders (Bennett, Glandon & Rasanathan, 2018). Moreover, there has been a call for studies that draw on policy analysis theory in this field to identify what enables successful intersectoral action or why efforts at implementation rarely succeed (Exworthy, 2008; Embrett & Randall, 2014).

2.5 CONCEPTUAL AND THEORETICAL LENSES ADOPTED IN THIS THESIS

The core theoretical frameworks adopted in this thesis include the policy analysis concepts of actors, ideas, interests and institutions (Hall, 1997) and the collaborative governance model by Ansell and Gash (2018).

2.5.1 Health policy analysis: Ideas, Interests and Institutions

This literature review has shown the many challenges facing the development of intersectoral collaboration and that experiences of successful implementation are rare. In order to examine why efforts at intersectoral collaboration succeed or fail during policy making, I have used concepts from policy analysis theory to analyse the FTD experience. Policy analysis is central to understanding efforts of health reform as it pays attention to how problems are defined, agendas set, and policies formulated and re-formulated, implemented and evaluated (Gilson & Raphaely, 2008).

The study of policy processes is based on the understanding that policies emerge out of a series of decisions or non-decisions over time within particular contexts and are influenced by many factors. Therefore, the field of health policy analysis is concerned with the study of

'who made what policy decisions, when, why and how and with what consequences' (Gilson, Agyepong & Shiffman, 2018). Inherent to policy analysis is recognition that policy decisions result from continuous interactions between policy actors within a particular policy sub-system or policy universe (Walt, 1994; Howlett & Ramesh, 1995; Fischer, Miller & Sidney, 2006). The policy sub-system consists of all possible actors and institutions who directly or indirectly affect a specific policy issue (Howlett & Ramesh, 1995). How actors pursue their interests and negotiate amongst each other therefore occurs in the context of various institutional arrangements surrounding the policy process. As a result, a number of policy scholars focus on the concepts of actors, ideas, interests and institutions ('3I's') as explanatory variables for how policies unfold (Howlett &Ramesh, 1995; Hall, 1997; Shearer *et al.*, 2016; Baum *et al.*, 2017; Gilson, Agyepong & Shiffman, 2018).

The policy analysis literature provides a useful theoretical base for studying intersectoral collaboration as successful collaboration requires an alignment of interests amongst a wide variety of actors. The nature of bureaucratic institutions also plays a role in how actors bargain for their interests within intersectoral networks (Bennett, Glandon & Rasanathan, 2018). Therefore, analysing the interests of different actors and the institutions through which negotiations occur is helpful to understanding the challenges and enablers of intersectoral collaboration (Baum *et al.*, 2017; Bennett, Glandon & Rasanathan, 2018).

Moreover, health policy analysis is an important lens in policies addressing the SDH because these are shaped by socio-economic systems that are dependent on political action or inaction. The consideration of the political nature of health polices in relation to intersectoral collaboration is thus crucial (Gilson, Agyepong & Shiffman, 2018).

In this thesis, I have used the analytical concepts of the 3I's – ideas, interests and institutions – to understand the formulation and implementation process of the FTD initiative. These three constructs have been linked to the governance of intersectoral collaboration which was helpful in connecting policy theories to collaborative work (Bennett, Glandon & Rasanathan, 2018). The 3I's also offered multiple possible dimensions of analysis and a range of possible explanations how the FTD initiative unfolded. I explain below how I approached each of the 3I's in relation to intersectoral collaboration.

Ideas

Ideas are products of our cognition that influence how we construct and interpret our surroundings, thus shaping how actors frame policy problems and solutions (Béland & Cox, 2010). Policy studies that focus on ideas recognise that these shape identities and the perceived interests of actors and become influential when interacting with institutional forces and actors' behaviours (Schmidt, 2008; Shiffman, 2009; Béland, 2010; Koon, Hawkins & Mayhew, 2016). Ideas can also become powerful ideological weapons that allow actors to challenge existing institutional arrangements.

However, the power of ideas lies in their expression through discourses and frames (Schmidt, 2008; Kern, 2011). Frames constitute a package of ideas and have been used as the unit of analysis in various forms of policy research (Koon, Hawkins & Mayhew, 2016). The concept of ideas, and specifically Schmidt's (2008) typology of ideas as policy solutions, as programs and as underlying worldviews, provided a relevant approach for examining policy discourses surrounding intersectoral action, how actors and sectors framed the FTD and whether there was a shared vision amongst various actors. The specific considerations of ideas and frames employed in this thesis are explained in Chapter 3.

Institutions

Institutions as a concept has been defined in a number of ways (Béland, 2009; Kern, 2011; Lencucha, Magati & Drope, 2016; Abimbola *et al.*, 2017; Baum *et al.*, 2017). For this thesis, I have drawn on the definition of institutions in relation to intersectoral collaboration by Bennett and colleagues, namely:

> *'how established institutions, including broader legal contexts, bureaucratic arrangements that govern relationships between different public sector entities and organisational capacity (within government and without) influence multi-sectoral collaboration.'* (Bennett, Glandon & Rasanathan, 2018, page 4)

Institutions in this case are the generally accepted rules which guide actor behaviour. These rules include both formal laws and standards, or informal norms and habits, that either enable or constrain policy options. In this way, institutions can facilitate the ability of some groups to achieve their goals while blocking or hindering the attempts of others (Fischer, 2003; Shearer *et al.*, 2016; Baum *et al.*, 2017).

Interests

Complementing the focus on ideas and institutions, interests are also considered as a potentially important explanatory category.

Interests embrace the identities of the actors involved, their preferences, strengths, and their capacities for mobilisation and action (Hall, 1997; Bennett, Glandon & Rasanathan, 2018). The ability of actors to exercise their interests depends on the distribution of resources and power in a policy sub-system, as well as the individual capacity and skills of the actors themselves (Shearer *et al.*, 2016). In the case of intersectoral collaboration, interests would also include the sources of power that actors may draw on to influence policy outcomes (Bennett, Glandon & Rasanathan, 2018).

Ideas, interests and institutions are interdependent and identifying the link between the three factors requires knowledge of the policy issue, context and history (Shearer *et al.*, 2016).

2.5.2 Collaborative governance

In order to understand the specific governance dynamics that shape intersectoral collaboration, I adopted the Ansell and Gash model of collaborative governance (Ansell & Gash, 2008) to analyse part of the research findings in Chapter 7. They refer to collaborative governance as:

> *'[a] governing arrangement where one or more public agencies directly engage non-state stakeholders in a collective decision-making process that is formal, consensus-oriented, and deliberative and that aims to make or implement public policy or manage public programs or assets.'* (Ansell & Gash, 2008, page 2)

This definition has been expanded in later models of collaborative governance to cover a range of broader agents, structures and processes that enable collaborations across organisations (Emerson, 2018).

Governance as a concept is the subject of a wide range of academic literature (Rhodes, 2007; Fawcett & Daugbjerg, 2012; Brinkerhoff & Bossert, 2013; Rasanathan *et al.*, 2018). In the broadest sense, governance determines how societies are organised and how power and resources are distributed (Kickbusch & Gleicher, 2012). Governance thus refers to the rules (both formal and informal) that guide collective decision making (Ansell & Gash, 2008; Abimbola *et al.*, 2017).

Recent work has considered governance a key, if not the central, dimension of intersectoral collaboration. This body of work has argued that effective governance is necessary for the development of shared goals and for the implementation of programmes that require co-ordination across different sectors and levels of government (Rasanathan *et al.*, 2017; Bennett, Glandon & Rasanathan, 2018; Schneider *et al.*, 2019).

Consequently, governance serves as an appropriate lens for examining intersectoral collaboration as the processes through which different groups or organisations interact to shape health outcomes (Bennett, Glandon & Rasanathan, 2018). As part of the broad field of governance, collaborative governance is concerned with forms of networked or horizontal governance that enable multiple stakeholders to engage collectively in consensus-oriented decision making. The literature on collaborative governance emphasises the need for iterative processes of engagement and learning that typically involve a diverse array of stakeholders in an effort to build common understandings and shared goals (Bennett, Glandon & Rasanathan, 2018). This literature therefore offered a range of factors that I could consider for examining collaboration in the FTD.

There are a range of frameworks and models that have been used to understand collaborative governance, which all have clear similarities (Bryson, Crosby & Stone, 2006, 2015; Thomson & Perry, 2006; Ansell & Gash, 2008). The existing models and literature on collaborative governance largely draw on experiences from high-income contexts, although a number of recent papers have linked LMIC experiences to collaborative governance theories (Bennett, Glandon & Rasanathan, 2018; Emerson, 2018; Schneider *et al.*, 2019).

As noted, in this thesis I have adopted the Ansell and Gash model, which proposes four main variables as shaping collaboration, namely starting conditions, institutional design, collaborative process and facilitative leadership (as shown in Figure 1).

Starting conditions refers to the factors at the onset of collaboration that set off the collaborative endeavour in a positive or negative way. They comprise three factors, the first being the power or resources imbalances among partners that affects the willingness or ability of players to collaborate. Resources can include the time, skills and energy to engage in collaboration. The second factor relates to the incentives to participate in collaboration that depend on the perception by stakeholders of whether the collaborative process will have a meaningful impact considering the time and energy that collaboration requires. The last

factor is the prehistory of conflict or collaboration that determines whether collaborative endeavours begin with high levels of trust based on past engagements or suspicion and distrust of partners (Ansell & Gash, 2008).

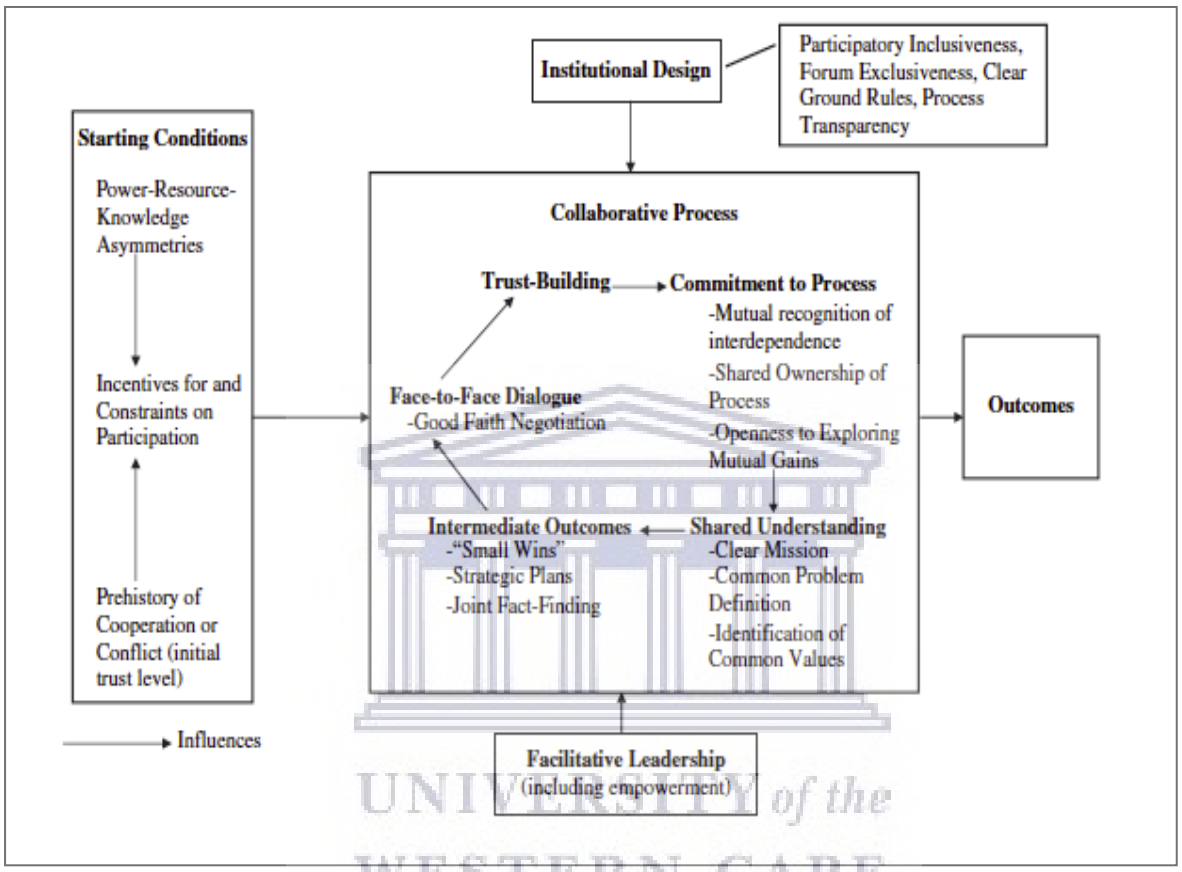

Figure 1: Ansell and Gash model of collaborative governance
(Ansell & Gash, 2008)

Leadership has been described as an important variable in exploring the success or failure of collaborative governance (Ansell & Gash, 2012; Bryson, Crosby & Stone, 2015; Emerson, 2018). Leadership in collaborative processes is needed to facilitate interactions between stakeholders and to enable effective problem solving. There is acknowledgement that there is no single way of exercising collaborative leadership as this depends on the context and tasks to be accomplished. In subsequent publications, Ansell and Gash have identified three roles that leaders need to play at different moments in collaborations. They can act as stewards where they protect the integrity of the process by taking ownership and exercising authority; they can also act as mediators or brokers who nurture the relationships between stakeholders

especially during conflicts. Lastly, leaders can be catalysts who help stakeholders identify and realise opportunities for collective action. Facilitative leadership therefore depends on the ability of leaders to play all three roles to safeguard the collaborative process (Ansell & Gash, 2012).

Institutional design factors set the basic protocols and ground rules for the collaboration that provide legitimacy to the process. A clear definition of the roles and formalisation of governance structures is seen as an important design feature that reassures stakeholders about the integrity of the collaborative process.

The last variable is the collaborative process itself, which is an iterative process that depends on face-to-face dialogue and the opportunity for identifying mutual goals and building respect, trust, commitment and shared understanding. Stakeholders' commitment relies on whether they believe that mutual gains will enable the achievement of set goals and whether there is ownership of the collaborative process. These factors are viewed as important across all the stages of collaboration (Ansell & Gash, 2008).

CHAPTER 3:
METHODOLOGY

3.1. INTRODUCTION

This chapter provides a descriptive account of the research design and specific data collection methods used in this thesis. Exploring and tracking the FTD initiative within the provincial context relied on a flexible, qualitative and case study approach to accommodate all the unfolding FTD events. The chapter begins by describing the epistemological assumptions that underpinned the research design to address the research aims and objectives outlined in Chapter 1. A detailed description of the case study approach, conducted in three phases, is then provided with the intention of laying out an audit trail of theories and methods used and data generated from each phase, including justifications and limitations.

Drawing from discourse analysis methodology, phase one comprised a documentary analysis that considered the impact of ideas and frames on the shaping of the intersectoral FTD policy process in the Western Cape. Adopting an institutional analysis approach, phase two triangulated observations, document analysis and interviews to analyse factors in the policy formulation and early implementation processes of the FTD. The last phase examined FTD in the context of experiments in joined-up government in specific local areas of the Province, drawing on collaborative governance theory.

Finally, a reflection of the researcher's positionality is offered along with ethical considerations that shaped this study.

3.2 RESEARCH DESIGN

For this study, I embraced the social constructivist paradigm (Creswell, 2014) in seeking to understand the FTD policy experience. Health policies and systems are complex socio-political phenomena constructed by human behaviour (Gilson, Hanson & Sheikh, 2011; Gilson, Agyepong& Shiffman, 2018). Essentially, actors socially construct health policies and systems through meanings and interpretations attached to various experiences (Shiffman, 2009; Gilson, Hanson & Sheikh, 2011). These meanings can be varied and multiple and should lead the researcher to look for the complexity of various views rather than narrowing the meanings into a few categories or ideas (Creswell, 2014). The constructivist lens has influenced a range of policy analysis studies, thinking and methodologies (Yanouw, 2000; Fischer, 2003; Fischer, Miller & Sidney, 2006; Shiffman & Smith, 2010; Gilson, Agyepong

& Shiffman, 2018) and was therefore a suitable starting point to examine the FTD policy process.

The constructivism epistemology allowed me to consider the contextually situated interpretations by policy actors of their experiences as the main line of inquiry. This was relevant for this study due to limited evidence on how intersectoral processes are affected by policy contexts, interactions between actors, politics and power dynamics (Glandon *et al.*, 2019). The focus on actor experiences, interests, roles and behaviour thus allowed me to move beyond the usual typology of successes and failures of intersectoral action to examining the influence of context and actor behaviour on collaborative efforts.

As a result, the research design for this study explored how FTD policy actors behave and act in their everyday, natural settings through a qualitative research design (Creswell, 2014). Qualitative interviews focused on broad and general questions that prompted those interviewed to share their interpretations and experiences of the FTD process. Similarly, the interpretive nature of qualitative research meant that the findings were inferred through interactions between the respondents and myself as the researcher (Creswell, 2014). Therefore, identifying and reflecting on my positionality and assumptions in relation to the research process was key and has been described in section 3.4.

3.2.1 Case study design

In order to understand the process of policy formulation and early implementation of the FTD, this study adopted a case study design, which is suitable for investigating a phenomenon within its real life context, and to obtaining an in-depth appreciation of the issue (Yin, 2014). Case studies are also considered suitable when the boundaries between the phenomenon and the context are not clear and where the researcher has little or no control of the events in a particular setting (Yin, 2014).

The case study approach has been used in policy research due to its ability to capture the multi-faceted and dynamic nature of policy making (Agyepong & Adjei, 2008; Walt *et al.*, 2008; Juma, Owuor & Bennett, 20155; McDougall, 2016). This has been useful in providing insights into policy processes including decision making, and the political and organisational environments from which policies emerge (Walt *et al.*, 2008). An examination of factors which influence policy allows for the '*interplay between formal presentations of public*

policy decision-making theory and actual practice, especially the imperfect, real world of policy-making' (Mills, Durepos & Wiebe, 2012, page 3).

Within the typology of case study approaches outlined by Yin (2014), this was a study of a single case, namely the policy formulation and the early implementation processes of the FTD at the provincial level. I selected the FTD as a single case due to the significant amount of attention it was receiving within provincial circles during the beginning of the study period in 2017. This provided a favourable opportunity to examine how the phenomena of the FTD, an initiative that required intersectoral collaboration, would unfold over time and provide wider lessons for intersectoral collaboration.

To study the FTD initiative as it was unfolding, two regions within the Western Cape Province were selected as embedded units of the case study, being the Saldanha Bay Municipality in the West Coast District and the Khayelitsha sub-district in the Cape Town Metropolitan Municipality. As the provincial plans had named these two regions as pilot areas for the FTD initiative, they were considered suitable for this study.

The intention at the beginning of the study was to compare the early implementation process of the FTD initiative in rural Saldanha with urban Khayelitsha, using the same analytic tools. However, the FTD process unfolded in very different ways in the two areas, rendering this common approach less meaningful. The emergence of the WoSA, described in Chapter 7, offered a unique collaborative space that influenced the Saldanha FTD process; in contrast the FTD initiative in the Khayelitsha region was implemented through the existing maternal and child health-driven agenda with limited intersectoral processes. As a result, I shifted from a direct replication logic in the two areas to sequential embedded cases, offering different kinds of insight into the collaborative process, and requiring different conceptual tools.

An overview of the study settings

I have provided a general description of the socio-economic context of the Western Cape Province in Chapter 1 which includes a description of the state of children in the province. In this chapter, I offer an overview of the governance structures in the Province and describe the two sub-districts of the study. The information included in this section also describes socio-economic factors that influenced the Province's selection of Khayelitsha and Saldanha Bay as pilot sites for the FTD initiative and is by no means a comprehensive description of the contexts as a whole.

The South African government consists of three spheres of government – namely national, provincial and local - all of which operate according to laws made by the National Parliament and have interdependent roles. The Western Cape Provincial Government works through a provincial parliament headed by the Premier. The parliament comprises 42 members elected through party-list representation, the majority of whom are from the Democratic Alliance Party (in contrast to the ruling party in the rest of South Africa, namely the African National Congress).

Every five years, the Western Cape Province develops a provincial strategy that details the overall framework and plan for developing the economy and providing services. The provincial plans relevant to the FTD initiative include the Provincial Strategic Plan 2014-2019 (Western Cape Government, 2014) and, more recently, the Provincial Strategic Plan 2019-2024 (Western Cape Government, 2019b).

The Province regulates provincial services through 13 provincial departments including the Department of Local Government, which is the sphere of the government closest to communities. The provincial Department of Local Government is responsible for co-ordinating and supporting local municipalities that run local services in line with the national and provincial legislation. Each municipality has a council comprising locally elected members that approves local laws and policies for their area. The work of the council is co-ordinated by a Mayor who is elected by the Council (Western Cape Government, 2020).

Alongside the social and socio-economic problems affecting families in the Western Cape Province, there are many challenges facing municipalities. An increase in political and administrative instability means that some councils are dysfunctional, while many municipalities are struggling with allegations of fraud, corruption, and maladministration. These negatively affect service delivery. Further, the rise in protests by frustrated communities has resulted in the destruction of service delivery facilities and infrastructure and this remains a constant reality within the province (Western Cape Government, 2019b).

Saldanha Bay Municipality

Saldanha Bay Municipality (SBM) is located on the West Coast of South Africa, and is a sub-district of the rural West Coast District. With a population of 115,269, Saldanha Bay is the second largest municipal area within the West Coast District. The total population of children in Saldanha Bay municipality was 34,889 in 2018 with the number of malnourished children under five increasing from 0.4 in 2017 to 1.8 in 2018. Although the neonatal mortality rate

improved to 5.6 in 2018, the region still features a low immunisation rate of 53.7% in 2018 (Western Cape Government, 2018b).

2018 mid-year population estimates (2002-2018) from Statistics South Africa predicted that the population in Saldanha Bay would increase to 137,134 by 2024 (Western Cape Government, 2018a). This is due to the influx of people seeking employment within a large planned industrial development linked to the deep sea harbour in Saldanha Bay, which is anticipated to attract considerable economic investment over the next 10 to15 years (Western Cape Government, 2018b). The increasing population numbers will be accompanied by an increased need for government services and pressure on both infrastructure and social services (Western Cape Government, 2018b). This will include social facilities such as ECD centres and older person facilities, due to growth in the related age cohorts (Western Cape Government, 2017a).

Saldanha Bay is burdened by numerous socio-economic challenges in the context of the planned industrial development, which include an increase in poverty, drug abuse, crime and violence, unemployment and inequality (Western Cape Government, 2017a, 2018b).

Khayelitsha

Khayelitsha is a densely populated peri-urban sub-district in the Cape Town Metro with an estimated population of 350,000 to 900,000 with 28.2% of the total population under 14 years of age (Dorrington & Moultrie, 2012). Housing in the region is both formal and informal with unemployment levels considerably higher than the national average (Dorrington & Moultrie, 2012). Similar to Saldanha, this sub-district experiences significant socio-economic challenges linked to its foundations in apartheid planning.

One of the main concerns is the high rates of violence and crime in the area related to poverty, unemployment and income inequality (Seekings, 2013). Due to concerns about crime, the Premier appointed a commission of enquiry into the state of policing. The findings pointed to significant challenges in the policing system linked to the history of violent oppression during apartheid and colonialism, the decay of the social fabric, as well as alcohol and drug abuse (Khayelitsha Commission of Inquiry, 2014).

3.2.2 An overview of data collection methods

The main theoretical concepts that shaped the study have been outlined in Chapter 2.

These include the focus on the 3I's (ideas, interests and institutions) and the Ansell and Gash model of collaborative governance (Hall, 1997; Ansell & Gash, 2008).

As shown in the table below, this study unfolded in three phases, each of which included data collection processes that were distinct and utilised specific theories or frameworks for analysis. The study objectives therefore overlapped in various phases to capture all the aspects of how the FTD initiative evolved. Because each phase had a specific angle of analysis, the findings presented in Chapters 5 to 7 align to phases one to three. A description of each phase and accompanying methods is discussed below.

Table 2: The link between study phases, objectives, data collection methods and conceptual frameworks applied

Study phases	**Objectives addressed in each phase**	**Data collection methods**	**Frameworks/ theories that influenced the analysis**
Phase one: Document analysis	1. To describe how the FTD evolves from an intersectoral policy idea to policy content and process for implementation. 2. To identify which FTD interventions and intersectoral coordination strategies are prioritised and why.	Qualitative document analysis	Schmidt's typology of ideas
Phase two: Formulation and early implementation process of the FTD initiative	3. To map and describe actors (as individuals, policy communities, institutions, networks) involved in the formulation of the FTD policy, their inter-relationships and the roles they play. 4. To examine how the intersectoral FTD initiative unfolds in the initial implementation phases.	Document analysis In-depth interviews Observations	3I's framework: Ideas, interests and institutions
Phase three: The FTD initiative within the Whole of Society Approach (Saldanha Bay)	4. To examine how the intersectoral FTD initiative unfolds in the initial implementation phases.	Document analysis In-depth interviews Observations	Ansell and Gash model of collaborative governance

Phase one: Document analysis process

The first phase of the research process analysed FTD policy and policy-related documents, primarily to address objectives one and two of the research. The specific purpose of this phase was to examine how frames of problem definitions and solutions proposed for the FTD initiative affected the potential for intersectoral work at the early stages of the policy development process. In order to do this, a qualitative documentary analysis method (Patton, 2002; Bowen, 2009) was adopted.

The analysis of documentary sources is recognised as a valuable qualitative analysis method and has been used, amongst others, to examine policy responses to the SDH (Bowen, 2009; Phillips *et al.*, 2016; Fisher *et al.*, 2017). Although reviewing written text may not reveal negotiations and contestation during policy making, policy documents illustrate the outcomes of a policy process and can provide insights into underlying values, ideas or meanings that influence policy action.

Ideas are products of our own cognition that influence how we interpret our surroundings and construct the social world, shaping world views, casual beliefs, frames, societal norms and cultures (Driedger & Eyles, 2003; Schmidt, 2008; Béland, 2009). Frames are a package of ideas that act as 'cognitive maps' or channels through which meaning is structured and preferences expressed, and which serve as reference points for viewing new information (Fischer, 2003; Espérance, 2013). In the development of policies, frames serve to focus attention on a selected part of the problem and on a specific solution while simultaneously diverting attention from any other solution that may be present (Koon, Hawkins & Mayhew, 2016). During policy formulation, frames evolve as actors interact in defining, debating and challenging problem definitions and solutions; these may become integrated into existing frames or may evolve into new definitions of the problem and explanation for the policy choices (Garvin & Eyles, 2001; Koon, Hawkins & Mayhew, 2016).

Various forms of framing analyses are available to those interested in studying frames (Garvin & Eyles, 2001; Blackman *et al.*, 2012; Tynkkynen, Lehto & Miettinen, 2012; Koon, Hawkins & Mayhew, 2016). In this study I was interested in how different points of view and interests were articulated in policy documents, as well as how arguments presented in documents discussed intersectoral processes. I applied Schmidt's typology of ideas (Schmidt,

2008) as it offered a way to organise data in order to elicit frames from examining policy ideas, including how they are conveyed through the discourse of policy documents.

Schmidt conceptualised ideas underpinning discourses and frames at three levels of generality (Schmidt, 2008). The first level refers to specific policy ideas or policy solutions to identified problems. The second level describes programmatic ideas, which define the problem, goals and objectives to be achieved, and methods to be applied. These programmes reflect the underlying assumptions of policy and can be thought of as programmatic beliefs that operate between world views and specific policy ideas. Ideas as policy programmes (programmatic ideas) are usually found in the centre of most policy debates and are favoured by policy actors as they help them determine solutions to policy problems (Campbell, 1998).

The third level considers a more general level of ideas. This includes public philosophies or world views which frame the policy within a deeper set of ideas, values and principles of knowledge that reflect larger constructions of society, economics or politics. While ideas in the first and second levels are often discussed and debated, philosophies that underpin policies and programmes normally remain in the background (Schmidt, 2008; Béland & Cox, 2010).

The document analysis process sought to answer the empirical question of how policy ideas regarding the FTD initiative reflected overall structures of meaning within frames. The document selection process specifically looked for documents which focused on the FTD period and not on the whole ECD period (which stretches from zero to nine years) during which other government sectors (notably education) may have more prominent roles than health. Some of the FTD-relevant text was, however, embedded in, or had to be inferred from ECD-related policies, especially those released before 2014, when the FTD concept was not as yet widely in circulation.

The document selection process was iterative and was done over a period of eight months (February to October 2018) while the FTD was unfolding at provincial level. Key informant interviews conducted during the course of document selection ensured that all the relevant documents shaping the initiative were included. Although the main analysis was completed in 2018, to accommodate new documents that had been released after 2018, an additional set of documents were added in August 2020, such as the newly released annual reports of relevant sectors.

Document selection occurred in three stages.

The first stage was informed by the researcher's observations of key provincial events related to the FTD initiative and attendance at two different intersectoral working group meetings. Documents received through these processes were largely health sector strategies, policy reports, newsletters and global literature that key informants felt had shaped the initiative in the Province.

In a second stage, references in the documents received in the first stage were followed up and searched for on the Western Cape Provincial website. Annual provincial reports and performance plans across sectors were scanned to identify if there was any text referring to the FTD, with a deliberate effort to explore whether the FTD was prioritised in policies of the departments of Education, Social Development and Community Safety.

In the last stage, broader national level policies or documents that focused on the FTD were identified, including maternal and child health policies and strategies and relevant international and national scientific literature. Through this process, a total of 41 documents was obtained and analysed, which are listed and described in Chapter 5.

Once the selection process was complete, documents were initially read to establish their main content, followed by the coding of each document in Microsoft Excel using a priori coding framework based on the conceptualisation of policy ideas by Schmidt (2008). An example of the deductive coding process is shown in Table 3 where ideas as solutions were coded as statements that referred to what each document identified as the solution/s to the problem. Ideas as programmes were also used to code the 'how' of the policy solution/s, including instruments or the detailed approach mentioned. Based on the 'what' and the 'how' – the choice of particular solutions and programmes and the arguments used to support choices – the underlying world views were inferred. During the coding process, text was extracted that spoke to the rationales used to justify the focus on ECD or the FTD as well as any statements on intersectoral collaboration.

Table 3: An example of the coding process of policy documents

A priori coding structure

Codes	Examples from document codes (Western Cape Government Health Annual Report 2015/2016)
Ideas as solutions	**'What'** '*The Department plays a leading role in the Provincial Cabinet strategy to increase wellness, safety and reduce social ills in collaboration with the departments of Social Services, Community Safety, Culture, Arts and Sport, Transport and Public Works. Seven projects have been developed in this regard: First 1000 days focusing on a range of intersectoral strategies to give children the best possible chance of a good start in life.'*
Ideas as programmes	**'How'** '*The initiative provides opportunities for lifelong health and wellness for children in the Western Cape through the implementation of health specific interventions, intersectoral interventions and effective communication. The initiative follows a whole society approach to work together and improve the lives of children and their caregivers in and beyond the first 1000 days of life.'*
Ideas as world views	**'Why are the above policy solutions and programmes selected'** *'A key indicator for any health system lies in how it cares for women and children. In the Western Cape we believe in the crucial importance of the first 1000 days of a child's development in securing a child's bright future. This starts from conception, moving through pregnancy, birth and the first two years of life.'*
Rationales	*'Child's bright future.'*
Discourse on intersectoral collaboration	*'The Department plays a leading role in the Provincial Cabinet strategy to increase wellness, safety and reduce social ills in collaboration with the departments of Social Services, Community Safety, Culture, Arts and Sport, Transport and Public Works.'*

Following the thematic analysis approach (Patton, 2002), coded texts were checked and later organised into three broader themes, which I considered core 'frames' (Chapter 5). Although I did the coding, the analysis process was discussed with my supervisors, after which the naming of the frames and overall structure of the findings was developed. This analysis process began by identifying general patterns through grouping policy solution/s and problem definitions that were similar along with accompanying arguments and world views. Thereafter frames were established by constant comparison with the rest of the data, leading to three main frames that targeted particular audiences namely the individual, families and society.

The frames and accompanying problem definitions and solutions were used to generate the findings in Chapter 5.

Phase two: Formulation and early implementation process of the FTD initiative

The second phase of this study analysed the formulation and early implementation processes of the FTD initiative in the Western Cape Province as a whole, with a more detailed focus on frontline realities and experiences in the Khayelitsha sub-district. Data collection for this phase occurred between May 2018 and August 2019 through reviewing documents, in-depth interviews and observations. Table 4 provides an overview of the data collection activities and the study participants in this phase.

Observations

Observation methods are an established qualitative method of inquiry rooted in ethnographic research that help the researcher understand actor behaviour and processes occurring within a context (Yin, 2015). Direct observations of relevant meetings were conducted to learn which stakeholders were involved, their levels of engagement and influence and how interventions were prioritised. The researcher attended and observed meetings of two working groups – the Parent, Infant and Child Health and Wellness (PICH) working group and the community-based services (CBS) working group – and five FTD-related workshops (Table 4).

Attendance at the meetings of the two working groups generated the initial interest in the study and direct observations during the course of 2017 were focused on understanding the FTD initiative in an effort to generate research questions. Once study objectives became clear and interviews began, direct observations in meetings and workshops assisted in triangulating

interview responses on the unfolding FTD activities. Attending meetings and workshops also offered an opportunity to ask informants for key documents.

The PICH meetings, for example, provided an update of FTD decisions (from the FTD Executive Committee), broader provincial directions from the provincial strategic goals, and insights into NGO activities related to the FTD. I could also ask key informants about specific policy directions that I had heard about in meetings, thus obtaining a fuller picture of why decisions were following particular directions. The CBS group, on the other hand, offered access to programme and service delivery (operational) managers within the health sector. This was useful in sampling participants for interviews and for establishing rapport with the interviewees. Tracking key decisions debated in meetings of the CBS group – such as the role of community health workers (CHWs) in the FTD – was also key in understanding tensions between operational managers and other actors.

Although observations were useful in establishing familiarity with key informants and accessing key documents, I acknowledge the limitations of this method in studying processes of policy making, especially as the emergence of decisions can be hard to identify within widely spread networks of actors (Walt *et al*., 2008). Observational data is also subject to researcher bias which I accounted for by triangulating field notes with interviews and documentary evidence.

Table 4: Data collection processes of Phase two

Data collection processes	**N**	**Examples**
Observed processes		**Events and policy communities**
FTD-related workshops	5	Community-based services workshop (*September 2017*) Drakenstein Parent Support Package Site Visit (*August 2018*) Nurturing Care Framework Workshop (*August 2018*) First 1000 Days Intersectoral Workshop (*November 2019*) The First 1000 Days Colloquium *(February 2020)*
Policy communities associated with the FTD	3	Parent, Infant, Child Health and Wellness (PICH) working group comprising members from the departments of Health, Social Development and Education, academics and NGOs. Provided platform for sharing insights and fostering collaboration between various partners. *(Observed seven meetings between 2017 and 2019.)*

Data collection processes	N	Examples
		Community-based services (CBS) group that met bi-monthly to discuss possible ways of organising community-based services for the FTD; and engaged with district and CBS as well as academics. *(Observed four meetings between 2017 and 2018.)* FTD Executive Committee responsible for organising formulation processes of the FTD. They consisted of deputy directors of Nutrition, Women's and Children's Health, a senior clinician, and a member of the Communications Directorate of the provincial Department of Health. (*Observed one meeting of the core FTD committee in 2018.*)
Key informant interviews		**Policy formulation actors**
Government sector (Health)	12	Provincial policy makers, members of the FTD Executive Committee, district and sub-district actors.
Government sector (Social Development)	1	Representative of the provincial Department of Early Childhood Development.
NGOs and civil society organisations	4	Largely part of the PICH group.
Academics	4	Associated with the PICH and CBS groups.
Total	**21**	
		Early implementation actors (Khayelitsha)
Health workers	5	Health workers comprising three nurses, a dietician and a health promoter.
NGOs	8	Four community health workers, two supervisors and two programme managers.
Social Development	2	Programme manager and a social work supervisor.
Total	**15**	

Document analysis

In addition to the documents collected from phase one, this phase added minutes of the meetings and workshops observed, and additional material generated from meetings such as presentations and reports. As opposed to the framing analysis from phase one, documents along with interview material and observation notes were analysed thematically at this stage, to provide a fuller picture and more complete overall FTD narrative – especially insights into the FTD timeline and how the FTD initiative was evolving. Data extracted from documents also provided information on administrative procedures, proposed interventions, actor involvement and collaborative engagements.

Interviews

Key informants were purposively sampled (Yin, 2015) based on their involvement in the adoption and early implementation processes of the FTD. Two sets of interviews were conducted.

The first set of interviews were with participants involved in policy formulation processes of the FTD, particularly at provincial level, while the second set were with participants who had early implementation experiences related to the FTD from Khayelitsha (Table 4). An initial list of key informants on FTD policy formulation was provided by one of the members of the CBS working group, while other informants were identified through snowballing (Patton, 2002). Following the development of an initial list, each participant was approached via an email which requested an interview and included a description of the study and the information sheet (Appendix 1).

To investigate the implementation of the FTD initiative, the recruitment of participants followed a different pattern. Health facility managers at institutions where frontline providers worked were approached who then recommended participants involved in FTD activities. NGOs, on the other hand, provided names of CHWs who were available along with their supervisors and programme managers. The provincial ECD counterpart recommended respondents from the Department of Social Development office. Seven participants were not available to respond to email requests for interviews while others felt that they were not primarily involved in FTD-related work and could not sufficiently contribute to FTD discussions.

Interviews continued until saturation was reached, resulting in a total of 36 interviewees. During the recruitment process, it became apparent that other key government departments (Education and Community Safety) had limited involvement in the formulation processes, and so respondents from these departments were not pursued for interviews. The lack of involvement of non-health sectors was a general indication of how limited intersectoral processes were and that the FTD was largely 'owned' by the health sector. This presented a limitation to the study as respondents were largely drawn from the health sector. Follow-up interviews were also conducted with two of the key informants from the FTD Executive Committee a year after initial interviews, to explore if any changes had occurred.

I conducted all the interviews for the study, guided by a semi-structured interview guide (Appendix 2). Interviews were conducted at the workplaces of participants, which included provincial offices, district and sub-district centres, health facilities, NGO centres and offices of the Department of Social Development. Two of the interviews were done at the School of Public Health as it was convenient for the interviewees. All the interviews were conducted one-on-one, bar one interview where two participants requested a joint interview to facilitate the discussion. In addition, all interviews were conducted face-to-face, except for three conducted telephonically.

Each interview commenced with an introduction to the study and information about the purpose of the research. At this stage, I also informed the interviewees that their participation in the study would remain anonymous and confidential and that they could withdraw at any stage of the research. This was followed by the handing out the consent form (Appendix 3) for signature after interviewees indicated that they understood the study. During this process, interviewees were also asked permission to audio record the interviews – to which they all consented.

Although an interview guide was used to structure questions in which I was interested, the interviews were semi-structured with the flow of discussions being guided by interview responses. Towards the end of the interview, particularly for policy formulation informants, I would use the opportunity to confirm whether governance structures were accurately depicted in a diagram I had generated. Moreover, interviews were useful for checking whether key moments from documents analysed presented an accurate account of FTD activities.

Respondents involved in formulation activities were asked about the FTD agenda-setting processes, the goals and interventions of the FTD, actor roles and relationships, collaborative processes and contextual factors influencing policy processes.

For implementation experiences, the semi-structured guide was adjusted (Appendix 4) to explore roles/responsibilities of frontline workers, knowledge regarding the FTD initiative, collaborative experiences, and contextual or policy environment factors. In these interviews, I explored collaborative experiences that were beyond the FTD initiative because some frontline workers had not engaged with the FTD specifically but could speak about other experiences for children within the 0 to 2 age group. This proved useful for two reasons. Firstly, it confirmed that although frontline providers had heard of the FTD, they could not identify specific interventions related to the initiative. Secondly, it was insightful to hear about informal forms of collaboration in which frontline providers were involved. It was also evident that informal networks that providers spoke about were not directly linked to the FTD process.

Interviews were recorded and transcribed verbatim and lasted between 30 minutes and one hour. Interviews with CHWs included a translator as three of the CHWs used isiXhosa occasionally to express their thoughts. These interviews were transcribed and translated by the translator used during the interview process.

Notes were made after the completion of interviews and were used to supplement insights during interviews and to record any occurrences that seemed significant. For example, in response to my question of how the FTD had unfolded, one of the interviewees phoned an official working at the provincial Health Minister's office and asked about the extent of FTD activities. The response, which the interviewee relayed to me, indicated that the FTD had lost its initial momentum. These insights were helpful during data analysis.

Data management and analysis

Interview transcripts, outputs of the document analysis process and field notes from observations were imported into Atlas.ti software. The analytical process began during data collection due to the continuous collection and preliminary analysis of data, such as the document analysis described earlier. As the research process unfolded, the ongoing process of analysis meant I was able to bring some of the findings into subsequent interviews which was useful for confirming if any changes regarding the FTD implementation had occurred.

Qualitative research uses analytical categories to describe and explain the social phenomena being studied (Pope *et al.*, 2000). These analytical categories can be derived inductively – where insights are obtained gradually from the data – or deductively either at the beginning or part of the way through the analysis, as a way of approaching the data (Pope *et al.*, 2000). For these data, I approached the analysis and coding process both inductively and deductively, based on policy analysis frameworks that were of interest to the study such as the attention to ideas, interests and institutions (Hall, 1997).

The specific thematic analysis process (Yin, 2015) comprised the general steps described below. However, it should be noted here, that the analysis was not a linear process; there was often a back and forth between the various steps, particularly in identifying which theoretical framework best represented the range of factors that influenced the FTD process.

The initial step of analysis comprised reading and re-reading the data while listening to audio files, to ensure familiarity with the data. An initial broad coding process that categorised data into codes followed this. The coding process drew on a priori issues and questions derived from the aims and objectives of the study, issues raised by the respondents as well as views or experiences that recurred in the data. All data were coded by comparing each coded segment with the rest of the data to establish whether the particular line fitted with the assigned code. At this stage, codes were added to reflect as many nuances in the data as possible, resulting in a large number of codes (about 83 codes).

Thereafter, this large set of codes was refined and reduced, largely through grouping codes that were similar. Some codes had also been repeated and were condensed, reducing the initial number of codes significantly. The grouping of codes was the beginning of the analytical process, especially when deciding which codes could be grouped together or were related. Once codes were grouped, they were charted on an Excel spreadsheet and discussed with the supervisors. This began the process of identifying the possible themes within the data.

The process of moving between code groups to themes took some time as I also began considering the potential narrative lines arising from the data. During this stage, I also generated a timeline, mapping the key events associated with the FTD initiative between 2015 and 2019, which assisted in developing the descriptive narrative of the FTD process.

Identifying potential themes that covered the 'why' narrative was an iterative process assisted by discussions with supervisors and peer support networks. Initial narratives had arranged the data according to the Walt and Gilson policy triangle (Walt & Gilson, 1994) and grouped codes in the broad categories of actors, content, context and process. After further discussions, I settled on the 3I's framework (Hall, 1997) as it appeared more suitable to the nuances of data and also linked the influence of ideas from the earlier documentary analysis to the institutions within which actors were embedded. The interaction between ideas, interests and institutions therefore offered a much more detailed theoretical understanding of the phenomena.

The three factors of ideas, interests and institutions – the 3I's framework – are part of various policy analysis theories and were therefore suited to describing the influencing factors of the FTD story. The literature review chapter offers a detailed description of the 3I's framework, particularly its use in understanding collaborative governance in low- and middle-income contexts, which enabled its use for this analysis.

A description of the findings based on this analysis is provided in Chapter 6.

Phase three: The FTD initiative within the Whole of Society Approach (Saldanha Bay)

The last stage of data collection was aimed at understanding the emergence of the FTD approach within the WoSA in the Saldanha Bay sub-district. Following the analysis from phase two, which had indicated the lack of institutional forms or bureaucratic support structures for intersectoral FTD activities (described in Chapters 4 and 6), this next phase sought to understand the factors that enabled the emerging intersectoral support and structures for the FTD initiative in the Saldanha Bay Municipality.

Data collection methods for this phase purposively sampled participants who were involved in the Saldanha Bay WoSA, particularly the Social Cluster team that organised FTD-related activities. Data collection methods employed to explore the Saldanha Bay FTD activities included interviews with key informants, observations of WoSA team meetings and documentary analysis.

The data collection process drew on constructs from the collaborative governance literature, specifically on propositions and constructs from the Emerson *et al.* and Ansell and Gash frameworks (Ansell & Gash, 2008; Emerson, Nabatchi & Balogh, 2012), which were used to

develop an observation tool (Appendix 5) and a semi-structured interview guide (Appendix 6). The collaborative governance literature emphasises that multi-sector action is a complex and dynamic process which involves multiple stakeholders with the goal of achieving common understandings and shared goals.

The two frameworks offered a range of propositions that allowed me to document and understand the collaborative WoSA-related governance processes linked to the FTD. These have been described in detail as part of the literature review and were further used to shape the narrative in Chapter 7.

Observations of Whole of Society Approach meetings

Data collection methods for this phase began with direct observations of WoSA meetings. Five meetings across three WoSA governance levels were observed between March and October 2019. The meetings included a workshop with frontline providers to introduce the WoSA approach, design and small team meetings (explained further in Chapter 7), a meeting with the FTD Executive Committee and a learning event that included actors involved in the four WoSA learning sites. These meetings occurred mainly in municipal venues within the Saldanha Bay Municipality, apart from the learning event that was held in Cape Town.

Guided by the observation tool (Appendix 5), the observed meetings and accompanying minutes provided insights into WoSA governance structures, how partners engaged with each other, who was included in the meetings and the quality of relationships between members in various teams. I was also able to identify the prominence of the FTD as a core idea within WoSA teams as well as how stakeholders spoke about collaboration and the need for intersectoral collaboration. I observed how meetings ensured legitimacy and enabled decision-making processes including how information moved across governance levels. Observations were also valuable for identifying potential interviewees.

One of the challenges of observing WoSA meetings was that the discussions within meetings included a broad range of issues related to the WoSA process as a whole, while the FTD, which was of interest to this study, was only one of the issues discussed. Some of the discussions served as a good background understanding for WoSA in general but it was difficult to ascertain and note what was relevant for this study in the midst of all other discussions related to municipal governance processes, for example.

Interviews

In-depth, semi-structured interviews were conducted with eight participants who were part of the Saldanha WoSA process. Through one of the social cluster team members, an email was sent out to members of the team to recruit participants for interviews, in a similar fashion to that undertaken for the phase two. Respondents were then followed up individually to arrange the interviews.

I began the interviews with a similar consent process as described in phase two. Seven face-to face and one telephonic interview were conducted. Interview respondents were senior and mid-level Ministry officials from six provincial departments (Health, Social Development, Education, Community Safety, Transport and Public Works, Cultural Affairs and Sports). The interviews took place at the workplaces of officials in Saldanha Bay, apart from one at the provincial offices and one at the School of Public Health. All the interviews lasted between 45 minutes to an hour and were audio recorded and transcribed verbatim.

Two of the interviews were conducted with one of the research supervisors observing, who then asked follow-up questions towards the end of the interview. One of the interviews had to be conducted with three respondents jointly in the form of a semi-structured discussion, given time constraints and the willingness of the three respondents to reflect on their experiences together.

Guided by the semi-structured interview guide (Appendix 6), interviewees were asked about the origins of the WoSA process, their involvement in past collaborative processes that were relevant for the FTD initiative, such as Better Spaces (Chapter 7). Additional questions explored their knowledge regarding the FTD initiative, WoSA-specific engagement processes with partners, the main drivers or actors involved in the WoSA process, decision-making processes and the specific achievements of WoSA.

It is worth noting that although the eight respondents offered WoSA-related narratives, later interviews in phase two, particularly the follow-up interviews with members of the FTD Executive Committee and a senior official in the Provincial Health Department, had reflected on the link between the FTD and emerging WoSA process. Information from the three interviews in phase two were thus included during data analysis.

Supplementary documentary data

Documentary data in this phase were valuable in providing information on WoSA timelines, governance structures, specific FTD activities and reflection/learning points often echoed in meetings and workshops. Documents collected comprised:

- the Better Spaces draft toolkit that provided guidance on the implementation of WoSA for heads of provincial departments (Western Cape Government Whole of Society Technical Team, 2017);
- previous research that had documented/evaluated the Better Spaces and the emerging WoSA approach (Besada & Daviaud, 2018);
- minutes of the five meetings attended and reports of the frontline workshop and learning event observed;
- a socio-economic situational analysis report of Saldanha (Western Cape Government, 2017a); and
- the Saldanha Bay WoSA Framework of Action (Western Cape Government, 2018b) that specified governance structures and responsibilities of each team.

Data Analysis

Observation notes, interview transcripts and documents were imported into Atlas.ti software and analysed thematically (Yin, 2015). Familiarisation with the data involved reading transcripts, notes and documents for content familiarity and to understand the overall story before the coding process began. Each transcript and document was manually coded in extensive detail for content-related categories, using the data management software. The coding process was influenced by the collaborative governance frameworks described earlier (Ansell & Gash, 2008; Emerson, Nabatchi & Balogh, 2012). However, inductive coding also revealed data that was unexpected and surprising or unique, such as the reflections on the sustainability of the WoSA process; tensions between immediate outcomes and long-term collaborative approaches; and how actors felt unseen in bureaucracies.

After coding of the data and discussions with my two supervisors, I organised the categories generated from the codes into themes related to the conceptual framework and research questions. Generating the narrative to describe themes from this phase involved another step of interpretation and synthesising, particularly thinking about whether and how the WoSA emerging process was linked to earlier FTD processes.

What was particularly helpful at this stage was paying attention to empirical examples offered by the interviewees which illustrated aspects of collaboration enablers or tensions. In developing the narrative that described the findings, I therefore paid attention to unforeseen connections that were not captured by the frameworks but were relevant to the study, as well as a rich narrative that linked WoSA narratives to earlier FTD processes, aided by documentary data and interview narratives.

In October 2020, a year after the data collection process for Phase three, I presented the main findings of the study to the WoSA FTD group in Saldanha Bay. Designed as a workshop that included members of the Saldanha Bay WoSA team, this process served as a member-checking process to confirm whether interpretations made in the study aligned with what the study participants experienced. After the findings of the study had been presented, the workshop participants shared their reflections of the WoSA and of the study findings – which included the value of collaborative spaces and relationships amongst stakeholders, as well as the role of leaders and facilitating actors in the process. All the points raised by workshop participants confirmed that the study findings had captured experiences of the WoSA team.

3.3 REFLECTIONS ON THE RESEARCHER'S POSITIONALITY AND THE RESEARCH PROCESS

Reflexivity refers to the '*the degree of influence that the researcher exerts, either intentionally or unintentionally, on the findings*' (Jootun, McGhee & Marland, 2009). Reflexivity involves the reflection of the researcher regarding how their personal background, culture and experiences shaped their interpretations and the meanings they attached to the data (Creswell, 2014).

In qualitative research, the continuous self-awareness of the researcher during the research process can contribute to the credibility of the research (Houghton *et al.*, 2013). This includes the recognition that the researcher is part of the social world that is being studied and is not only being affected by being in the field but also has an effect on the phenomena being studied (Jootun, McGhee & Marland, 2009). To this end, I attempt in this section to reflect on the research process I undertook while highlighting my positionality, assumptions, and biases as necessary.

In their paper on doing health policy research, Walt *et al*. (2008) discuss the positionality of researchers as a core issue that affects how policy analysts are viewed which affects their access to policy environments and their ability to conduct meaningful research. In conducting this research, I considered myself to be an outsider in the sense that I was not involved in any FTD-related processes, I had not conducted any research in the Western Cape provincial context nor had I worked in the provincial health system.

The outsider position meant that I was not associated with any particular position on the FTD or related policies and was considered, to some extent, as a neutral party by participants. This meant that I could observe meeting processes from a neutral position, often listening without being burdened by prior involvement or by being perceived as having particular views that supported one opinion over the other. Moreover, participants often felt comfortable sharing both negative and positive experiences related to the FTD initiative, including frustrations and anxieties regarding bureaucratic decision-making processes. The added advantage of not being familiar with the health system meant that participants often had to explain some experiences in a lot of detail, allowing me to better understand decision making or reporting lines of the health system, for example.

At the same time, my limited familiarity with the context meant that nuances within interviewee narratives could be missed or misunderstood. Debriefing sessions and discussions with both of my supervisors who had extensive experience of working with the provincial health system was therefore vital to counteract this potential bias and assisted in accessing the field and particular policy makers. Moreover, my training as a pharmacist meant that this was my first exposure to conducting a policy analysis study and engaging with methodologies such as discourse analysis. Research communities such as the Health Policy Analysis Fellowship Programme (World Health Organization, 2018a) were spaces in which I could engage with peers and mentors, enhancing my understanding of methodologies and principles of health policy and systems research. As a result, I approached the data analysis influenced predominantly by policy analysis theories and frameworks that shaped my understanding of the findings. The findings in this thesis could be interpreted differently if one considered different lenses.

Accessing policy makers and officials in this research who were open and welcoming also made me question the initial assumptions I had of policy makers in general. I had initially assumed that policy makers would be resistant to being interviewed or would provide 'politically correct' responses, telling me what they thought I wanted to hear. However, I found that most participants involved in formulation activities were open to stating their biases and frustrations and sharing the reasons behind opinions they had. This may have been influenced by a familiarity with me, based on their having met me at various meetings and workshops. Policy makers would also recommend interviewees who they felt had negative opinions or different opinions to theirs, which I found quite interesting as it allowed me to get a more balanced picture of views of what had happened.

On the other hand, I found that frontline providers were guarded in their responses, especially CHWs who thought I was evaluating their knowledge of maternal and child health programmes that their NGOs offered. Realising that I needed to build rapport with them, I changed the interview process, starting with asking about their general roles and responsibilities before exploring collaborative experiences.

My other assumption at the beginning of the research process was that there was some form of rationality to policy making and that I would be able to find clear decision-making processes that explained how the FTD had unfolded. My repeated engagement revealed that multiple factors were responsible for how the policies are formulated and implemented.

There is also an acknowledgement that the researcher can be affected by being in the field of study and that positionality can shift as the research progresses (Jootun, McGhee & Marland, 2009). Although my positionality did not shift, I was mindful of how my views and assumptions regarding the policy process and policy makers had shifted. One of the main insights was getting an idea of the realities that policy makers had to navigate. This enabled me to understand the value of safe spaces for policy makers and managers within bureaucratic institutions to reflect and grapple with the realities of their day-to-day work.

Awareness of my positionality and biases was aided by keeping research diaries as well as by opportunities to present my study at various forums, both within my university and at local public health conferences. This was particularly helpful as I could engage with insiders in the system who could comment and ask about my interpretations of the FTD initiative and provide advice based on what they had encountered.

During the course of the study, one of the reflections I grappled with was whether the FTD was adequate as a single case to reveal intersectoral collaboration processes or whether additional cases were needed to further explore collaborative experiences. Along with my supervisors, we considered potential cases that we could explore in addition to the FTD initiative such as the Community-Oriented Primary Health Care approach (Mullan & Epstein, 2002). However, the Primary Health Care approach was still in its conceptualisation process and would have been difficult to analyse at the time. Instead, I focused on the Whole of Society Approach experiences in Saldanha Bay as a way of considering the transition of the FTD initiative within the broader joined-up approach. The ongoing process of producing data, and of confirming and questioning the research process in some ways helped construct a more reliable account of the process, staying close to how the FTD was unfolding at the provincial level.

3.4 ETHICAL CONSIDERATIONS

All data collection activities received prior ethics approval from the University of the Western Cape Biomedical Health Committee (Appendix 7) and the Provincial Department of Health (Appendix 8). Additional ethics approval was obtained from the research ethics committee of the Provincial Department of Social Development, which allowed access to respondents from their department.

For NGOs, access to CHWs and supervisors was done through an official permission process for each NGO. Frontline providers in health facilities were also interviewed after approval by facility managers and written permission from facilities.

This chapter described the various methodological considerations that were employed for this study. The next three chapters describe the findings of the study.

CHAPTER 4:
THE FTD POLICY PROCESS:
AGENDA SETTING, POLICY THINNING AND RE-EMERGENCE OF INTERSECTORAL GOALS

4.1. INTRODUCTION

The aim of this study was to explore intersectoral collaboration processes during the formulation and implementation of the FTD initiative. To do this, one of the objectives of the study was to describe how the FTD evolved from a policy idea to implementation activities. For this reason, this chapter serves as an introduction to the findings of the thesis by providing the overarching story and timeline of the FTD initiative, focusing on key moments that shaped the FTD policy process.

Findings presented here were drawn from documentary analysis and key informant interviews supplemented by reports of FTD events and observation notes. Although the narrative covers the development of the FTD between 2015 and 2019, reflections from key informants included events that influenced the FTD from as early as 2003.

The chapter begins with outlining windows of opportunity at global, national and provincial levels that allowed the FTD idea to take hold in the provincial sphere. This includes the role of policy entrepreneurs who connected contextual local ECD challenges with the global emerging FTD ideas. The rest of the chapter is organised into key moments during policy formulation of the FTD, along with associated actors who were involved in the various activities. Thereafter, the chapter offers a glimpse of early implementation plans of the FTD and a description of the loss of intersectoral goals that then re-emerged in selected sub-districts at later stages. This chapter will thus serve as a descriptive account of how the FTD developed while the remaining chapters analyse the transitions of the FTD, and offer possible explanations of why the FTD unfolded in this manner.

Although policy processes are rarely linear, FTD policy development activities are organised in this thesis as ‘agenda setting’, ‘policy thinning and a loss of intersectoral goals’ and ‘re-emergence’ to allow for an in-depth analysis of how the FTD policy evolved through each phase. Figure 2 below shows the aforementioned transitions of the FTD highlighting the key events that shaped the FTD. This figure distinguishes between activities in the political sphere that contributed to agenda setting processes, events and workshops organised by the

FTD Executive Committee, and broader factors in the provincial context that shaped the FTD process such as the Burden of Disease report. Each of these key moments are explained within this chapter.

4.2 THE AGENDA-SETTING PROCESS OF THE FTD AND FACTORS SHAPING THIS

The political prioritisation of the FTD was a result of the convergence of factors relating to a favourable provincial context, increasing global attention to the FTD and the actions of policy entrepreneurs. These factors are discussed in more detail below.

4.2.1 Emerging global FTD evidence align with national Early Childhood Development priorities

Global moments were responsible for creating the original awareness of, and attention and priority given to, the idea of the FTD. The idea was significantly advanced in 2008 by a series in The Lancet on maternal and child undernutrition that made the scientific case for the FTD period being vital to improving nutrition and development (Black *et al.*, 2008).

In response to the growing scientific evidence that identified the FTD as a crucial window of opportunity, the United States-based 1,000 Days Partnership was established, which, through its website, acted as a hub focusing on issues that affect the nutrition and wellbeing of mothers and children (1,000 Days Organisation, 2021). As a result of the growing momentum towards the FTD, international institutions, development organisations and the private sector acted to scale up nutrition interventions (Takahashi *et al.*, 2017). This thinking found its way into the UN's SDGs, which ushered in a new policy window that allowed sustained attention to the FTD by linking child survival to ECD. The circulating ideas at the start of the SDG era argued that while child survival was improving, children were not realising their human potential and contributing to sustainable development (United Nations, 2015).

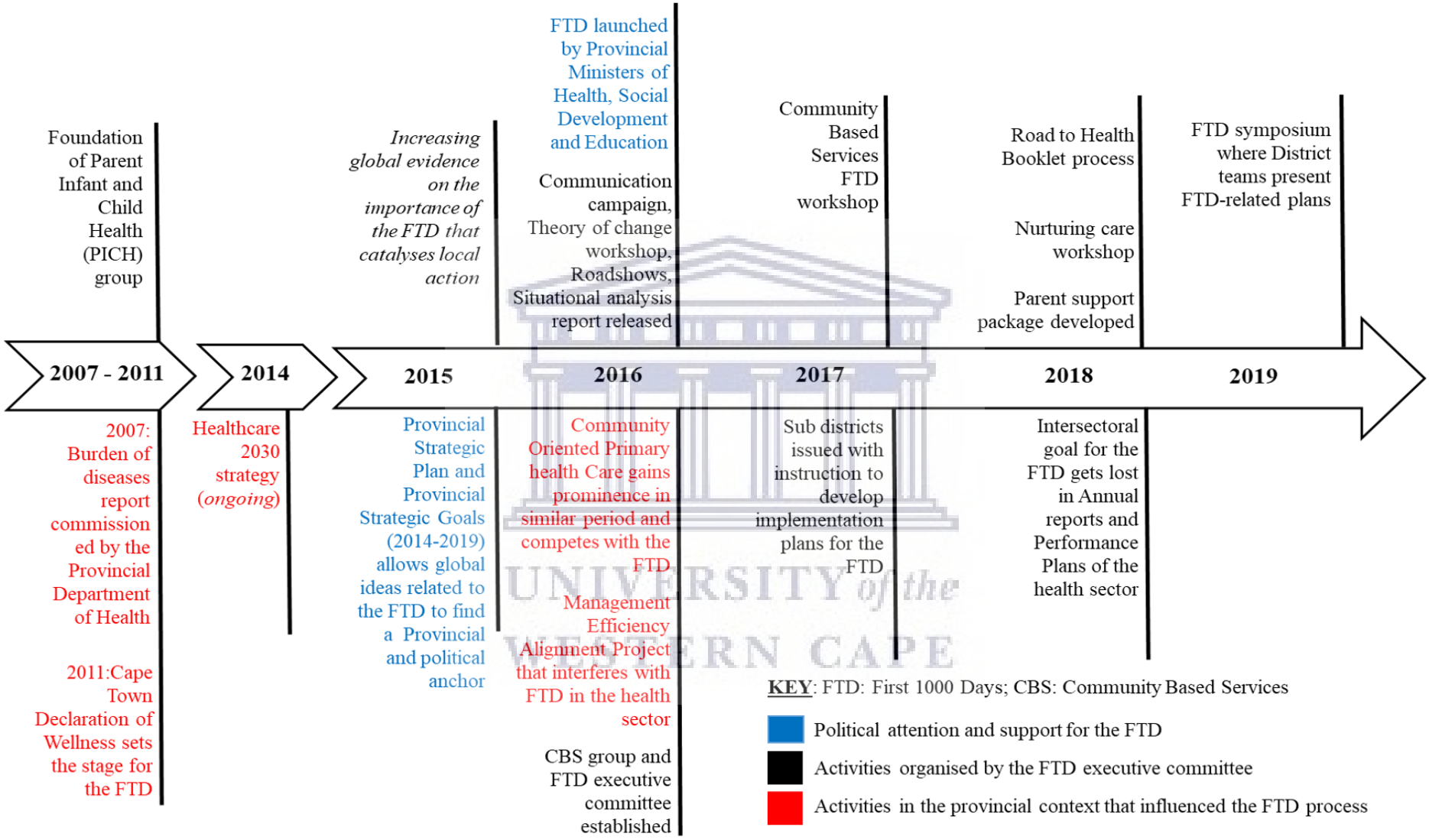

Figure 2: Timeline and key events that shaped the FTD initiative

The sentiments in the SDGs were also reflected in the WHO Global Strategy for Women's, Children's and Adolescents' Health. This expanded the frame of child survival and introduced the notions of Survive, Thrive and Transform, centred on the wellbeing, not just of children, but also of women and adolescents (World Health Organization, 2016). Thereafter, The Lancet series on Advancing Early Childhood Development (Britto *et al.*, 2016) published in 2016, became the point of reference on the severity, causes, costing and solutions to the challenges facing ECD, promoting the concept of 'nurturing care' as a holistic approach to ensuring child wellbeing. Other relevant global processes that drew attention to the FTD included the launch of the 'Critical 1,001 Days' in Edinburgh and Harvard's Centre of Research on Child Development that published research linking brain development to ECD outcomes (Center on the Developing Child, 2010).

The global discourse regarding the FTD and the SDGs circulated at an opportune time, coinciding with the release by the South African Social Development Department of the NIECD policy. This policy was particularly relevant as it embraced the child development goals of the SDGs and placed high priority on the FTD period. It also outlined a comprehensive service package for children, which mandated the health sector to be at the forefront of providing services for early childhood through the support of caregivers (Republic of South Africa, 2015). Furthermore, the idea of paying attention to children's early years seemed favourable nationally; it had been emphasised in 2012 in the NDP (National Planning Commission, 2011) which proposed that a focus on addressing needs of children in their early years would enhance human potential and assist in alleviating poverty.

At the provincial level, support for the FTD as an idea emerged as a convergence of the global moments outlined above, the national discussions surrounding the NIECD policy and shifts in thinking at provincial level:

> *"There was an accumulation of evidence over time and a building up of conversations ... around the significance of a particular window in terms of long-term outcomes. I think the shift in the orientation of the SDGs … and the advent of neuroscience showing … hard traditional scientific evidence which is a lot more digestible and attractive to … practitioners, policy makers – that kind of evidence reached a critical mass."*
> (Interviewee 4, academic)

The Survive, Thrive and Transform approach and the Nurturing Care Framework (World Health Organization, 2016, 2018b), along with the NIECD policy, offered policy interventions that could be used to address the FTD in South Africa. Ideas emerging from global literature – such as the value of relationships between caregivers and young children and the need to consider conditions that can ensure children thrive – had been discussed in various spaces within the provincial context. These included local conferences where members of the Health Programmes Directorate presented the link between the FTD and its potential to address stunting. As a result, many of the key informants had first heard of the FTD as a term in relation to addressing nutrition.

In addition, research conducted by local academics, and NGOs had shown the value of attachment bonding long before the FTD was launched (Lindland *et al.*, 2016).

4.2.2 The FTD as a solution for long-term ECD challenges

The global literature showing the impact of the FTD on adult health outcomes resonated with a number of existing ECD-related challenges, landing on fertile ground in the provincial context and catalysing action towards addressing the FTD. This was particularly relevant in the Western Cape that was shaped by socio-economic problems and 'social ills' such as high rates of alcohol and drug abuse and related violence, which impacted children and families (Western Cape Government, 2014). As a result, the FTD became viewed as the vehicle to address the social determinants of child health in the province. The FTD also provided a meaningful frame for senior, influential clinicians as the emerging global evidence provided them with a legitimate response to the problems they were confronting in practice:

> *"So what happened was [that] Red Cross Hospital [tertiary children's hospital] was saying that they see a lot of children from the ages of three upwards that have conditions that could have been prevented at an earlier age. And then they arrive there at three, there is not much… you can do and resources are limited. So we were ... trying to do something earlier. And then when the FTD came out, it gave us permission to .. go aggressively and continue."* (Interviewee 5, health sector)

In fact, some clinicians had begun experimenting with preventive options for the FTD period before the prioritisation of the FTD initiative. This included, for example, community projects which begun prior to 2016 and which identified children at risk of developmental delays. These projects were later co-opted as part of FTD interventions, as the launch of the FTD initiative allowed clinicians to continue with preventative options to address child development.

4.2.3 An adequate political atmosphere for intersectoral FTD agenda in the Province

The agenda-setting process for the FTD was further enabled by the political atmosphere within the Province, that was favourable to the emerging global narratives surrounding the FTD.

Interviewees agreed that "*the soil was tilled and the seeds had been planted* " (Interviewee 14) well before 2016 – in processes that paved the way for the FTD through the Burden of Disease report and the Wellness Summit. The 2007 Burden of Disease report, commissioned by the Provincial Department of Health, signalled a recognition of the impact of the SDH and the importance of focusing on prevention (Western Cape Department of Health, 2008). The Wellness Summit in 2011 specifically proposed a focus on intersectoral action to address ill health and also prioritised attention to child wellness, citing early childhood nutrition and creating safe environments as key requirements of development (Western Cape Government, 2011b). These two processes provided the impetus to begin engaging with concepts of child wellness and triggered the formation of policy communities like the PICH group, which became a prominent actor in the FTD policy process.

The transition to the Provincial Strategic Plan (PSP) at the beginning of 2015 offered a new political window, which centred on the value of collaboration and proposed that the security and safety of children and families should be addressed. The PSP had accompanying Provincial Strategic Goals, one of which was the vision of safe and healthy children that included the FTD as one of the projects (Western Cape Government, 2014). This allowed the FTD to find a political space – or a "*home in government"* (Interviewee 10) – implying the FTD and its accompanying solutions made sense within the provincial climate.

Similarly, some interviewees also believed that the FTD agenda was strengthened by the appointment of the provincial Health Minister in 2015 who was known to be passionate about child health.

4.2.4 Actions of policy entrepreneurs focus attention on the FTD

Policy entrepreneurs are actors who take advantage of opportunities to influence policy outcomes by linking or coupling policy problems and solutions together with political opportunities (Kingdon, 1995). In the FTD case, policy entrepreneurs included child health researchers and clinicians who used the available intervention frameworks to lobby for attention to the FTD.

The Parent Infant Child Health and Wellness group

A number of policy entrepreneurs were involved in the PICH group, a networking structure consisting of various NGO representatives, academics and provincial Health Department staff. Since 2013 it had acted as a form of policy community by advocating for maternal and child health issues. When the PICH meetings began, it was viewed as an intersectoral forum with mandated representatives from various sectors. By the time the FTD was in circulation, participation changed to voluntary involvement.

PICH was credited by a number of interviewees as one of the early communities that drew on the increasing global literature on nutrition and which began engaging with the FTD concept through meetings and workshops. Some of the key activities associated with PICH included their creation of the initial awareness and focus on the FTD by drawing on their engagement with international literature and global platforms such as forums related to the Nurturing Care Framework. They also played a role in the South African launch of The Lancet series at the end of 2016.

Many perceived the PICH group to have had a continual and substantial influence on the adoption and implementation processes of the FTD. As such the PICH was included in a number of FTD policy documents as a supporting group (Western Cape Department of Health, 2017b):

> *"The ongoing PICH meetings were also constantly shaping the direction of the First Thousand Days initiative, driven by who was showing up."* (Interviewee 13, NGO*)*

PICH's influence was noted in several versions of the FTD-related reports where it was described as an intersectoral partner. It was assigned a number of roles such as providing advocacy for the FTD, the sharing of best practices, acting as a scientific advisory group, and participating in the design, implementation and evaluation of the FTD (Western Cape Department of Health, 2017b).

PICH lobbied actors in the Provincial Department of Health's Programmes Directorate and the Provincial Strategic Goal 3 (PSG 3) Executive Committee. This committee was created to operationalise the third Provincial Strategic Goal of the PSP which aimed to 'increase wellness and safety and tackle social ills' – and this included the FTD. The Committee consisted of representatives of the departments of Health, Social Development, Community Safety, Public Works and Transport, who were to report to the provincial cabinet through the provincial health minister. The initial concept of the FTD was first presented in October 2015 at the Health Programmes Directorate preceding its approval by the PSG 3 Committee.

The ability of certain PICH members to navigate key provincial health spaces was favourable to advancing the FTD agenda, as was the strategic position of actors within government who supported the FTD idea – such as the Chief Director of Health Programmes who engaged with the top provincial management and top structures of the health system.

4.2.5 Summary

In summary, an alignment of global discourses and key moments between 2012 and 2018 – notably the launch of SDGs, The Lancet series on advancing ECD and the WHO Global strategy for Women's Children's and Adolescent's Health – built momentum for FTD. Global ideas surrounding the FTD found fertile ground in South Africa in the NDP and the NIECD, as a means to reduce inequality and poverty.

Both global ideas and national policy frameworks offered suitable interventions for the FTD that made sense in the provincial context shaped by ECD and socio-economic challenges. The key actions of policy entrepreneurs and supportive actors ensured that FTD received attention, leading to the political prioritisation of the FTD provincially.

4.3 FTD ACTIVITIES BEYOND POLITICAL PRIORITISATION

4.3.1 Peak of FTD activities in 2016

The attention paid to the FTD initiative by political and bureaucratic actors in the Western Cape Province peaked in 2016, when it was formally launched by the provincial ministers from the Departments of Health, Social Development and Education. Media articles referred to the FTD as a 'project' and a 'child health campaign' aimed at raising awareness of the first crucial days of a child's life (Cape Argus, 2016; Chiriseri, 2016).

Within the bureaucracy, it was agreed that the FTD mandate would be housed under Health Programmes Directorate in the Department of Health, steered by an FTD Executive Committee responsible for organising the adoption and implementation processes. The FTD was also discussed in the annual plans of both the departments of Health and Social Development and was included within the multi-sectoral PSP (2014-2019) (Western Cape Government, 2014), highlighting its acceptance as a provincial priority. Some of the key events and actors that shaped the FTD process will be highlighted below.

The launch of the FTD in 2016 was accompanied by a transversal communication campaign designed by the departments of Health, Education and Social Development. This involved the distribution of taxi wraps and promotional material that targeted the public to promote awareness of the FTD.

Unfortunately the communication campaign occurred prior to the engagement and sensitisation of bureaucrats and frontline providers from all the relevant sectors. As the FTD-related information campaign continued in the public domain, members of the FTD Executive Committee mentioned that they first had to make sense of the FTD, particularly with respect to identifying the role of health workers.

To complement the public campaign and sensitise health workers, the first range of activities that the FTD Executive Committee facilitated were the roadshows, which continued throughout the FTD process.

Roadshows were structured workshops that served to raise awareness regarding the FTD among health workers. They comprised three to four hour workshops facilitated by trainers who focused on FTD-relevant topics (Thanjan, 2017). This included showing videos and documentaries covering topics related to neuroscience, pregnancy and maternal care, child health and, lastly, the implications of the FTD for health services.

The roadshows were initially a combined endeavour of the health departments of the Province and the City of Cape Town although workers from other relevant sectors and NGOs could attend the workshops.

A review study of some of the early FTD roadshows revealed that in 2016, eleven roadshows were conducted in different venues within the City of Cape Town involving 667 participants (Thanjan, 2017). The majority were from the departments of Health, with the Social Development sector and NGO representatives making up 17% and 12% of participants, respectively (Thanjan, 2017).

Over time, roadshows spread to rural sites and were organised by local sub-district teams with limited input from the FTD committee.

During the course of 2016, a provincial research day was held which focused on the FTD – and the FTD was also identified as one of the service priorities to improve maternal and child health outcomes adopting the global Survive, Thrive and Transform framework.

Other activities in 2016 included 'Theory of Change' workshops which engaged organisations and stakeholders across sectors to develop an intersectoral plan of action for the FTD. The workshops used the theory of change (ToC) methodology, an idea recommended by the Health Impact Assessment Unit due to a perceived lack of clear definitions for the FTD initiative.

Funded by an NGO and assisted by the Health Impact Assessment Unit, the ToC process involved stakeholders from the departments of Health, Social Development, Community Safety and Cultural Affairs and Sport, the Office of the Premier, the City of Cape Town, non-profit organisations (NPOs) and academics (Breuer& Petersen, 2016). This process was viewed as an achievement for the FTD as it offered the first opportunity to engage with intersectoral actors about possible FTD interventions.

One of the interviewees expressed the following view regarding the ToC workshop:

> *"Talking about collaboration and intersectoral engagement, there was good engagement during the theory of change process and all the workshops that were held... That in itself was quite a good achievement I think, that they [the FTD committee] were able to bring together so many different people in a room to really figure out what is it that we're trying to do here, … in order to bring about the changes we want to see."* (Interviewee 13, NGO)

After three stakeholder meetings, the ToC process provided an overarching framework aimed at enabling a realisation of FTD goals. This consisted of interventions that addressed nutrition and health, early learning, safety and protection, SDH and poverty (Breuer & Petersen, 2016). Some interviewees indicated that the framework was useful for senior officials of the Provincial Health Department as a communication tool but many others criticised how broad and 'complex' the set of interventions were.

One of the core recommendations from the ToC process was to use the framework which was initially generated to plan for the next stages of the FTD, to assess the feasibility of the proposed interventions and to develop indicators for monitoring progress. The next steps in the process were supposed to convert the complex maps into concrete interventions, with the input of implementation actors and programme planners:

> *'This ToC process was a participatory process designed to get input and buy-in for the First 1,000 Days initiative as part of the Provincial Strategic Goal 3. Most of the participants were from management level and therefore do not necessarily reflect the views of health care providers, service users or the broader community. As participants in the workshop suggested, it may be useful to conduct community level ToC workshops or engagement events in the specific geographic areas where the initiatives will be implemented. This could also involve a community resource mapping exercise.'* Theory of Change process report (Breuer, 2016, page 25).

However, these next steps beyond the initial ToC process were not done, leaving a number of interviewees feeling uneasy about what this meant for intersectoral processes:

> *"There has been some criticism in terms of the fact that people say it's not simple; it's too complex… But … the stumbling blocks are that the interventions are not clearly*

defined and therefore we couldn't go to the next stage which was really designing the main indicators – and currently …they are basically just using routine indicators which I think is not ideal, especially if you want to see change in other sectors. There needs to be capacity behind that to identify indicators in other sectors and see if there are changes."
(Interviewee 2, health sector)

4.3.2 The role of the FTD Executive Committee and associated groups in FTD-related activities

As indicated earlier, the FTD Executive Committee was responsible for the FTD mandate. This committee was closely linked to a range of other actors who contributed to the FTD process. This included policy communities such as PICH, technical groups such as the CBS group, a Perinatal Task Team and others such as the Health Impact Assessment Unit.

The core FTD Executive Committee had a unique position, located both within the provincial health system and the intersectoral PSG 3 space. The main members in the Committee were the deputy directors of the Nutrition, Women's and Child Health directorates, a senior paediatrician, and representative of the Communications Directorate. In the health system, the Health Programmes Directorate was in charge of developing and co-ordinating public health programmes – such as child health programmes for example – but was not directly responsible for service delivery.

The direct provision of health services was managed through the operational executive committee and line managers (shown in the Figure 3 below). The positioning of the FTD Executive Committee in the Health Programmes Directorate therefore meant that they could recommend and design intervention ideas for the FTD, but these activities had to be accepted by service line managers through committees such as the Metro Management Forum which included district managers in charge of service delivery. The interaction between technical support groups, policy communities and service line managers had a significant impact on the uptake and implementation of FTD, detailed in Chapter 6.

The complex positioning of all these actors in relation to the FTD mandate is shown below in Figure 3, which details where actors were positioned in relation to the PSG 3 space and the line management responsible for health service delivery.

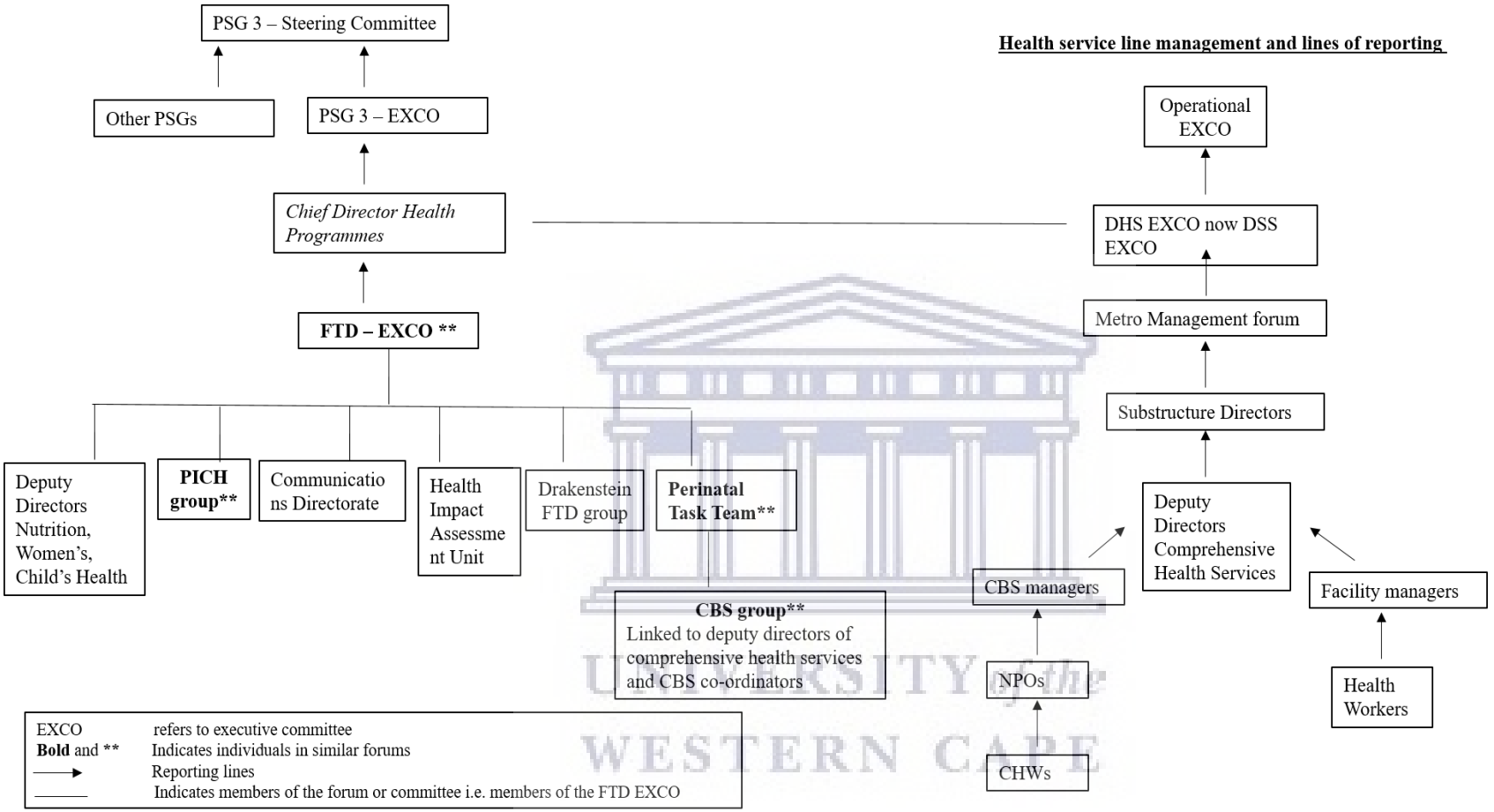

Figure 3: The position of the FTD Executive Committee in relation to other groups and health services reporting lines

Acronyms: PSG: Provincial Strategic Goal; EXCO: Executive Committee; PICH: Parent Infant and Child Health and Wellness group; DHS: District Health Services; CBS: Community-Based Services; NPOs: Non-Profit Organisations; CHWs: Community Health Workers

In this organisational configuration, the FTD Executive Committee, the CBS group and the Perinatal Task Team were termed 'technical support groups' as they provided specialist support for the implementation of programmes such as the FTD. In the intersectoral PSG 3 fora, the FTD Executive Committee had a direct link through the Chief Director of Health Programmes. This allowed for the co-ordination of the FTD along with the other projects within the PSG 3 fora. The Chief Director of Health Programmes also served as the link between the FTD Executive Committee, the PSG 3 Committee and the line management responsible for health service delivery through the District Health System Executive Committee (DHS EXCO).

The Perinatal Task Team, which became an increasingly central player in the FTD over the 2016/2017 period, consisted of a number of specialists involved in perinatal services and was chaired by a senior official of the Health Department. In 2016 as part of the new Survive, Thrive and Transform approach, senior managers of the Health Department subsequently mandated a sub-group of the Perinatal Task Team to conduct a situational analysis of FTD in the Province. The analysis provided a detailed assessment of the nature and volume of health service needs during the FTD.

To improve the outcomes identified in the situational analysis, a systematic intervention framework was offered with the necessary accountability structures (Western Cape Department of Health, 2016d). The framework, released in 2016, described seven main activities which are located within the Survive, Thrive and Transform approach (Table 5 below). Key areas for intervention included provincial clinical care interventions, community-based interventions, advocacy, and liaison to improve and address the SDH.

A number of the above interventions proposed by the intervention framework were related to health services. The Perinatal Task Team had, in fact, been involved in an earlier situational analysis to assess service delivery needs in relation to neonatal services. This analysis was later stretched beyond neonatal services to include the FTD period which explains why a number of FTD-recommended interventions were health-service driven.

Table 5: Intervention framework for the FTD in the Situational Analysis Report
(Western Cape Department of Health, 2016d, page 91)

1. SURVIVE, THRIVE and TRANSFORM: Implement a clear communication and engagement strategy which engages all stakeholders.
2. SURVIVE, THRIVE and TRANSFORM: Develop and implement an appropriate First 1,000 Days monitoring, evaluation and response system across the care continuum, with focus on a clinical performance dashboard of indicators.
3. THRIVE and TRANSFORM: Improve maternal and child wellbeing by initiating intersectoral health promotion programmes.
4. SURVIVE and THRIVE: Ensure the re-alignment and equitable distribution of health service resources across the 3 ecosystems to align resources with needs, in particular focusing on proportional bed allocation and linked affordable staffing norms.
5. SURVIVE, THRIVE and some TRANSFORM: Develop and implement an appropriate First 1,000 Days clinical governance system for oversight and accountability of the clinical care received by patients across the care continuum.
6. SURVIVE, THRIVE and some TRANSFORM: Develop and implement an appropriate First 1,000 Days minimum Package of Care (POC) across the care continuum, which in particular supports comprehensive low birth weight baby care.
7. SURVIVE and THRIVE: Improve maternal, perinatal and child mortality by addressing avoidable causes of deaths related to patient factors, health worker factors, health systems factors and community factors, via specific interventions.

The CBS group that emerged in 2017 was closely linked to the Perinatal Task Team (Figure 3). It was formed after a realisation of the need to engage with CBS co-ordinators and comprehensive service managers who were involved in the CBS programme at the time. The CBS group was composed of representatives of the FTD Executive Committee, Comprehensive Health Services, Health Impact Assessment, specialised services support, clinicians, deputy directors (health services) and academics. The group's main activities were developing a screening and referral tool for at-risk women; developing effective CBS interventions and a Package of Care for the FTD; and monitoring and evaluation of CBS interventions.

As part of these range of activities, the CBS Group organised a CBS workshop in 2017 to discuss the roles of CHWs amongst service managers and CBS co-ordinators from all over the Province. This workshop was used to discuss the main activities of the CBS Group and to clarify which cases required referrals to CBS services.

After 2018, CBS Group meetings were no longer held and recommendations regarding the activities stated earlier were offered to service managers to implement at their discretion. Within this context, the CBS Team nonetheless appeared successful in being able to co-ordinate, develop and pilot a mental health screening tool which was added to the maternal case record.

As it was evident that intersectoral FTD processes were receding and health services agendas were being prioritised, the PICH group and the FTD Committee began working more closely with the rural FTD group which, at the time, was involved in the Better Spaces pilot detailed in Chapter 7.

4.3.3 FTD activities: 2017-2018

During 2017 and 2018, FTD activities within the health sector involved integrating FTD information materials into the new national Road to Health booklet and the Side-by-Side campaign. Led by the National Department of Health, the campaign focused on ensuring a nurturing relationship between children and their caregivers, as well as a supportive relationship with healthcare workers to assist caregivers. At the centre of the Side-by Side campaign was the new Road to Health booklet, a patient-held record used to document the growth and development of children used widely in primary healthcare facilities (National Department of Health, 2018, 2020). In 2018, the National Department of Health updated the Road to Health booklet to make it more user-friendly and to maximise its potential as a communication tool with caregivers by focusing on the pillars of nutrition, love, protection and healthcare (Slemming & Bamford, 2018).

Informants mentioned that the process of ushering in the Road to Health booklet provided a window of opportunity to introduce FTD-related messages for caregivers. Both the FTD Committee and the PICH became involved in trying to align messages in the booklet with the FTD initiative.

4.4 A GLIMPSE OF IMPLEMENTATION PLANS: POLICY THINNING AND LOSS OF INTERSECTORAL GOALS

Annual reports and annual performance plans of the provincial Health Department mirrored the transitioning journey of the FTD between 2016 and 2019.

For the first planning year (2015/2016 which runs from mid-2015 to mid-2016), activities reported on in the provincial Health Department's Annual Report embraced the globally proposed multi-sector Nurturing Care Framework (World Health Organization, 2018b), specifying outcomes that stretched beyond health to education, parenting and safety (Table 6).

Table 6: FTD commitment in the Provincial Department of Health annual reports and annual performance plans

	Provincial Department of Health Annual Performance Plans	**Provincial Department of Health Annual Reports**
2015-2016	'Parenting Programme (first 1,000 days), a focused programme on tracking every pregnant women (100,000 by year 5) from antenatal care – delivery – post natal care.'	'The initiative aims to improve outcomes for children in terms of nutrition, health, education, care/support and parenting, and protection and safety." 'Health specific interventions, intersectoral interventions and effective communication ... Whole of Society approach.'
2016 - 2017	'Designing and implementing a campaign that raises awareness and facilitates action at the community and service provision levels concerning the first 1,000 days of a child's life … Key messages with related actions by parents or main carers and service providers will be determined, using a transversal and multi sectoral approach. The campaign will also promote the important role of men as caring, engaged fathers, supportive partners and carers.'	'Project management plans have been aligned with the Survive, Thrive, Transform framework. **Survive**: 1. Health systems interventions addressing avoidable causes of deaths 2. Monitoring, evaluation and response system across the care continuum. **Thrive:** Develop a service design framework , wellness maps and Package of Care for the 1st 1000 days. **Transform:** 1. Communication and engagement strategy 2. Identify and support at risk households in the 4 prioritised geographic areas with inter-sectoral support, via Provincial Strategic Goal 3'

	Provincial Department of Health Annual Performance Plans	**Provincial Department of Health Annual Reports**
2017 - 2018	'Some of the key activities would be: Well baby and childcare, quality and links, development of First 1,000 Days initiative social media campaign with information and links for referrals - Review standard minimum content for antenatal care education that includes addressing issues of substance abuse - Expansion of First 1,000 Days dashboard (Western Cape Government) departments through review process - Explore and identify areas for research and innovation (Catch and Match & Social Impact Bond) - Intersectoral engagement to encourage departments to promote breastfeeding'	'The First 1000 Days programme managed by the Department aims to improve performance on maternal and child health indicators.'
2018 – 2019	*No mention of the FTD in the Plan*	'The First 1000 Days programme managed by the Department aims to improve performance on maternal and child health indicators'
2019 - 2020	'The overarching goal of the First 1000 Days initiative is to ensure that every pregnant woman and child is nurtured; parents and caregivers are supported .., through a Whole of Society approach' 'The first 1000 days will be a focal area as part of the early childhood development continuum, encompassing the following: **Survive:** Health systems interventions; Monitoring across the care continuum. **Thrive:** Service re-design to assess and respond to antenatal risks; Implement the new Road to Health Booklet; Introduce a parent/ caregiver support package. **Transform:** Communication and engagement strategy; Identify and support at risk households in prioritised geographic areas with inter-sectoral support, via PSG 3.'	*Not available*

In the second planning year (2016/2017), FTD interventions shifted to being framed by the Survive, Thrive and Transform framework, as influenced by the situational analysis (Western Cape Department of Health, 2016c). The Annual Performance Plan detailed FTD plans as comprising the communication campaign (which was paid a lot of attention during the first year of the initiative). In the Annual Report for that period, the 'Transform' element, which

ideally should have embraced intersectoral interventions, was linked to communication agendas.

Later, in the third planning year (2017/2018), intersectoral engagements in the performance plan were only related to improving breastfeeding activities – and the annual report described the FTD plans as improving maternal and child health indicators. In the 2018/2019 performance plan, the FTD disappears all together.

In the last planning year of 2019/2020, the performance plan had a much wider focus on nurturing both children and caregivers. The 2019/2020 focus also embraced the WoSA approach while retaining the Survive, Thrive, Transform framework. The influence of the WoSA agendas and the shifts in the PSG 3 space are thus evident in the 2019 planning for the FTD.

Besides the articulation of FTD plans by the health sector, there also seemed to be limited evidence of FTD-specific plans in other provincial sectors. Annual performance plans and reports of relevant sectors (Health, Education, Community Safety) for the period 2015 to 2019 were examined to ascertain the extent of cross-sector FTD interventions. The resulting picture showed that, apart from the Health and Social Development departments, other departments had not included the FTD in their annual plans. The Department of Social Development described the FTD as a priority and continued to mention it as an ongoing commitment although it did not list any specific operational plans or interventions.

Other departments such as Education did not have an updated list of annual reports, which made it difficult to analyse whether provincial Education had prioritised the FTD. However, an extensive analysis of policy documents in Chapter 5 will show how the Education sector recognised the FTD period as significant but that this occurred only in national policies.

In a similar fashion, the end of 2019 offered a glimpse into early implementation plans of district health teams, following earlier mandates to develop FTD-specific plans for each region. In a workshop hosted by the FTD Executive Committee, district teams presented their various FTD-related activities ranging from improvements in antenatal and post-natal care, improvements in referrals with NPOs, CHW training, and addressing nutrition practices. These are summarised in Table 7.

Table 7: List of FTD activities in all districts according to the Survive, Thrive, and Transform framework[2]

Districts	***Survive***	***Thrive***	***Transform***
Overberg	- Strengthening routine care during the FTD (breastfeeding, immunisation programme)	- FTD training of CHWs - Antenatal education for mothers - Emphasising role of fathers	- Training of ECD staff in the provision of food for young children - FTD health days and symposiums
Cape Winelands	- Increasing access to sexual and reproductive services - Promoting early bookings and psycho-social support visits	- Addressing ECD, specifically nutrition and promoting breastfeeding - Roadshows to address mental health during the FTD - Development of the parent support guide - Relational capacity enhancement (blanket project) - Involved in Side-by-Side campaign	- Department of Social Development food and security projects - Sensitization workshops - Community activation workshops - Worcester Young Child Forum established - Drakenstein FTD working group and Better Spaces activities
Central Karoo	- Adolescent health - Antenatal vare, intra partum and post-natal care - Child health outcomes	Training (immunisation programme, Road to Health Booklet)	- Community-Oriented Primary Health Care - Open days / health days (women's health and nutrition week)
West Coast	Antenatal support groups and infant feeding education training	Parent support package training	- Develop referral toolkit and network for high-risk mothers and children - Teenage pregnancy awareness programmes - Social cluster team developed as part of Whole of Society Approach
Northern/ Tygerberg	- Basic antenatal care services - Other health services (childcare, women's health services, dietetics, speech and audiology)	- Preventative child services that include outreach services to NGOs and local ECD facilities (immunisations, Vitamin A supplementation, deworming)	Referrals between primary health care facilities with CBS

[2] All activities presented in this table were extracted from power point presentations given by representatives of all the above district teams at the November 2019 workshop.

Districts	*Survive*	*Thrive*	*Transform*
Southern/Western	Emergency care arrangements / preparedness	- Recognising important role of men and fathers - Caregiver support /Family/partner support before, during and after pregnancy - Empathetic counselling- Substance, smoking & alcohol intervention services	- Self-care and wellness (mentoring and peer support of providers) - Social support services (linked to social grant) - Workplace support (maternity leave, breastfeeding, child care support)
Klipfontein/ Mitchell's Plain	- Improved access at health facilities and attention to retaining patients in care - Introduction of rehabilitation services	- Mental health screening - Support visits and groups to all but especially to at-risk mothers and children - Defaulter tracing	- Prevention and promotion talks and pre/post-natal exercises in waiting area at Mitchells Plain Maternity Obstetric Unit
Khayelitsha Eastern	- Increasing exclusive breastfeeding rates - Vitamin A outreaches for NGOs - Growth monitoring and screening for stunting - Mental health screening for all antenatal women	- Nutrition counselling of referred clients by dieticians - Early childhood development workshops twice a year	- Training for NPOs - Support groups for teenage mothers

When examining the range of activities that districts identified as FTD-related, it is worth noting that majority of the proposed interventions were integrated into existing maternal and child health programmes in various ways. It is thus unclear whether the range of health-specific activities represented the FTD initiative or were ongoing activities of the Health Department. Nonetheless, after 2016 the FTD initiative appears to have illuminated the significance of addressing health-based interventions – for instance there was a noticeable focus on nutritional support services for most districts.

Intersectoral engagements were limited and mainly included outreach visits to provide health services, training of NGOs and links to social support services. These early implementation plans also show the influence of technical support groups and the PICH on some of the selected interventions such as mental health screening and caregiver support.

One possible explanation for the limited FTD activities after 2016, was the limited budget provided. Informants reported that in 2018, the majority of the budget provided for FTD activities was spent on the communication and engagement strategy. This involved the development of promotional materials and video streaming these in ante- and post-natal spaces, led by the FTD Committee. These activities were considered part of the 'Transform' pillar of the FTD. The other two pillars depended on the small remainder. 'Thrive' received a small portion of the budget to pilot activities for the development of the parent support package while 'Survive' interventions had the lowest portion, used to support an emerging FTD-group in the Drakenstein sub-district.

An additional explanation for receding FTD activities beyond 2016 was the shifting context of the PSG 3 space, which expanded into the WoSA – which was an attempt to engage with joined-up government approaches across the 13 provincial departments that began gaining momentum at the end of 2017. As the WoSA approach began in a number of sub-districts, FTD activities had receded in the provincial spaces and re-emerged in WoSA sub-districts (see Chapter 7).

In conclusion, both Health Department documents and early implementation plans show that intersectoral activities in the FTD process were limited. Moreover, apart from the ToC process and the recognition of the FTD as a priority, other sectors did not appear to have specific FTD plans.

To capture the shifts that occurred to the FTD process between 2015 to 2019, I have distinguished between the change from multi-sector FTD goals in 2016 to narrow health-based activities – naming this notion as 'policy thinning'. The policy thinning phase also includes the reduced activities between 2017 and 2018. The re-appearance of intersectoral agendas towards the end of 2019 as part of WoSA is termed 're-emergence'.

4.5 CHAPTER SUMMARY

The FTD policy process described in this chapter shows the rise of political prioritisation, following a confluence of numerous factors in both global and provincial contexts. Attempts to operationalise the FTD in the period 2016 to 2019, show the shifting interventions between the years and limited intersectoral processes.

The remaining chapters explore the varied meanings and interpretations of the FTD (Chapter 5), the impact of ideas, actors' interests and institutions on the FTD (Chapter 6), and describe the re-emergence of intersectoral ideas in the WoSA (Chapter 7).

CHAPTER 5:
THE IMPACT OF DIFFERING FRAMES OF THE FTD ON INTERSECTORAL COLLABORATION

5.1 INTRODUCTION

The overview of the FTD policy process in Chapter 4 showed immense challenges despite political intentions of adopting and implementing an intersectoral approach to the FTD initiative. This chapter, and the one following, seek to provide possible explanations for why the policy thinning of intersectoral approaches to the FTD occurred. The focus of this chapter is to demonstrate how different understandings of problems and solutions for the FTD affected the potential for cross-sectoral work at the early stages of the policy process. Chapter 6 then presents the analysis of how varied ideas of the FTD, coupled with institutional constraints of the Provincial Department of Health and policy actors' differing interests, contributed to a loss of intersectoral goals.

In this chapter, the enquiry draws on the discourse analysis concepts of ideas and frames that shape the formulations of policy problems, define preferences, and organise meaning (Fischer, Miller & Sidney, 2006; Schmidt, 2008). In the case of intersectoral collaboration, ideas and frames become particularly important as they play a role in channelling policy resources and in shaping governance arrangements.

To demonstrate the impact of different frames of problems and solutions on intersectoral action, 41 policy-related documents on the FTD, or broad ECD strategies that considered the FTD period, were analysed. These documents included both global frameworks that had shaped the provincial FTD agenda as well as national and sub-national documents that recommended approaches to address the FTD. The document selection process was informed by my observations at key provincial events related to the FTD initiative as well as attendance at two different intersectoral working group meetings. Documents selected for the analysis included health sector policies, strategies, reports, newsletters and global literature that key informants felt had shaped the initiative in the Province.

Frames of the problem definitions and policy solutions within the documents were established based on an initial coding of text according to Schmidt's (2008) typology of ideas. Details of these techniques have already been discussed in Chapter 3 but will be briefly reiterated here.

Schmidt's typology of ideas enabled policy text to be coded in relation to the following categories: ideas as policy solutions, ideas as programmes and ideas as underlying world views. During the coding process, text was extracted that spoke to the rationales used to justify the focus on ECD or the FTD, as well as any statements on intersectoral collaboration. Following the initial coding process, coded texts were checked and later organised into three broader themes, which I considered core 'frames'. This led to the identification of three broad policy frames on the FTD (Table 8), which are termed 1) the biomedical frame, 2) the nurturing care frame, and 3) the socio-economic frame. Extracting policy solutions, recommendations and world views allowed each frame to be linked to particular audiences (individual, family, and societal), and corresponding intersectoral approaches for each audience.

This chapter explores the three frames, detailing the boundaries of each frame, problem definitions, and solutions proposed within each frame. The relationship between frames and intersectoral approaches recommended are also outlined.

5.2 DIFFERING FRAMES, PROBLEM DEFINITIONS AND POLICY SOLUTIONS

Table 8 provides the record of all the documents that were analysed, giving the authors and the location of each document at global, national or sub-national levels. This table also shows what the dominant frames were in each document, demonstrating that some documents aligned to a single frame while others had multiple frames. The impact of each frame is discussed in the sections below.

Linked to Table 8 is Figure 4 which contains a selection of some of the key documents analysed. Figure 4 demonstrates the dominant ideas emerging from these key documents (assigned individual colours) and how these ideas were linked (through the colours of arrows and dots) across documents. This figure also includes the Millennium Development Goals and The Lancet series on child survival to show how the global ideas of child survival were absorbed into national maternal health policies. Other influential global frameworks included the SDGs, the nurturing care concept and the Survive, Thrive and Transform framework which triggered agenda-setting moments for the FTD at sub-national level.

Table 8: Documents analysed and associated frames

	GLOBAL DOCUMENTS OR STRATEGIES (Largely used to shape the initiative locally)				
	Document origin/authors	**Type of document**	**Year**	**Document title**	**Frames**
1	Center on the Developing Child, Harvard University	Report	2010	The foundations of lifelong health are built in early childhood	Socio-economic Biomedical, socio-economic, nurturing care
2	United Nations	General Assembly Resolution	2015	Transforming our world: The 2030 agenda for sustainable development	Socio-economic
3	Britto, P.R. et al	The Lancet Series	2016	Nurturing care: promoting early childhood development	Nurturing care
4	Black, M. et al	The Lancet Series	2016	Early childhood development coming of age: science through the life course	Nurturing care, Socio-economic
5	World Health Organization	Strategy	2016	Global strategy for women's, children's and adolescents' health (2016-2030)	Biomedical, nurturing care, socio-economic
6	Richter, L M. et al	The Lancet Series	2017	Investing in the foundation of sustainable development: pathways to scale up for early childhood development	Socio-economic
7	World Health Organization	Framework	2018	Nurturing care for early childhood development: a framework for helping children survive and thrive to transform health and human potential	Nurturing care, Socio-economic

NATIONAL DOCUMENTS					
	Document origin/authors	**Type of document**	**Year**	**Document title**	**Frames**
Whole of Society policies (that were FTD-sensitive)					
8	UNICEF	Policy/Plan	2005	National integrated plan for early childhood development (2005-2010)	Socio-economic
9	National Planning Commission	Strategic Plan	2011	National development plan vision 2030	Nurturing care
10	Republic of South Africa	Policy	2015	National integrated early childhood development policy	Nurturing care
11	Department of Basic Education	Policy	2015	The South African national curriculum framework for children from birth to four	Nurturing care
Health-sector specific policies					
12	National Department of Health	Policy	2012	Strategic plan for maternal, newborn, child and women's health and nutrition in South Africa (2012–2016)	Biomedical
13	National Department of Health	Report	2014	National Report for the mid-term review of the strategic plan for maternal, newborn, child and women's health and nutrition in South Africa (2012-2016)	Biomedical
Non-sector related documents and journal articles					
14	Morgan, B.	Report	No date	Relationships matter most, especially in the first 1,000 days. the interdisciplinary neuroscience of early childhood development	Socio-economic
15	Hall, K., Sambu, W., Berry, L., Giese, S., Almeleh, C., & Rosa, S	Report	2016	South African early childhood review 2016	Nurturing care, socio-economic

	Document origin/authors	Type of document	Year	Document title	Frames
16	Turner, R.E., & Honikman, S.	Journal Article	2016	Maternal mental health and the first 1,000 days	Nurturing care
17	English, R., Peer, N., Honikman, S., Tugendhaft, A., & Hofman, K.J.	Journal Article	2017	'First 1,000 days' health interventions in low- and middle-income countries: alignment of South African policies with high-quality evidence	Biomedical
18	Jamieson, L., Berry, L. and Lake	Journal Article	2017	South African child gauge 2017	Nurturing care, socio-economic
PROVINCIAL / SUB-NATIONAL DOCUMENTS					
	Document origin/authors	**Type of document**	**Year**	**Document title**	**Frames**
Whole of Society policies or plans (that anchored the FTD)					
19	Western Cape Government	Strategy	2011	Integrated provincial early childhood development strategy 2011-2016	Nurturing care
20	Western Cape Government	Declaration	2011	The Cape Town declaration on wellness	Socio-economic
21	Western Cape Government	Strategy	2014	Provincial strategic plan 2014–2019	Socio-economic
22	Western Cape Department of Health	Strategy	2014	Healthcare 2030: the road to wellness	Biomedical, nurturing care

	Document origin/authors	Type of document	Year	Document title	Frames
				Health sector	
23	Western Cape Department of Health	Plan	2015	Annual performance plan 2015/2016	Nurturing care
24	Western Cape Department of Health	Report	2016	First 1,000 days rapid situational analysis for the Western Cape: Survive, Thrive, Transform	Biomedical
25	Western Cape Department of Health	Framework	2016	Intervention framework to guide service planning for the first 1,000 Days	Biomedical
26	Western Cape Department of Health	Report	2016	The first 1,000 days initiative. Cape Town, South Africa.	Socio-economic
27	Western Cape Department of Health	Newsletter	2016	Research newsletter 2016	Biomedical
28	Western Cape Department of Health	Report	2016	Annual report 2015 – 2016	Nurturing care
29	Breuer E., and Petersen S.	Report	2016	The first 1,000 days theory of change process report	Socio-economic
30	Western Cape Department of Health	Plan	2016	Annual performance plan 2016/2017	Nurturing care
31	Western Cape Department of Health	Newsletter	2017	Research newsletter 2017	Nurturing care
32	Thanjan, S.	Report	2017	Report on the first round of the first 1,000 days roadshows conducted in the Cape Town Metro between April - September 2016	Nurturing care

	Document origin/authors	Type of document	Year	Document title	Frames
33	Western Cape Department of Health	Report	2017	Provincial strategic plan goal 3: increase wellness and safety, reduce social ills. Project charter 2017/2018.	Nurturing care
34	Western Cape Department of Health	Report	2017	Annual report 2016 – 2017	Nurturing care
35	Western Cape Department of Health	Plan	2017	Annual performance plan 2017/2018	Biomedical
36	Western Cape Department of Health	Report	2018	Annual report 2017 – 2018	Biomedical
37	Western Cape Department of Health	Report	2019	Annual report 2018 - 2019	Biomedical
38	Western Cape Department of Health	Plan	2019	Annual performance plan 2019/2020	Nurturing care
				Social Development	
39	Western Cape Department of Social Development	Report	2018	Annual performance plan 2018/2019	Nurturing care
40	Western Cape Department of Social Development	Plan	2018	Service delivery improvement plan 2015-2020	Nurturing care
41	Western Cape Department of Social Development	Report	2019	Annual report 2018/2019	Nurturing care

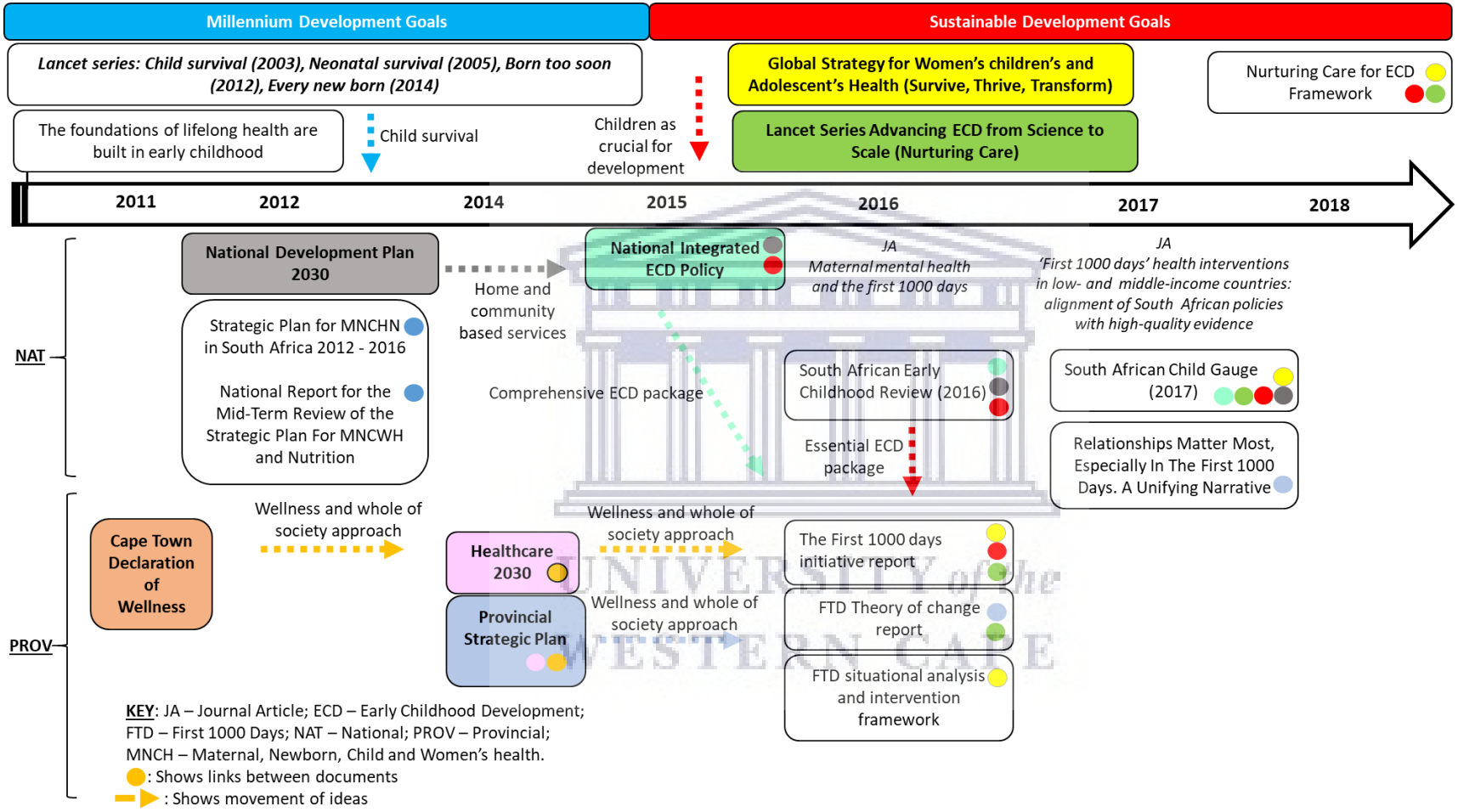

Figure 4: Flow of ideas and intersectoral approaches between key documents linked to the FTD

In addition, some of the policy ideas within documents had moved across different periods - such as 'wellness' in the provincial sphere or the focus on 'home and community-based services' in ECD policies. A discussion of the impact of these ideas on interventions for the FTD will be analysed throughout the chapter.

Finally, Figure 4 shows the culmination of all the global and national ideas at sub-national level through the arrows between documents, thus displaying what key informants referred to as the "*an accumulation of evidence over time"* (Interviewee 4) regarding the FTD concept.

Although the documents analysed agreed on the need to focus on the FTD period, there was a variety of ideas on the 'what', 'how' and 'why' of the FTD. The sections below describe the three predominant frames within the policy documents reviewed, while acknowledging that some documents had overlapping frames.

5.2.1 Biomedical frame

The biomedical frame refers to the location of the FTD within the boundaries of maternal and child health, exemplified in the provincial situational analysis report (Western Cape Department of Health, 2016c) and the national maternal, child and women's health policy (National Department of Health, 2016b). In this frame, all behaviours or conditions within the FTD period were expressed in terms of health and illness, and the problem was defined principally as one of preventing maternal and child deaths.

The report of the Intervention Framework of the Situational Analysis (Document 24 in Table 8) asserted that '*Maternal mortality is a / the key marker of effective health systems, and there is a need to reduce maternal mortality within FTD'* (Western Cape Department of Health, 2016d, page 82) – while the 2017/18 Annual Report of the Western Cape Government noted that '*[t]he First 1,000 Days programme managed by the Department aims to improve performance on maternal and child health indicators*' (Western Cape Department of Health, 2018, page 59).

Similar to the above statements, the National Strategic Plan for Maternal, Newborn, Child and Women's Health and Nutrition in South Africa (2012 – 2016) (National Department of Health, 2016b) – Document 12 in Table 8 – predominantly reflected the same ideas of child survival in relation to reducing mortality. These ideas were linked to global imperatives to improve child survival: '*On an international level, recent efforts to improve maternal,*

newborn and child survival have focused on ensuring full coverage with packages of interventions with proven effectiveness' (National Department of Health, 2016b, page 7).

The above child survival considerations were based on addressing the Millennium Development Goals during the pre-2015 era that placed attention on addressing weak health systems to reduce child and maternal mortality, such that these mortality levels became a core indicator of health system performance. This was noted in the report of the Intervention Framework of the Situational Analysis (Document 24 in Table 8) as follows:

> *'Safeguarding and preserving the lives of mothers during childbirth, is one of the globally accepted essential functions of a health care system. The maternal mortality ratio is therefore viewed as one of the key markers of the effectiveness of health care systems globally. Western Cape Government: Health is therefore committed to reducing maternity mortality, in line with this imperative.'* (Western Cape Department of Health, 2016d, page 2)

As a result, this frame positioned the Provincial Health Department as having primary responsibility for driving the action on the FTD. The frequent interaction of the staff of the Department with pregnant women and children made it easy to position this Department as best placed to develop FTD programmes, and to frame the FTD initiative centrally as a problem of maternal and child mortality. Based on this problem definition, policy solutions suggested were clinical-based strategies that emphasised clinical governance systems, including clinical guidelines, the training of health workers and health service improvement.

Although ideas in national health sector policies regarding child survival have largely remained unchanged, there was often an additional broad acknowledgement of the need to address the SDH. A typical statement would be that *'[departments of health] could, and should, take the lead in mobilising other government departments to address these broader social determinants of child health*' (Jamieson, Berry & Lake, 2017, page 75).

However, in documents with predominant biomedical frames, the need for intersectoral approaches to address the SDH often remained as a general statement such as the one above. Moreover, addressing SDH or intersectoral action was often added as the last bullet point in the list of medical-based solutions. There was also very little engagement on how collaboration was expected to unfold.

A similar picture emerged within provincial Health Department documents such as annual reports, which would refer to intersectoral collaboration under the blanket umbrella of health promotion, with no specific ideas of what health promotion involved. Common statements of '*Intersectoral health promotion programmes should impact on children's wellbeing*' (Western Cape Department of Health, 2018) or '*Improve Maternal and Child wellbeing by initiating inter-sectoral health promotion programmes*' (Western Cape Department of Health, 2016c) were included in the list of health-specific interventions that were proposed. Additionally, intersectoral approaches that were proposed were linked to the communication strategy in FTD plans that largely included providing promotional materials to the public.

Similarly, when compared with the more expansive global 'Survive, Thrive, Transform' objectives, the provincial FTD Intervention Framework approach to intersectoral initiatives was minimal. For instance, the global 'Transform' objective had argued for an extensive focus on environments that influenced social determinants, including addressing poverty and reducing discrimination (World Health Organization, 2016). The Intervention Framework (Document 24 in Table 8), on the other hand, included 'transform' as an addition to improving health services, often using the phrase '*some transform*':

> *'Survive, Thrive and some Transform: Develop and implement an appropriate First 1,000 Days Clinical Governance system for oversight and accountability of the clinical care received by patients across the care continuum.'* (Western Cape Department of Health, 2016d: page 8)

5.2.2 Nurturing care frame

The second frame was the nurturing care frame present in ECD-related documents such as the NIECD Policy (Document 10 in Table 8), a policy developed by the Department of Social Development in 2015 (Republic of South Africa, 2015). The NIECD argued for the need to transform traditional maternal and child services into a more comprehensive approach that enhanced child development. Having the FTD initiative complement maternal and child health services was based on the emerging evidence on brain development beginning at birth that shifted how interventions were selected:

> *'Overwhelming scientific evidence attests to the tremendous importance of the early years for human development and to the need for investing resources to support and promote optimal child development from conception.* (Republic of South Africa, 2015, page 8)

And the Perinatal Task Team's situational analysis of the FTD (Document 24 in Table 8) noted:

> *'The concept of child care starting at conception is relatively new and requires a shift in thinking within maternity services and governance structures to allow for conversations with regard to maternal and infant mental health and the promotion of early childhood development, starting from conception.'* (Western Cape Department of Health, 2016c, page 75)

The NIECD (Document 10 in Table 8) also foregrounded the need to address the poor quality of existing ECD services:

> *'Lack of opportunities and interventions, or poor quality interventions, during early childhood can significantly disadvantage young children and diminish their potential for success.'* (Republic of South Africa, 2015, page 8)

At the national level, the NIECD, therefore, offered a comprehensive multi-sector approach to support caregivers in the FTD period, largely through maximising health facility encounters and home visits through CHWs. The NIECD also proposed inter-ministerial or multi-sectoral committees as the best way to ensure action across sectors on ECD, including specifying accountability roles at all levels:

> *'The Presidency will support the Inter-Ministerial Committee on Early Childhood Development to reinforce the national importance of early childhood development. At provincial level, Premiers will be similarly responsible for reinforcing early childhood development as a provincial priority and for ensuring sufficient resources, and inter-departmental commitment and collaboration. At municipal level, Mayors will be similarly responsible for reinforcing early childhood development as a municipal priority, and for ensuring its inclusion in the municipality's Integrated Development Plans, as well as sufficient resources, commitment and collaboration.'* (Republic of South Africa, 2015, page 86)

A large proportion of the above interventions in the NIECD were first articulated in the National Government's overarching NDP, released in 2011. The NDP presented a long-term perspective that aimed to eliminate poverty and reduce inequality by 2030 (National Planning Commission, 2011). The NDP interestingly had recognised the FTD period as key, showing that ideas surrounding the FTD were in circulation as early as 2011. The NDP also offered home- and community-based services as the approach to addressing FTD-related services which become part of the intervention package of the NIECD in 2015.

Other documents such as the South African Early Childhood Review published in 2016 (Hall *et al.*, 2016) cautioned the need for a comprehensive plan for ECD. As the comprehensive plan was extensive and too ambitious, however, it proposed an essential package of services to address the current needs of children which was a more realistic option for the South African context. The essential package, however, was similar to the components in the NIECD.

The comprehensive set of services recommended by the NDP and the NIECD were similar to both the global Nurturing Care Framework and The Lancet Advancing Early Childhood Development series (Britto *et al.*, 2016; World Health Organization, 2018b), both of which had highlighted the 0-3 year period as distinct for particular interventions. The NDP and NIECD had also suggested strengthening existing services in health and social sectors as well as agriculture and environmental sectors.

The Nurturing Care Framework (World Health Organization, 2018b) suggested the need for a high-level multi-sector co-ordinating mechanism with clear roles at all levels and a long-term financial strategy. This corresponded with the NIECD's vision of inter-ministerial committees.

The main difference between global and national documents within the nurturing care frame was the extent of interventions and associated intersectoral approaches suggested. The Nurturing Care Framework endorsed promoting cross-sector working by using in-service training to bring professionals from different sectors together. The Lancet series offered numerous suggestions including recommendations at each stage of the policy process from agenda setting to monitoring and evaluation. The following examples show the extent to which global documents approached nurturing care and associated intersectoral approaches. The first is from the WHO's framework on Nurturing Care for Early Childhood Development (Document 7 in Table 8):

> *'Strategic action 3 - Strengthen services:*
> *1. Identify opportunities for strengthening existing services in sectors (health, education, child and social protection, agriculture and the environment).*
> *2. Update national standards and service packages to reflect the five components of nurturing care.*
> *3. Update competency profiles and strengthen the workforce's capacity. Use both pre-service and in-service and bring professionals from different sectors together…'* (World Health Organization, 2018, page 30)

> *'Recommendations for agenda setting:*
> *1. Improve data availability, quality, frequency, and dissemination relating to ECD, particularly for children 0–3 years.*
> *2. Improve integration and multi-sectoral co-ordination of ECD with other sectors.*
> *3. Receive guidelines from the ECD community on programming, co-ordination, and integration strategies.'* (Black et al., 2016, page 7)

Interventions offered by The Lancet series were quite pragmatic, including the idea that ECD services could be considered as 'packages' which combined various sector services (health, nutrition and social development) in various combinations depending on the context. These packages were documented as a strategic way to focus on risk factors hindering child

development at appropriate stages in the life course. An example was the 'multi-generational intervention package' proposed by The Lancet series (Britto *et al.*, 2016).

Thus, global documents promoted the idea of combining sector services within long-term sustainable strategies entrenched into existing services.

Policy documents in this second frame had a more holistic focus on child development, as solutions assimilated ideas from other sectors, such as parenting support programmes from Social Development or a focus on early stimulation from Education. Many of the policy solutions focused on the family level to provide a nurturing environment for early childhood. To target the family or caregivers, interventions for this frame proposed home- and community-based programmes to support caregivers, in addition to health and nutrition services.

Compared to the strategies and packages in global and national documents, the initial FTD plans and the Department of Health's annual report for 2015/2016 (Western Cape Department of Health, 2016b) embraced the nurturing care frame (see Chapter 4) – although this intersectoral agenda subsequently transitioned to maternal and child health goals. This frame also appeared in provincial plans linked to the Social Development Department (Document 39 in Table 8) that were set on addressing the NIECD components. The following statement shows how ECD-related plans and the FTD were positioned in provincial Social Development plans:

> *'Sub-Programme 3.4 ECD and Partial Care. …*
> *The Department will continue with the following projects:*
> *1. In collaboration with the Department of Health, a focus on the First 1,000 Days to deliver comprehensive services to young children;*
> *2. Parent support programmes;*
> *3. Continuing the registration of ECD programmes in partnership with the WCED [Western Cape Education Department]; and*
> *4. A special ECD programme for English language and cognitive development at sites where school readiness is poor.'* (Western Cape Department of Social Development, 2018, page 57)

However, these plans rarely offered specific packages to address the FTD and the NIECD policy provisions.

In summary, a number of the comprehensive approaches for enhancing child development in the FTD were, for the most part, clearly outlined within national and global documents. Most of the documents that endorsed the nurturing care approach justified the need to improve early childhood services as crucial for addressing the SDGs.

5.2.3 Socio-economic frame

Compared to the previous two frames, the socio-economic frame pushed for more ambitious and integrated forms of governance to address the FTD and broader ECD goals. Documents that embraced this frame went beyond a general acknowledgement of the need to address SDH and encouraged a broader societal or political responsibility for addressing these determinants. This included the involvement of the community and private sector in tandem with government departments to address SDH. For example, the WHO's Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) (Document 5 in Table 8) outlined the main areas of action across individual efforts, communities, government sectors, countries and other partners:

> *'To succeed, countries and their partners will have to take simultaneous action in nine interconnected and interdependent areas: country leadership; financing for health; health systems resilience; individual potential; community engagement; multi-sector action; humanitarian and fragile settings; research and innovation; and accountability....This will require a more integrated and holistic way of working across sectors, as envisioned by the SDG.'* (World Health Organization, 2016, page 7)

This thinking also featured in the first provincial Department of Health Annual Report (Document 28 in Table 8) that mentioned the FTD:

> *'The First 1,000 Days project goes beyond preaching the virtues of good nutrition for childhood development but emphasises the crucial role communities as a whole play in creating safe and healthy environments for both mothers and their children to thrive.'* (Western Cape Department of Health, 2016b, page 17)

Documents that reflected this frame viewed children as having the right to equitable access to services, especially in environments shaped by social disparities. The PSP (Document 21 in Table 8) referred to the challenging socio-economic challenges as 'social ills':

> *'The Western Cape Government acknowledges that we have a society that still carries the burdens of inequity… often leading them to fall prey to social ills in society such as alcohol and drug abuse …. there is a widespread breakdown in communities right down to the family unit, leaving many people vulnerable; in particular children and youth who have to grow up in a dysfunctional society where violence, child abuse and preventable diseases occur frequently.'*(Western Cape Government, 2014, page 36)

While focusing on social issues contributing to poor health, proponents of this approach presented a general view of policy programmes which broadened the options for interventions that affect communities as opposed to specific interventions that might target individuals. Thus, approaches offered to address social determinants within this frame included the whole of government or WoSA that stimulated greater forms of integration than that of cross-sector packages in the nurturing care frame.

Sub-national documents that embraced WoSA were the Western Cape Province's Cape Town Declaration on Wellness, the PSP, and the Healthcare 2030 strategy (Western Cape Government, 2011b, 2014; Western Cape Government Department of Health, 2014). These documents identified, as a core strategy of the Province, the shift from a focus on illness to addressing social determinants that affect health. This shift was referred to as 'wellness', an idea that took hold after the Cape Town Declaration on Wellness. For the PSP, the increased investment in the FTD and a strong focus on whole of society approaches were phrased as engaging all aspects of society including citizens, civil society and the state.

The PSP stated that governance would be organised through a provincial transversal management system which provided the platform for cross-sector engagements. Each provincial goal was to be managed by a steering committee that would address a range of projects to improve the SDH such as the FTD and would include all the relevant sectors as part of the project (Western Cape Government, 2014).

Global documents, on the other hand, focused on more ambitious targets. For instance the transform objective in the WHO's Global Strategy for Women's, Children's and Adolescents' Health recommended addressing discrimination and violence, providing universal and equitable access to services and combating poverty, among others. Most of these recommendations identified vulnerable groups and recognised the structural determinants of health (World Health Organization, 2016). The Global Strategy (Document 5 in Table 8) also referred to multi-sector enablers to improve working across sectors and civil society, with extensive focus areas as follows:

> *'Multisector enablers: Policies and interventions in key sectors: finance and social protection; education; gender; protection-registration, law and justice; water and sanitation; agriculture and nutrition; environment and energy; labour and trade; infrastructure, including facilities and roads; information and communication technologies; and transport.'* (World Health Organization, 2016, page 17)

The framework published by Harvard University's Centre on the Developing Child (Document 1 in Table 8) proposed similar far-reaching goals that included private sector involvement (Center on the Developing Child, 2010). The framework had influenced early provincial FTD plans and had suggested public assistance and employment programmes for low-income parents; housing policies; and community development initiatives. These goals were termed policy and programme levers to enhance health and nurturing care efforts:

> *'Public and private sector policies and programmes strengthen the foundations of health through their ability to enhance the capacities of caregivers and communities in the multiple settings in which children develop. Relevant policies include both legislative and administrative actions that affect systems responsible for public health, childcare and early education, child welfare, early intervention, family economic stability (including employment support for parents and public assistance), community development, housing, and primary health care, among others.'* (Center on the Developing Child, 2010, page 4)

Despite the envisioned broad involvement of sectors and other societal structures, there was little specificity regarding what this approach would look like, and especially how governance structures were envisioned. As a result, although integrated and whole of society approaches were often recommended, the responsibilities and roles of various role players were left unclear.

5.3 CHAPTER SUMMARY

In summary, the analysis of frames revealed the three main ways in which documents represented the FTD. These frames showed that framing policy problems created boundaries regarding the extent of policy solutions that were possible, including intersectoral approaches. A summary of the solutions and problem linked to each frame is given in Table 9.

Table 9: Problem definitions and solutions for each frame

Levels	**Frames**	**Problem definitions** (What is the problem?)	**Policy solutions and intersectoral processes suggested** (What is the solution?)
Individual	Biomedical	FTD as a maternal and child health mortality problem	- Improve maternal, perinatal and child mortality through clinical governance systems, the training of health workers, and health service improvement - Acknowledge the need to address social determinants
Family	Nurturing care	FTD as showing the importance of early interventions in the life course Existing ECD services are poor in quality	- Nurturing care packages that stretch beyond health services including social support programmes, home- and community-based programmes to target caregivers - Strengthen existing services - A high-level multi-sector co-ordinating mechanism, such as inter-ministerial committees
Community /societal	Socio-economic	FTD indicating the need to address social determinants of health	Whole of society approaches that involve engaging all aspects of society including citizens, civil society, the state and the private sector.

Some policy documents had multiple frames that intersected in various ways, showing that all three frames were necessary and could be used to address the FTD. The three frames were therefore not entirely incompatible and, in fact, were similar in two ways.

The first was that there was agreement on the need to prioritise action for maternal and child health in the first two years of life. The second was that an intersectoral approach was needed to address social determinants.

However, the point of contention amongst the three frames was the level of involvement of other sectors in addressing the FTD. Health and social sectors featured prominently in the

three problem definitions and solutions while other sectors, such as those responsible for safety, were rarely considered. Figure 5 below positions the frames in relation to the sectors involved.

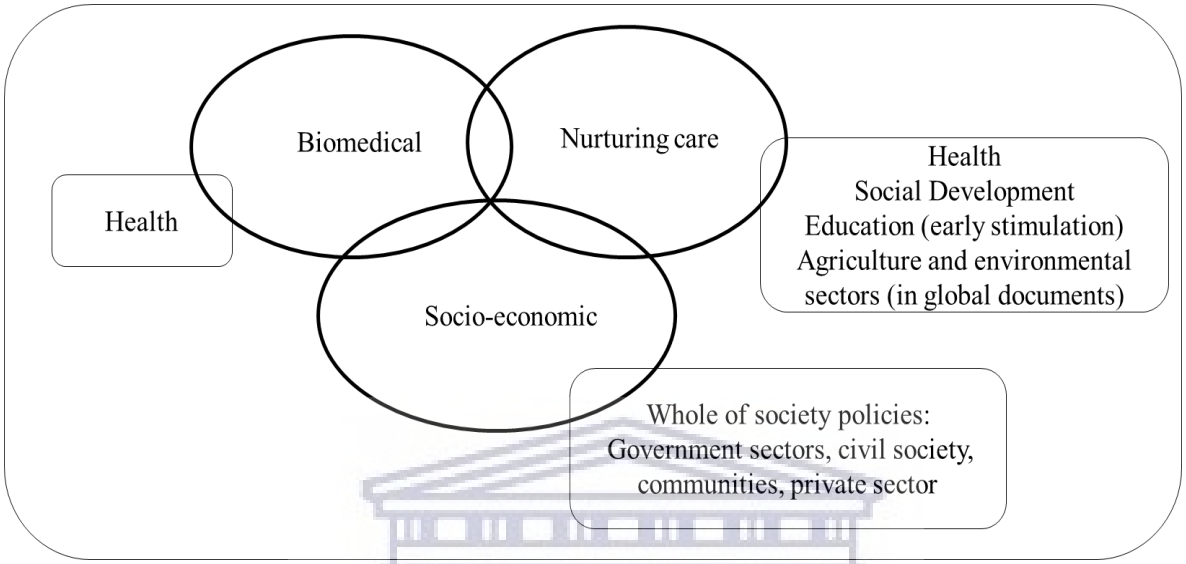

Figure 5: The three frames of the FTD based on policy documents and corresponding sectors for each frame

Each of the three frames proposed policy responses that have an impact on motivating intersectoral action as they form the basis for decisions regarding resources and governance arrangements.

The biomedical frame advocated for solutions that required knowledge of the health sector and clinical governance, leaving little opportunity for cross-sector engagements. Interventions in the biomedical frame also addressed solutions that targeted individual patients largely through improving health services. There was also limited conception of intersectoral action beyond the broad acknowledgement of its importance.

The nurturing care frame overlapped with the biomedical frame as it advocated for an extension of traditional maternal and child health services to address developmental needs. However, initiatives could be combined in various packages largely involving the health, education and social sectors. This allowed intersectoral work to be conceptualised for nurturing care in response to particular initiatives or opportunities.

The last frame embraced both biomedical and nurturing care components and advocated for a more extensive focus on social determinants through integrated governance approaches such

as the WoSA. By virtue of its extensive focus on multiple sectors and communities, the socio-economic frame did not align to any specific government department.

There were also distinct similarities and differences between global, national, and sub-national documents. One of the common differences between global and sub-national documents was the shift from the comprehensive approaches to address the FTD expressed in the global documents to selective interventions in FTD-related sub-national plans. The analysis of text within these documents also uncovered underlying assumptions or world views regarding how children were viewed. The proposed policy interventions were based on whether children were viewed as health service recipients, as resources for development, or as having the right to equitable services. To some extent, these ideas could be linked to global agendas. Another way of considering the three frames in this study would be to relate the frames to the global framework of Survive, Thrive and Transform showing how services for children are considered in relation to health services (survive), broader than health services and including nurturing care (thrive) as well as the transformation of systems to allow for determinants of child health to be addressed in a multi-sectoral way (transform).

In conclusion, if treated as equal, the three frames for the FTD can be seen as complementary. However, frames and resultant differences in focus and prioritisation require negotiation between the key sectors and organisations involved so that adequate starting points, interventions, and governance arrangements could be agreed to. The next chapter will analyse the interaction between the various ideas for the FTD and the impact of institutions and actor interactions on the FTD policy process.

CHAPTER 6:
POLICY ADOPTION AND IMPLEMENTATION WOES OF THE INTERSECTORAL FTD INITIATIVE

6.1 INTRODUCTION

The previous chapter outlined the three frames of problems and solutions from FTD-related policy documents showing that the FTD was viewed through biomedical, nurturing care and socio-economic lenses. This allowed us to begin considering how varied policy ideas along sectoral lines can affect the potential for formulating intersectoral policy processes. This chapter continues to describe the fate of the FTD initiative as it moved through further stages of the policy process, specifically from political prioritisation at provincial level to adoption and implementation processes.

A significant outcome of the FTD process was the policy thinning and a loss of intersectoral goals. This will be explored in depth and the reasons why these goals got lost during adoption and implementation processes will be analysed. This chapter draws on triangulated data from the analysis of policy documents, observations and interviews with key informants at both provincial level and at sub-district level. The narratives of early implementation activities at the sub-district level are shaped by frontline providers' experiences in the Khayelitsha sub-district.

This chapter examines why, despite what appeared to be a successful political agenda-setting process, the FTD was never anchored as a mainstream multi-sector strategy in the Province. A modified version of the 3I's framework (Hall, 1997) – ideas, interests and institutions – is used to illustrate the adoption and implementation woes of the FTD, and to present the findings.

Section 6.2 will begin by outlining the perceptions of actors regarding ideas surrounding the FTD following the divergent policy ideas from Chapter 5. The next section will analyse the interests and resulting actions of the various groups of actors who shaped the FTD process. Lastly, section 6.4 will describe institutional constraints that affected the potential for the intersectoral FTD agenda. The chapter will conclude by summarising how the resulting FTD process was a consequence of the interaction between ideas, actors' interests and institutions.

6.2 LACK OF CLARITY AND VARIED IDEAS SURROUNDING THE FTD

Following the range of different understandings of policy solutions for the FTD in policy documents, it was not entirely surprising that there were various policy ideas as well as a general lack of clarity regarding the FTD initiative amongst policy actors.

> *"The objectives.. and the strategies have been vague and unarticulated and ill defined. So this is not all bad because it allowed for ... iterative processes of trial and error. But I have felt ... concerned about the wishy-washiness of this initiative. The fact that a lot of people don't know whether it's a campaign, ... an initiative, ... a programme; a lot of people don't know what it is."* (Interviewee 4, academic)

> *"So there's very few people that work in the health system that doesn't know about the First Thousand Days. You can literally ask anybody. Yes, I heard about the First Thousand Days, but everyone [has] a different perception of what it is and what it stands for"* (Interviewee 17, health sector)

The statements above reflect the lack of clarity surrounding the concept of the FTD and difficulty of ascertaining the main objectives of the initiative. This was attributed to the fact that the FTD represented a period in the life course as opposed to a specific programme or policy. Key processes, such as the ToC workshop that were meant to identify specific interventions, instead resulted in complex maps that failed to clarify the main activities needed to achieve the FTD goal. As a result, actors both in provincial policy spaces and at service delivery level had different ideas regarding policy solutions and the goals of the FTD. Moreover, some interviewees felt that the FTD was largely an academic concept that was not operationalised for implementation:

> *"I'm not sure if I saw it translated to kind of programmatic goals, so it was kind of quite theoretical still."* (Interviewee 13, NGO)

The FTD was also viewed by interviewees as having two different goals. One was linked to the early conceptualisation of the FTD in the PSG 3 fora while the other was defined by the provincial Department of Health. Within the PSG 3 fora, the aim of the FTD was to focus on communication, health interventions and intersectoral interventions (Western Cape Government, 2014). The PSG 3 fora provided an intersectoral platform where multiple provincial sectors were expected to engage with the notion of addressing wellness through

intersectoral projects meant to be implemented with other sectors. At the same time, the FTD was also identified by the provincial Health Department as one of its service priorities – to improve maternal and child health outcomes by adopting the global Survive, Thrive, Transform framework (Western Cape Department of Health, 2016c; World Health Organization, 2016).

This dual conceptualisation of the FTD across the provincial Health Department and the PSG 3 was described as *"confusedly conceptualised"* (Interviewee 17). It led to differences of views among stakeholders about whether the FTD should primarily focus on maternal and child health aspects as opposed to an intersectoral focus. Most Interviewees felt that intersectoral processes belonged within the PSG fora as opposed to the Health Department, despite the fact that the PSG 3 committee was led by the Department.

The lack of clear policy directives from provincial level led to wide ranging interpretations by frontline actors tasked with implementation who seemed be involved in a range of FTD-related activities that did not fully embrace the envisioned goals. NGO-based actors, particularly CHWs, identified FTD interventions as being similar to their organisations' ECD-related work – and the FTD simply represented a change in terminology for maternal and child health services. This was similar to some actors in provincial health facilities who viewed the FTD as part of existing maternal and child health programmes, such as interventions to improve breastfeeding.

For others, the lack of clear directives from provincial structures meant that frontline providers did not have enough information regarding the FTD, including how long the initiative would last and what its goals were:

> *"I don't think we have a sense of, maybe it's just our level [implying service delivery level], maybe the managers have, …. like how long is this going to last, what is the goal, what's the aim, other than to promote healthy families and input in these important days of everyone's lives."* (Interviewee 22, NGO)

This left actors and organisations at service delivery level unsure of how to approach intersectoral activities for the FTD:

"What is almost the mandate? I think that that for me feels like it's missing, because it feels as if the organisations at the bottom are kind of struggling to do the partnerships and running around..." (Interviewee 23, NGO)

6.3 INTERESTS, ACTORS' TENSIONS AND RESULTING FRUSTRATIONS

This section will highlight the interests of various actors involved in the FTD initiative and the sources of power they drew on to influence the FTD outcomes, particularly decision-making power over FTD interventions.

Policy actors[3] were classified based on their involvement in the FTD initiative as shown in Table 10. Similarly, although the core FTD Executive Committee consisted of members of the Health Programmes Directorate, the extended committee invited representatives of other relevant groups such as the CBS Group. The links between the various actors, committees and health service line management have been described in Chapter 4.

The Provincial Minister of Health was a key figure in the early stages and during the political prioritisation of the FTD; she was said to have "*kept the Department [of Health] on their toes*" (Interviewee 7). Her attention subsequently faded during policy thinning, however, which was seen by some respondents as representing a decrease in the political attention being paid to the initiative.

The other significant group at provincial level was the Perinatal Task Team which was perceived by many to gain legitimacy at it was chaired by a senior official of the Health Department:

"It seems to have legitimacy, and I'm not sure if that legitimacy is being given just by virtue of it being under the [senior Provincial Health Department official]. So, unfortunately, this is where it comes back to leadership. So when you've got that [person] … that we perceive as the Department as strong leaders being focussed on the initiative…and they are also high-level clinicians. So I think that is a very important structure that keeps people on their toes in terms of the initiative." (Interviewee 7, health sector)

[3] It is worth noting here that some actors overlapped across technical and interest groups

However, the Perinatal Task Team and the closely linked CBS Group were not involved in FTD-related activities after 2019.

Table 10: Key actors involved in the FTD initiative – their interests, power and resulting actions

Key actors*	Interests	Sources of power	Relation to the FTD and resulting policy actions
Provincial Minister of Health	Passionate about child health.	Political	Visible political support at the launch of the FTD.
FTD Executive Committee	Organising FTD formulation and implementation activities.	Linked to technical groups, the PICH community and service managers. No decision-making power but could recommend policy directives to top provincial structures.	Organised and led all FTD-related events and processes throughout the period.
Technical support groups (Perinatal Task Team, CBS Group)	Providing support to provincial top management and implementation teams.	Influence implementation priorities and considered powerful due to proximity to the senior health officials.	Supportive of the FTD. Designed the intervention framework for the FTD.
Academics	Ensuring attention to the FTD and advocating for an intersectoral FTD agenda.	No decision-making power but offer interventions that are influential in technical support groups and policy communities such as PICH and the CBS Group. Linked to international ECD communities such as the Nurturing Care network.	Supportive of the FTD idea and processes, including hosting some FTD-related workshops.
Interest groups (NGOs, academics, PICH group)	Varied interests depending on NGO mandates but focusing on improving ECD generally and support the FTD. NGOs linked to informal networks at implementation level with service providers from various sectors.	No decision-making power but could lobby through association with technical support groups and links to provincial top structures via the Health Programmes Directorate.	Enabled agenda-setting process of the FTD and a few supported all other FTD-related activities.

Key actors*	Interests	Sources of power	Relation to the FTD and resulting policy actions
Provincial Health Department – senior decision makers	Aligning with existing priorities and ensuring frontline actors at service delivery level are not overwhelmed with competing mandates from both policy makers and various technical groups.	Decision-making power over health-based interventions.	Focused on improving maternal and child health services as opposed to unclear intersectoral FTD mandate.
Provincial Health Department – sub-district level	Focusing on coping with top policy demands and overwhelming service delivery numbers in complex implementation realities at the frontline.	Decision-making power at the frontline	Perceived the FTD as a top-down policy idea without sufficient engagement with implementers. Predominantly focus on health services.
Other sectors; Social Development Department, at both provincial and sub-district levels	Generally involved in ensuring ECD mandate and ensuring safety and secure environments for families.	Not involved in the FTD process. Involved in formalised ECD-related intersectoral forums which are not explicitly linked to the FTD.	Supportive of the idea but not involved in bureaucratic decision-making processes. Occasionally attended PICH meetings.
Other departments which should have been involved: Community Safety, Education	Not clear, but assumed to be ensuring the primary mandates of their sectors.	Involved in informal networks at service delivery level but not formalised for implementation of the FTD.	Not involved in FTD processes.

* *All inferred from interview material with key informants and confirmed (particularly the absence of key actors) through observation reports. Resulting actions on the FTD are summarised from all sections presented in the analysis of this chapter.*

The other two key groups of actors who were influential in the FTD policy process were policy entrepreneurs and actors at the service delivery level. Policy entrepreneurs were involved in interest groups and policy communities such as PICH while actors at the service delivery level were responsible for the implementation of programmes within the health system. The FTD process revealed underlying tensions between them at both provincial and district levels.

At the provincial level, contestation emerged during decision-making processes regarding interventions, such as during the design of CHW packages for the FTD. The demands of the FTD interest groups and policy communities regarding the set of interventions that CHWs should perform conflicted with the opinions of service managers regarding what was feasible for CHWs. Service managers felt that including a large set of FTD interventions would negatively influence the provision of other services, while policy entrepreneurs pushed for a focus on various specific interventions, depending on their interests.

This tension between addressing interventions recommended by interest groups versus implementation realities therefore shaped decisions regarding a number of FTD interventions. In some cases, interest groups managed to focus attention on specific issues – such as developing the screening tool for mental health which was included in the maternal health case record – whereas for many other interventions, service managers often stuck to health-related mandates.

At the district and sub-district levels, implementation actors had to navigate between multiple demands from top managerial structures (such as the implementation of other priority focus areas like immunisation programmes) and from interest groups advocating for various vertical initiatives. One of the respondents expressed the pressures in this manner:

> *"There is this group for the FTD [referring to interest groups and technical groups], there are groups like this for mental health, there are groups like this for chronic disease management… All those groups come and all those groups want a piece of you, so if we are not doing enough for children .. then they criticise but not understanding that [the] same resources has to provide [for] other services as well."* (Interviewee 5, health sector)

Interviewees also identified a range of missing actors who many felt could have had a positive impact on the realisation of the FTD goals. These included actors from the Departments of Social Development and Education as well as representatives of human resources and finance departments who would be necessary to support the goals of the FTD. Although policy documents from 2016 to 2018 cited the FTD as a priority for Social Development sector (Western Cape Department of Social Development, 2015, 2017, 2018) there was limited attendance of actors from the Department in forums such as the PICH meetings.

> *"I think it's very sad that there is not regular strong involvement from the Department of Social Development and the Department of Education. I don't know how you overcome that. I think it's incredibly frustrating for, you know, people who are driving processes."* (Interviewee 18, NGO)

The ability of the FTD policy entrepreneurs to continue to lobby for attention to be paid to the FTD within senior management structures of the Provincial Health Department was also negatively impacted by the resignation of a key senior champion of the initiative who had been involved in early prioritisation processes of the FTD:

> *"My sense is that there's particular people that are passionate about specific initiatives and that person had a passion to see this as a key priority, competing with all the other multiple priorities. But because that person's voice is no longer in top management meetings …there is a little bit [of] a loss for this initiative."* (Interviewee 7, health sector)

The gradual loss of other actors who had been involved in the initial formulation activities only worsened the situation. This included some NGOs who had supported initial FTD processes but began focusing on emerging FTD-related activities in the Drakenstein sub-district instead (see Chapter 7).

As a result, many respondents felt that there was limited ownership of the initiative by the actors responsible for service delivery, and judged that they largely viewed the FTD as an externally driven agenda of the policy entrepreneurs. Senior management structures then felt they had to 'protect' service providers against the FTD, with one interviewee wondering *"what planet"* policy advocates for the FTD were in and wanted to *"reign them in"* (Interviewee 19). This impacted how actors at service delivery level approached the implementation of the FTD:

"Maybe I must be blunt and say that the First Thousand Days, even though it's there on paper, is not a priority in the form that was envisaged in terms of... Survive Thrive and Transform. I don't know if some of that stuff is doable. Let me be honest and say even though we put ... in First Thousand Days as a priority and we call it a priority, essentially what we're talking about is maternal services and neonatal services, and then we throw a bit of immunisation in to spice it up a little bit.. We are giving attention to that, focused attention to that period, but are we ... fully implementing the recommendations of the Task Team? The answer is, probably, no." (Interviewee 19, health sector)

Implementation actors were also frustrated by the expectation of having to implement an intersectoral initiative that had unclear interventions and by their inability to express their discontent of the process:

"A lot of feedback that you would get on this topic is somewhat…it's about mothers and babies… and you can't express your frustration on that. You can't say that you are skewing the system and pulling resources from other places. I think there was a lot of quiet resentment about this topic, because you're not allowed to express your frustration with the modus operandi." (Interviewee 20, health sector *)*

On the other hand, for policy entrepreneurs who had been lobbying for a long time for attention to be paid to the FTD, the loss of momentum due to the lack of institutional support and fading political support was a source of frustration.

6.4 INSTITUTIONAL CONSTRAINTS THAT SHAPED THE FTD PROCESS

This section identifies constraints in the institutional domain shaped by the provincial departments and organisations involved in the FTD. These factors affected how actors within established organisations or departments engaged with the intersectoral processes for the FTD.

The first part of this section will outline constraints that affected intersectoral processes, while the second part focuses on specific challenges within the Health Department that affected the development of the FTD initiative.

6.4.1 Constraints peculiar to intersectoral processes

The intersectoral approach of the FTD initiative was thought to have been impacted by the historical pattern of prioritising vertical projects managed by specific sectors within planning spaces that were meant to be intersectoral, such as within the PSG 3 fora. The FTD was prioritised as one of the vertical initiatives along with six other similar initiatives spread across three government sectors, setting the precedent for how it unfolded as a vertical initiative within the provincial Health Department.

> *"It [the FTD] was landed in the … supposedly intersectoral space [referring to the PSG 3 fora] as a vertical project, alongside vertical projects of other departments. So that was the conceptualisation of the FTD: as a parallel project within ostensibly an intersectoral space."* (Interviewee 17, health sector)

An additional constraint was related to the inability of government and NGOs involved in ECD-related work to develop a shared intersectoral FTD goal. This was worsened by fragmented ECD services across various provincial government departments and within NGOs contracted by individual sectors, resulting in the duplication of services. Government departments and NGOs thus implemented fragmented versions of the FTD, replicating the ways in which ECD services had been organised in the past. Some actors attributed this to limited information sharing regarding the FTD across the various sectors and organisations related to the FTD:

> *"So if you talk to somebody in [Department of] Health they understand this First 1000-Day concept. And people are starting to use it as almost a 'hashtag' in the conversation. And if I go into [the Department of] Social Development spaces they're like, ... you know, "That's not cascaded down to us at all". So for me it's really about that mandate being given to all levels to say that this is what we do. So how can the First 1000 Days campaign work more closely across departments, and then filter that down..? . I don't know if it's because the Department of Health is the lead organisation. So how do they the share [the] lead role? For me, I don't know."* (Interviewee 23, NGO)

Related to intersectoral working at the frontline, there appeared to be an inherent understanding among frontline providers that addressing community needs required networks across sectors. However many of these networks were not formalised nor were they explicitly linked to the FTD process. Apart from referral networks of established NGOs, many of these

frontline relationships were largely informal, emerging without clear forums or channels for discussions amongst cross-sector frontline players. These included, for example, informal networks between various configurations of frontline actors that included health providers in facilities, allied health professional teams, CHWs in NGOs, social workers, neighbourhood forums, police services among others. These relationships were organised as referral networks through which CHWs linked community members to the necessary services in their communities. Informal networks such as these appeared to rely on the proximity of cross-sector players within the same community or region.

In contrast to the range of informal intersectoral relationships, Social Development at both provincial and district levels had various formalised intersectoral relationships with other sectors. Many of these relationships involved meeting processes in forums organised by the Social Development Department such as the provincial child protection forum and the intersectoral forum for ECD – both of which were relevant to the FTD initiative. The extent to which these forums were integrated with FTD-related activities and processes was not clear, however.

6.4.2 Broader institutional constraints related to the health sector

Intersectoral ideas relating to the FTD were viewed as too ambitious for the provincial Health Department to undertake due to the limited consideration of complex implementation contexts during agenda-setting processes. Moreover, intersectoral activities were also considered to be intangible and outside the boundaries of the work of the Health Department, making it difficult for actors at service delivery level to engage with them. Some felt that intersectoral action should not be a key focus when the Health Department was struggling to ensure child survival, which was its core mandate:

> *"I don't recall ever agreeing that we've got past the 'Survive' [child survival] part, ... I don't know, we're talking about transformation [intersectoral action] and there's still children dying…we need to get the basics right. And I don't think the basics are there."* (Interviewee 19, health sector)

Systemic support for the FTD initiative was also hindered by service delivery contexts shaped by extensive social disparities, high patient numbers, and ineffective referral systems. Similarly, some respondents felt the FTD focus on parental support and empathetic care was undermined by poor provider skills and the traditional focus on record keeping over patient

engagement. These systemic challenges, combined with the lack of clarity surrounding the concept of the FTD, led senior managers in the provincial Health Department to resist the FTD:

> *"We're going to buffer the services [health workers] from this [the FTD]. Because they can quite easily focus a hundred percent of their time on this and then everything else collapses... So the concern is that inappropriate focus without good planning and ... prioritisation will lead to us providing a service which is not commensurate with the needs of the population."* (Interviewee 19, health sector)

Frontline providers recognised their line managers' lack of enthusiasm and resistance to the FTD initiative, as seen in their low attendance in FTD-related training workshops. This left some health workers feeling that they were inadequately supported to implement the FTD.

The FTD also appears to have lost the attention of some senior managers of the health department as other institutional priorities within the health system were regarded as more tangible gained prominence during the same period. An example is the community-oriented primary care (COPC) approach, which was built on the provision of primary health care services in co-ordinated geographical locations or communities (Mullan & Epstein, 2002).

> *"COPC is robust, it's been around for a long time. It doesn't really need anyone to fight for it; it just needs an 'aha' moment which has now happened and it will emerge naturally from the system. So I think the difference is, one is an idea [the FTD] and the other is far more tangible."* (Interviewee 20, health sector)

At the same time, a wider organisational restructuring process - the Management Efficiency Alignment Project (MEAP) - disrupted information and reporting lines in ways that were felt to have undermined the focus on the FTD:

> *"It's a bit loose fitting at the moment in my opinion. …. Most of us are at least loose fitting in the Department; you are not sure where you fit in the future structure. People feel that it's that floatingness…I'm not sure where it's going to end up…. So must I take it [the FTD] forward? Is it worthwhile? Who is going to support this? Is it going get the attention that it requires for me to put that effort?"* (Interviewee 7, health sector)

MEAP processes, the COPC plus other health sector priorities such as the need to pay attention to non-communicable diseases, left providers with the sense that other priorities were taking over from the FTD initiative and that it struggled to fit within the newly established priorities:

> *"It [the FTD] has fizzled out….It was an expansive idea, it was meant to be an intersectoral project but there was too little concrete to keep it going. And maybe the intersectoral collaboration killed it, or maybe that's not fair; there are just so many other confounding things with this case … So the energy that was in First Thousand Days is quickly absorbed towards these other concepts of… Management Efficiency Alignment Project (MEAP) restructuring, community-oriented primary care."* (Interviewee 20, health sector)

Lastly, the fact that health services were also delivered through the Metro District Health Services as part of the Provincial Health Department and the City Health Department – meant that the implementation of initiatives such as the FTD would need to be co-ordinated and negotiated between the Province and the City. This made the implementation processes of the FTD challenging for senior provincial Health officials who had to negotiate maternal and child health services between these two structures:

> *"I must mention that within the Metro we have an added complexity of our relationship with the City of Cape Town. So only twenty percent of the interactions with children is with provincial facilities [Metro District Health services] on an outpatient basis and eighty percent with the City…We hold a contract with the City of Cape Town and we're busy fighting over that contract for the last eighteen years. So they're unlikely to put stuff in the contract which requires additional resource. The difficulty of rapid implementation [for the FTD] is that we're dealing via an intermediary for children. And that's always difficult."* (Interviewee 19, health sector)

6.5 INTERACTION OF IDEAS, INTERESTS AND INSTITUTIONS

In summary, the ideas surrounding the FTD initiative arose from the interests of policy entrepreneurs.

Due to historical patterns of priority setting within sectors, the provincial Health Department prioritised the FTD initiative as another vertical (health-based) initiative. The proliferation of vertical initiatives created resistance among provincial implementation actors (interests) who had to navigate multiple demands and the systemic challenges (institutions). Implementation actors from the Provincial Health Department who largely had decision-making power over implementation activities, therefore, behaved in ways that resisted the intersectoral goal of the FTD (interests) and focused instead on health-based mandates which seemed to fit with their perceived idea of what the Health Department could manage (institutions). The location of the FTD mandate within the Health Department (institutions) and the limited engagement with other sectors, further isolated the FTD as another health intervention (ideas). In addition the FTD initiative appeared to lose relevance even within the provincial Health Department, given competing institutional priorities such as MEAP and COPC (institutions).

Apart from health-based mandates, other intersectoral activities that frontline providers engaged with were largely unclear. Actors such as NGOs who were based outside the provincial Health Department implemented versions of the FTD in a fragmented fashion, similar to the organisation of ECD services and through largely informal networks with other frontline providers (institutions). The FTD's intersectoral mandate was ultimately lost through the interaction of unclear ideas and vertical initiatives, institutional constraints and challenges that affected the process, and divergent interests between policy entrepreneurs and system actors.

Table 11 below summarises the key themes that shaped the FTD process related to ideas, institutions and interests.

Table 11: Summary of key findings using ideas, institutions and interests constructs

Ideas

- Ambiguity surrounding the FTD initiative occurred despite wide awareness of the initiative.
- Actors had different ideas regarding interventions for the FTD initiative.
- Contention regarding narrow maternal and child health focus versus a broader intersectoral focus.
- FTD viewed as a separate agenda for two spaces (provincial Health Department and intersectoral Provincial Strategic Goal 3 space) which contributed to different ideas regarding interventions.
- Actors at service delivery level unsure of how to approach the unclear intersectoral FTD mandate.

Institutions

Constraints peculiar to the intersectoral process:

- FTD prioritised as a vertical initiative within intersectoral planning spaces.
- Lack of shared intersectoral FTD goal amongst organisations and sectors involved in ECD-related work.
- Informal and formal intersectoral networks not explicitly linked to FTD processes.

Broader constraints related to the health sector:

- Intersectoral activities perceived by implementation players as being unreasonable and outside the boundaries of the provincial Health Department especially as it still needed to address its core mandate of ensuring adequate maternal and child health services.
- Limited consideration of implementation realities of service delivery in health facilities during agenda-setting.
- Overwhelmed facilities due to increasing patient numbers, limited effective referral systems between sectors and organisations.
- Lack of capacity of provincial Health staff to engage intersectorally.
- Competing institutional priorities such as the Community-Oriented Primary Health Care approach.
- The ongoing Management Efficiency Alignment Project that disrupted information and reporting lines in the provincial Health Department.

Interests

- The pressure to address various vertical initiatives such as the FTD initiative overwhelmed implementation actors.
- The loss of key champions involved in earlier FTD processes limited the ability of policy entrepreneurs to sustain attention to the FTD initiative.
- Different interests between policy entrepreneurs and implementation actors in the provincial Health Department resulted in frustration for both groups of actors.

6.6 CHAPTER SUMMARY

This chapter documents the adoption and implementation woes of the FTD related to ideas, actors' interests and institutions. The narrowing of the intersectoral FTD goal after agenda setting was due to the prioritisation of the FTD as a vertical initiative, along with limited cross-sector engagement and the lack of consideration of implementation realities. Although health-based mandates of the FTD appear to have taken hold in a number of districts, the ambiguity surrounding interventions for the FTD plus institutional barriers (such as overwhelmed facilities), contributed to the thinning of the goals originally set for the FTD.

The lack of common intersectoral FTD agendas amongst sectors and organisations involved in ECD further exacerbated the pattern of fragmented provision of services. Existing formal and informal cross-sector networks also appear to have been underutilised for the implementation of the FTD. The ongoing FTD process therefore frustrates actors due to differing interests between policy advocates and actors at service delivery level.

The next chapter considers experiences from two rural sub-districts where intersectoral approaches to the FTD were widely accepted in bureaucratic spaces.

CHAPTER 7:
THE FTD INITIATIVE WITHIN JOINED-UP GOVERNMENT APPROACHES

7.1 INTRODUCTION

The development of policies that require intersectoral approaches such as the FTD initiative is a challenging and complex process. Previous chapters demonstrated how the intersectoral FTD initiative received political and bureaucratic attention in early stages but later became re-formulated as a vertical health-focused initiative. Drawing on policy analysis methodologies and theories, Chapter 6 showed how the loss of intersectoral mandates was influenced by the interaction of unclear ideas regarding FTD interventions, the prioritisation of vertical health-based initiatives, organisational constraints such as limited capacity and ongoing priorities of the provincial Health Department and divergent interests amongst actors. The main purpose of this chapter is to analyse the particular instances where, contrary to the rest of the Province, an intersectoral approach to FTD was achieved. This occurred in sub-districts that were experimenting with approaches to joined-up government referred to as 'Better Spaces' and the 'Whole of Society Approach' – WoSA.

This chapter draws on interviews with key informants involved in Saldanha Bay FTD activities, observations of WoSA team meetings and document analysis described as part of the data collection process of Phase three in Chapter 3. This chapter will begin by outlining the Better Spaces and WoSA processes in the Drakenstein and Saldanha Bay sub-districts focusing on how the FTD initiative emerged and was formulated within these areas. This narrative will show how the FTD initiative received wide acceptance and maintained its intersectoral focus in contrast to vertical health-based FTD iterations shown in Chapter 4. The chapter will then analyse the collaborative elements within the WoSA that allowed intersectoral processes of the FTD to take hold, drawing on the collaborative governance propositions from the Ansell and Gash framework (Ansell & Gash, 2008).

The overall goal of the chapter is, therefore, to explore the mechanisms required to ensure a widespread commitment to intersectoral initiatives using the FTD experience.

7.2 OVERVIEW OF FTD-RELATED ACTIVITIES IN DRAKENSTEIN AND SALDANHA BAY

Figure 6 provides an overview of the start of the Better Spaces Approach and its transition to WoSA as well as the FTD activities specific to the Drakenstein and Saldanha Bay regions. The aim of this figure is to link the provincial FTD process, particularly its prioritisation provincially, with unfolding events in Drakenstein. The figure also displays how the PSG 3 committee was at the centre of both the provincial and, later, WoSA emergence. Each of the events displayed are discussed in more detail below.

In 2015, while the FTD was in its early stages of policy development at the provincial level, a number of activities were unfolding in the Drakenstein sub-district where the integrated service delivery model, known as Better Spaces, was being piloted. The Drakenstein sub district, situated in the Cape Winelands district of the Western Cape was selected as a pilot region for Better Spaces due to a range of socio-economic challenges which mirrored that of Saldanha Bay (chapter 3). With a population of 284 475 in 2019, the total population in the Drakenstein area is expected to grow to 301 349 by 2023, equating to an average annual growth rate of 1.5% (Western Cape Government, 2019 c). This increase in population would predispose the region to increased need for government services and pressure on existing infrastructures. The population growth trends along with high incidence of drug-related crime, increasing levels of unemployment and poverty, required appropriate attention in the sub district (Western Cape Government, 2017 b)

As a result, the Drakenstein Better Spaces pilot was an attempt to operationalise the third Provincial Strategic Goal – PSG 3 – of the PSP which aimed to 'increase wellness and safety and tackle social ills' through the PSG 3 Committee, described in Chapter 4 (Western Cape Government, 2014; Besada & Daviaud, 2018). Two of the key provincial champions of the FTD initiative from the Health Department were active participants in PSG 3 Committee meetings up to 2017, drawing attention to the FTD initiative through early advocacy and lobbying at provincial level. When the PSG 3 Committee approved the inclusion of the FTD as one of the focus areas within the PSG 3 activities, it was therefore not surprising that the Drakenstein Better Spaces team selected the FTD as one of its core focus areas.

The PSG 3 goal of wellness involved ensuring physical, psychological, financial and social wellbeing that had to be achieved through partnerships across government sectors, civil society and the private sector (Western Cape Government, 2014). The Better Spaces pilot in

the Drakenstein focused on health and social interventions and was governed by an intergovernmental working group that included local government actors at sub-district level and NGO partners linked to the PSG 3 Committee (Besada & Daviaud, 2018).

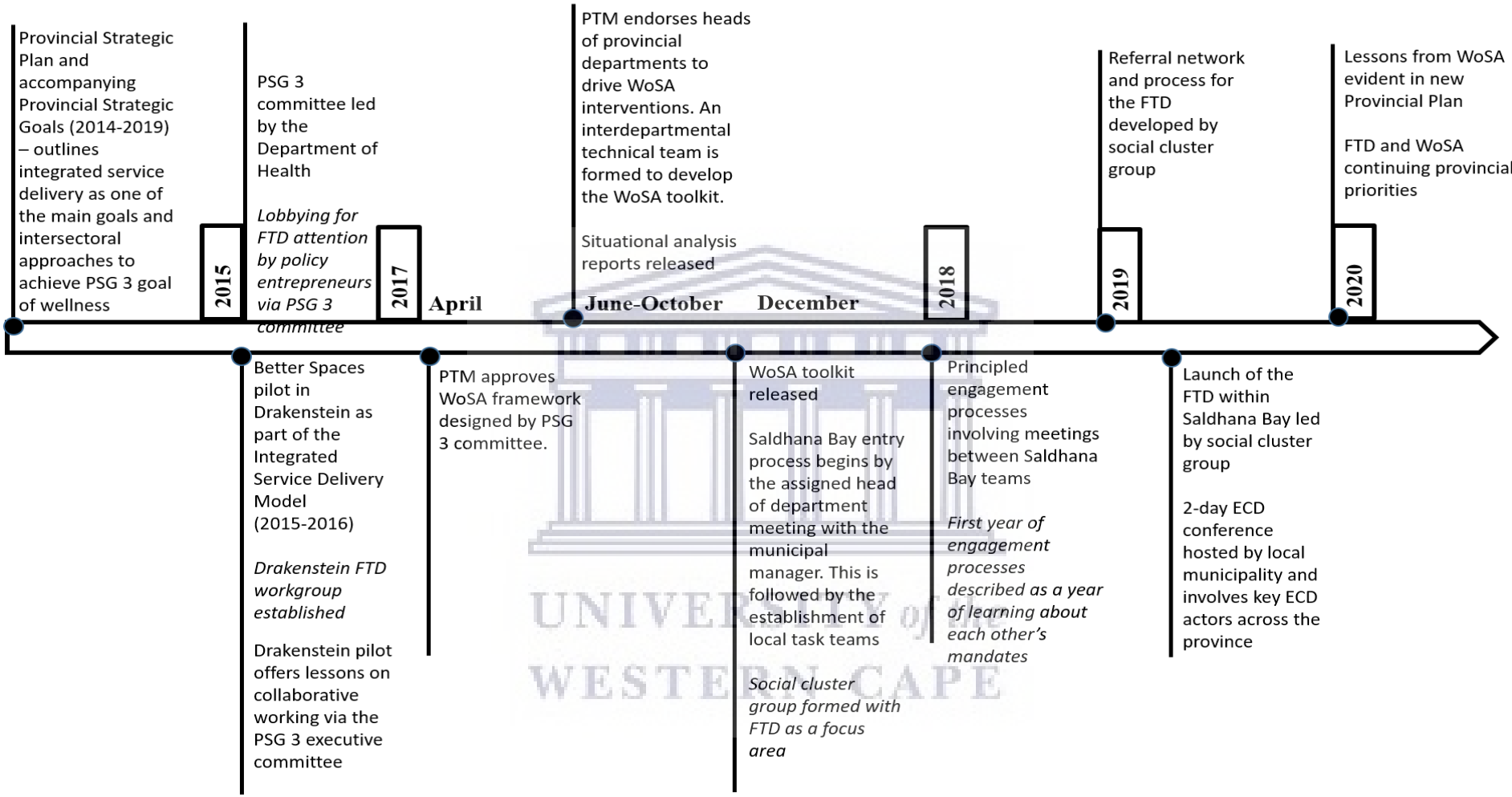

Figure 6: Timeline of Better Spaces Approach, Whole of Society Approach and FTD activities: 2015 - 2020

Some of the goals that the Better Spaces pilot hoped to achieve between 2015 and 2016 under PSG 3 included attention to streamlining ECD services, combating youth substance abuse, improving safety and developing programmes for the elderly (Besada & Daviaud, 2018). Another core activity included the establishment of a local Drakenstein FTD workgroup that consisted of actors from the sub-districts' Health and Social Development departments, as well as representatives of the local municipality and NGOs involved in ECD-related work. This Drakenstein FTD workgroup was linked to the PICH community and the FTD Executive Committee and has since been involved in a range of FTD-related activities.

In contrast to the loss of an intersectoral focus on the FTD initiative in other parts of the Province, the intersectoral activities of the Drakenstein FTD workgroup, together with the PICH, continued into 2017 and 2018 – including awareness-raising roadshows within the sub-district. During 2018, the workgroup and members of the PICH community, along with the FTD Executive Committee, began to develop the parent support package, which was seen as one of the successful FTD-related products produced by the Drakenstein team. Other core FTD activities in which the workgroup was involved included workshops related to the new national Road to Health booklet and the Side-by-Side campaign (National Department of Health, 2018, 2020).

In the meantime, in late 2016 towards the end of the Drakenstein pilot, insights that emerged regarding the opportunities and challenges of intersectoral working were shared and discussed through the PSG 3 Committee. These lessons included the necessity of a wider intersectoral approach to address challenges of unemployment, poverty and safety. In addition, the Better Spaces experience signalled the role and positional power that sector managers could harness to initiate and manage collaborative efforts (Besada & Daviaud, 2018). As a result, the PSG 3 Committee advocated for a broader intersectoral approach – the WoSA – that stretched beyond the health and social sectors. A detailed WoSA framework was then developed by the Whole of Society Technical Team linked to the PSG 3 Committee. This WoSA framework was sent for approval to the Provincial Cabinet in the early months of 2017, and was later approved by the Cabinet in April 2017.

Later in 2017, the Provincial Transversal Management mandated an inter-departmental technical team to develop a toolkit to assist the designated heads of provincial sectors to implement and sustain the WoSA in each of four prioritised geographical areas. In the toolkit the WoSA was framed as a co-created and collaborative endeavour between provincial

government sectors and local municipalities and was to be piloted in two rural sub-districts (Drakenstein and Saldanha Bay) and two urban sub-districts (Khayelitsha and Hanover Park/Manenburg) (Western Cape Government Whole of Society Technical Team, 2017). The goals of the WoSA were linked to broader policies and frameworks at all levels; the SDGs, the country's NDP, the PSP and Integrated Development Plans of local government (Western Cape Government Whole of Society Technical Team, 2017). General WoSA plans outlined in the WoSA toolkit for each region included the assignment of heads of provincial departments to lead each area and an entry process into each community that would be guided by the local municipalities (Western Cape Government Whole of Society Technical Team, 2017).

The Saldanha Bay WoSA process, which progressed much quicker than the process in the Drakenstein, began at the end of the 2017, and was led by the head of the provincial Health Department along with local municipal players. One of the earliest activities in Saldanha Bay was the establishment of strategic focus areas and accompanying teams, as documented in the Saldanha Bay WoSA framework of action (Western Cape Government, 2018b). The WoSA entry process in Saldanha Bay, driven by the newly established local WoSA teams, began as the FTD process at provincial level was losing its intersectoral focus.

In Saldanha Bay, the WoSA strategic focus areas that emerged from discussions within local teams were initially framed as social wellness, education, and urban reconstruction and economic development (Western Cape Government, 2018b); these were later reformulated as the social, economic, governance, safety and spatial clusters (Figure 7 and Figure 8). The FTD process in Saldanha Bay emerged as one of the focus areas of the WoSA social cluster group and became one of the core anchoring ideas of the WoSA network. The Saldanha Bay social cluster group was led by a senior official from the provincial Department of Social Development and consisted of actors from various provincial departments that included health, social development, community safety and education.

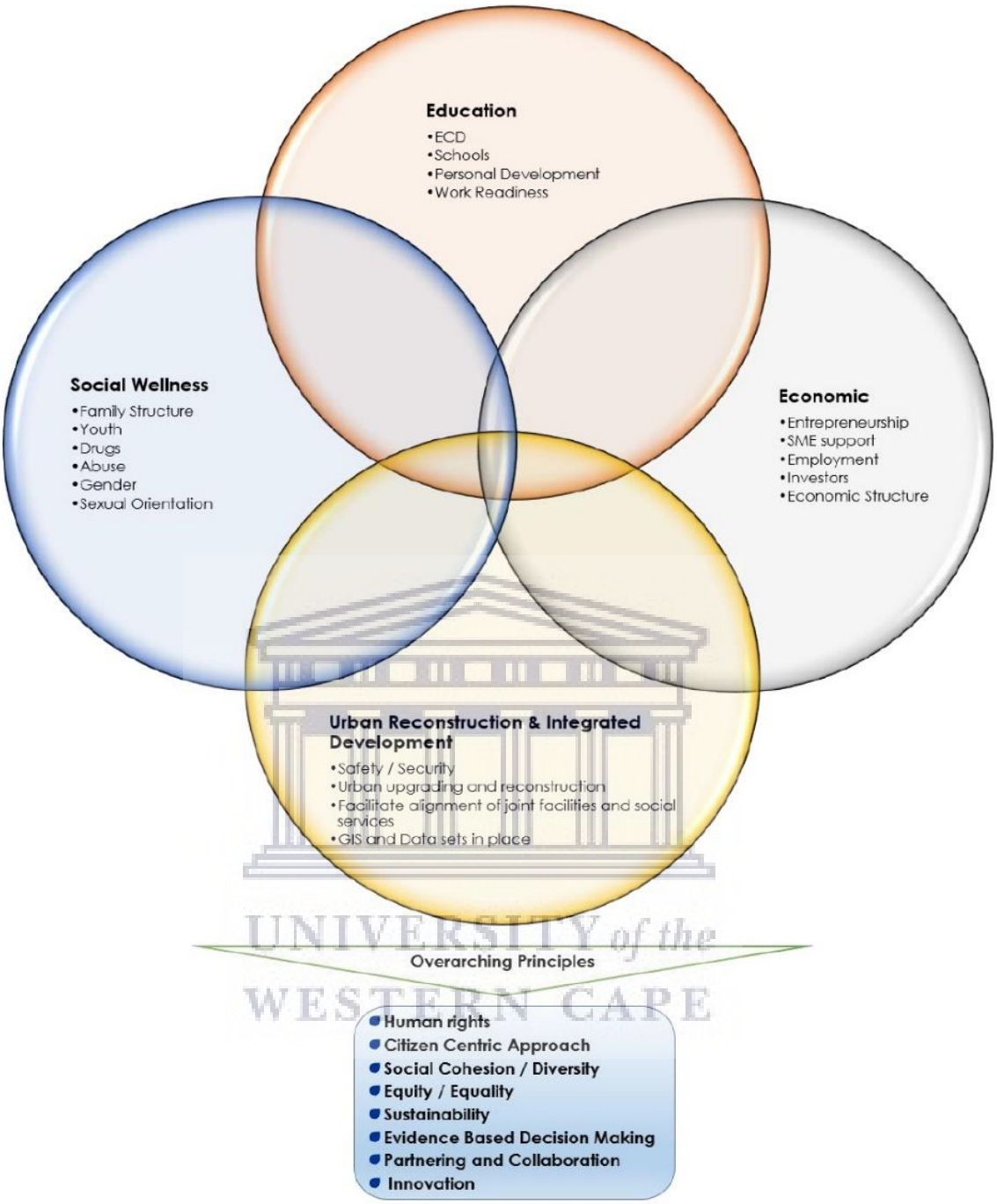

Figure 7: Whole of Society Approach initial strategic focus areas
(Western Cape Government, 2018, page 17)

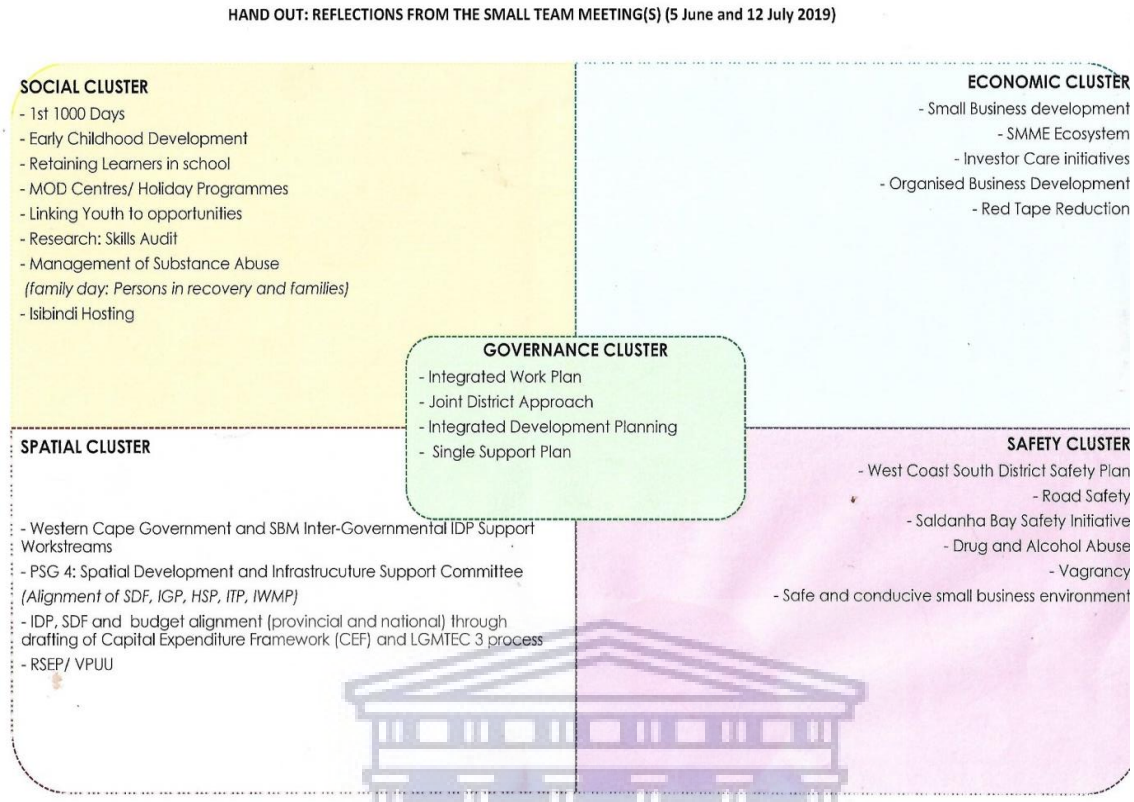

Figure 8: Social, Economic, Safety, Spatial and Governance clusters from the Small Team meeting (July 2019)

The FTD initiative in Saldanha Bay was launched in 2019 by the members of the WoSA social cluster group, mirroring the earlier political support and prioritisation of the FTD at provincial level in 2016. This was followed by the establishment of a referral network between core sectors involved in pregnancy and early child care. The referral pathway was a co-created endeavour between four core provincial departments of Health, Social Development, Education and Community Safety, reflecting a commitment towards intersectoral processes in the social cluster group.

Later in 2019, an ECD conference held in Saldanha Bay and hosted by the local municipality was viewed as a significant event. This was mainly due to the convergence of numerous multi-sector actors and stakeholders interested in addressing challenges related to ECD (Saldanha Bay Municipality, 2019). The conference was seen as the beginning of intersectoral relationships between both local Saldanha Bay actors and provincial actors, including members of the FTD Executive Committee who attended the event. As one of the interviewees put it: *'I think first thousand days, the fact that we have the document now*

saying these are the steps that we take, one, two, three and this is how we going to monitor to see whether it works. I think we are in the process of taking it a bit further. With the ECDs the momentum that we had ..there was the conference. It was a really good conference and I think that is a start'.

7.3 WIDE ACCEPTANCE OF INTERSECTORAL FTD PROCESSES WITHIN WoSA SITES

Considering that the FTD was an idea that had emerged from the PSG 3 processes, some viewed the transition of the FTD initiative into WoSA sites as a natural progression of events that was made possible by the acceptance of intersectoral processes. It was not surprising, then, that the idea was subsequently adopted by the social cluster group in the Saldanha Bay WoSA:

> *"First 1,000 Days emerging as a project in Better Spaces, and because Better Spaces shifts to WoSA, FTD then becomes incorporated into the same space."* (Interviewee 17, health sector)

In follow-up interviews, one of the key champions of the FTD identified WoSA spaces in Saldanha Bay as enabling "*a sort of safety net, a basket, a holding space, a safe space among all sectors to say "Let's work together*" " (Interviewee 12). In addition, there was a general perception among key informants that the rural Drakenstein and Saldanha Bay spaces, with fewer role players and lower complexity, were more favourable for the implementation of FTD-related activities than the urban sites. An example of how favourable Drakenstein was emerged during the development of the parent support package:

> *"We were going to do it [develop the parent support package] in Khayelitsha and Paarl East, and we started with this in Paarl East and in Khayelitsha. It just got really tricky and time consuming. So we decided to pause it there and just do it for Paarl East. And we completed it. We got good support from the Drakenstein First Thousand Days working group and we developed it and completed it."* (Interviewee 13, health sector)

Interviewees attributed the intersectoral FTD support to the wider initiatives to foster intersectoral collaboration in Saldanha Bay and Drakenstein.

In the rest of this section, I explore elements in the collaborative WoSA space that created the 'safety net' for actors to engage with the intersectoral FTD agenda. These elements are

addressed through the five propositions from the collaborative governance framework by Ansell and Gash (Ansell & Gash, 2008) focusing on starting conditions, facilitative leadership, institutional design, collaborative dynamics and outcomes – each being addressed in a separate sub-section.

7.3.1 Starting conditions of the WoSA collaborative process

This proposition focuses on the starting conditions of collaborative processes that can either facilitate or discourage collaboration. This includes power imbalances between stakeholders, incentives to collaborate, and any prehistory of conflict or co-operation among stakeholders. There is a recognition that this set of factors can influence the levels of trust, conflict and social capital that drive the momentum of collaborative endeavours (Ansell & Gash, 2008).

The impetus to collaborate and to implement the WoSA approach were triggered by the existing socio-economic challenges within the province and in Saldanha Bay which pushed actors to work in a collaborative way. Key challenges in Saldanha Bay outlined in its WoSA framework document included the following:

> *'The drug problem must be alleviated; Basic living standards need to be improved upon; Greater access to employment must be made; Racial inequality needs to be addressed; Greater access to education for children must be made; Creating a better future for the youth must be realised; Envisaged economic development in the region must be realised; Dealing with the reality of corruption, nepotism and mistrust must be undertaken.'* (Western Cape Government, 2018, page 8).

While the planned industrial developments linked to Saldanha Bay's deep sea harbour created economic opportunities, key informants also anticipated new social disruptions in Saldanha Bay arising from an economic boom, such as a rapid increase in population, crime and violence (Western Cape Government, 2018b).

In addition, policy frameworks such as the SDGs, the NDP and the more local PSP and their accompanying goals provided the mandate to collaborate. These were reiterated in a number of WoSA-related documents, including the Saldanha Bay WoSA framework of action which also stated that existing policy frameworks mandating the need to collaborate should be aligned (Western Cape Government, 2018b).

> *'International, national, provincial and local policy environments increasingly focus on integrated problem identification – collaborative and whole of society solutions as strong common threads.'* (Western Cape Government, 2018, page 4)

Moreover, the WoSA process did not start from a blank slate as it was able to draw on past collaborative endeavours between the provincial and local governments, such as the Regional Socio-Economic Programme, the Better Spaces project and the Mayoral Urban Renewal Programme (MURP). These offered pre-existing platforms and developed networks of stakeholders, providing the momentum and energy which WoSA could leverage. For example, actors involved in the Better Spaces pilot had engaged with social cluster activities involving ECD, as well as the FTD, which offered small wins that the emerging WoSA network could draw on.

At the same time, lessons from the MURP experience and others also offered insights into navigating collaborative relationships and tensions that the WoSA approach could consider. This included the difficulty of community engagement, sustaining attendance and momentum of stakeholders, and the time and effort it took to achieve set targets.

In the early stages of the WoSA the buy-in of heads of all 13 provincial sectors was viewed by interviewees as being key to addressing the perceptions of power imbalances between sectors. This enabled the experience of equality amongst actors from different departments within WoSA. One of the interviewees reflected as follows on the impact of the buy-in of provincial department heads in alleviating power imbalances:

> *"Sometimes, you know, the Department of Health is quite big. There are 32,000 plus staff. The smaller government [departments] sometimes felt..[that]..the Department of Health is this big brother that comes in here and tells everyone else what to do and then [they] can immediately say "You are not my line manager and I will decide what I will do. ...and do not come and tell me what I must do or prioritise!". And so that was kind of the feel I got and there was no-one from above that said "This is now the way we are going to do business"... For me this is the turning point. There is buy-in from above, at the department level [referring to heads of provincial departments] and they must also give feedback on their levels."* (Interviewee 43, health sector)

The approval of heads of provincial departments also provided the mandate that authorised stakeholders to participate in WoSA, especially those at lower levels of government sectors.

Other accompanying factors, such as clear governance structures, also drew participants into WoSA. This was enhanced by the endorsement of the WoSA approach by the provincial Minister of Health and the Provincial Cabinet.

7.3.2 Facilitative leadership as a driver of intersectoral processes

Facilitative leadership is necessary for driving action and contributes to effective collaborative governance (Ansell & Gash, 2008). In the WoSA network, careful processes, referred to by Emerson (2018) as 'principled engagement', were followed. These involved a series of face-to-face meetings between actors led by key senior managers such as heads of provincial departments and district managers from various sectors. For example, the social cluster group in which the FTD was embedded was led and actively championed by a senior official from the Social Development Department. This role entailed chairing team meetings and then communicating objectives and representing the views of the smaller project teams to higher governance structures i.e. WoSA executive meetings. The active and regular attendance of senior managers at WoSA meetings showed a consistent commitment to the process that many considered positive. Officials who were not as senior felt that access to senior managers within WoSA structures was different to previous collaborative efforts and, in many ways, legitimised the WoSA collaborative process.

The ongoing attendance and commitment of senior officials also meant that they had to juggle the political agendas and tensions at provincial top management structures while continuing to sustain momentum in local WoSA teams. This brokerage role between different governance levels was a key facilitating role for WoSA leaders that required time, resources and particular skills.

Another influencing factor was the personality of particular leaders which enriched the process. One particular leader from the local government was known for being *"charismatic"*, *"friendly"* and *"enthusiastic"*. These traits, along with his visible actions such as wearing a 'WoSA' t-shirt during a number of meetings, motivated the group and made meetings positive and cheerful. It was also evident that some leaders were cognisant of the challenge that their departure would present to the sustainability and transition process. They tried to mitigate this and by including in meetings officials from their sectors who were junior to them, to ensure continuity of the process.

The facilitating role of leaders was assisted by the use of what Ansell and Gash refer to as '*instruments*' (Ansell and Gash, 2012). This includes problem framing and definitions that leaders deploy to enable stakeholders to appreciate the relevance of collaboration and to win over stakeholders (Ansell and Gash, 2012). An example of this was the use of the 'Carol and Lindi' story, a story line developed by members of the PICH group of a mother and child living in an ideal state with the necessary tools, opportunities and appropriate services to cater for their needs. The use of this story by leaders in most engagements was powerful in winning over stakeholders to the idea of collaboration and to promoting a sense of interdependence between sectors. This story line and accompanying rhetoric (such as viewing WoSA as a 'way of doing things') served as the prompt for stakeholders to view collaboration as an innovative approach to complex problems within resource-limited contexts. In a number of interviews conducted, key informants often repeated the Carol and Lindi story, as well as the view that WoSA symbolised a new way of doing things, showing that these ideas were widely accepted in the network.

The facilitative role of key leaders was enhanced by a number of supportive actors who kept the momentum going through various activities. These included boundary-spanning across WoSA regions and team meetings, keeping up with deadlines and activities, arranging meetings and venue spaces and holding stakeholders accountable for activities they had to deliver. These boundary-spanning actors, who were called 'learning champions' in WoSA spaces, included actors who were linked to the Drakenstein FTD workgroup as well as other WoSA sites in the Metro area. Other institutional actors, such as the Economic Development Partnership, offered valuable facilitating roles for a number of engagements, especially amongst frontline providers.

7.3.3 Institutional design

This proposition points to the necessity of basic protocols and rules that ensure procedural legitimacy of the collaborative process and enable the capacity for joint action (Ansell & Gash, 2008). The capacity for joint action within WoSA was enhanced by clearly outlined procedural and governance arrangements – made available at the early stages of the WoSA framework of action for Saldanha Bay – which provided terms of reference for set governance structures (Figure 9) with a level of flexibility for each geographical area and which recognised past intergovernmental structures (Western Cape Government, 2018b).

The WoSA governance at the political level comprised a committee of the Mayor of Saldanha Bay Municipality – SBM – and the ministers of all the lead departments for the Saldanha Bay area. At an executive level, the steering committee was structured to provide policy and strategic direction to the SBM WoSA, guided by the heads of provincial departments and the Municipal Manager of SBM. At a co-ordination level, the SBM WoSA Co-ordinating Committee, led by the SBM Municipal Manager and comprising representatives of the lead departments, was established to monitor and evaluate the WoSA. On the programme level, the strategic focus area workgroups were designed to develop programme implementation plans and report on progress to the SBM WoSA Co-ordinating Committee. These plans, which include specific projects would be implemented by specific project teams.

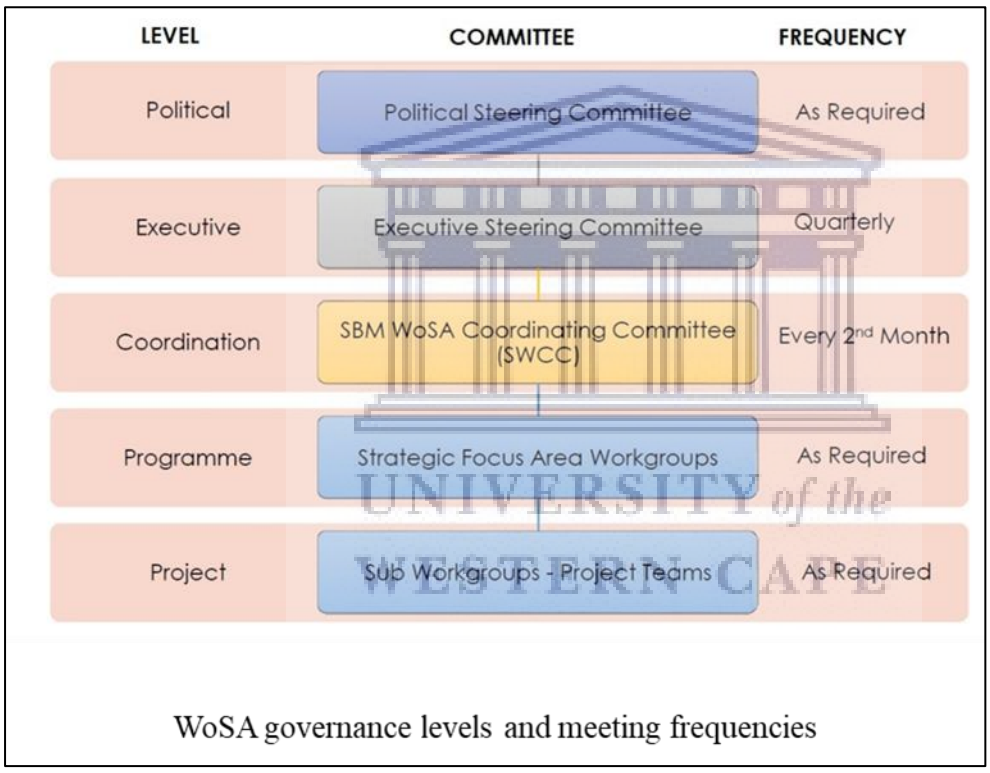

Figure 9: WoSA governance levels in the Saldanha Bay Framework of Action

The designation of formal governance arrangements for WoSA allowed for the integration of WoSA activities into reporting channels of sector-specific structures. This would be done through the inclusion of WoSA into performance agreements of heads of provincial departments and the creation of sector-specific reporting systems for intersectoral activities:

> *"So I think the governance was sound and the governance was thought of and there was a well thought through strategy, that Whole of Society strategy. And there is a narrative*

written about it and then the commitment – and then people are held accountable. So, basically, because it is supported [by] priorities, my head of department said ... it gets reported. If I don't attend the WoSA then he gets informed that .. his department[is] not there." (Interviewee 37, Department of Community Safety)

"As a result, in our department, the Whole of Society formed part of our time reporting. We have reports that we normally submit every six months. The WoSA has a slot there and so I am reporting on all the programmes that Education is involved in. And as a result it also strengthens the provincial office in terms of stakeholders because they also have a responsibility to work closely with the municipality" (*Interviewee 42, Department of Education)*

The value of learning and knowledge generated within WoSA governance teams was highlighted as one of the successes of WoSA. Knowledge generation emerged through the frequent, structured meeting processes that allowed for reflection, learning and sharing from a range of stakeholders. These spaces allowed interviewees to identify what they termed 'potential linkages' across different sectors to solve complex problems. Knowledge generation within collaboration spaces made stakeholders feel safe to ask for assistance for issues they faced within their day-to-day mandates.

Another early recognition by WoSA Technical Team was the value of joint information sharing as the basis for determining appropriate responses and planning processes. This was shown by selecting focus areas based on a situational analysis report (Western Cape Government, 2018b). One of the identified challenges of siloed bureaucracies was the vertical collection of data and resulting sector-specific strategies that were not feasible for addressing multi-dimensional socio-economic challenges. Early WoSA plans therefore centred the notion of "integrated data processes that cut across spheres" (Western Cape Government, 2018b) with the goal to develop a common data repository that compiled indicators from a number of sectors. In addition, the data and generated information was used to illuminate challenges that frontline workers were facing as well as incentivise stakeholders to join the collaboration process.

A similar contributing factor to the capacity for joint action was the ability of stakeholders to share resources which was particularly useful for the social cluster group. This included sharing venues for workshops or meetings and co-ordinating transport across sectors for

frontline providers accessing the same communities. This was particularly helpful for sectors without a broad infrastructure of frontline workers and activities such as the Department of Cultural Affairs and Sport, as this enabled them to access community areas through the networks of other sectors such as the Department of Social Development.

7.3.4 Collaboration process

Collaboration dynamics are the unfolding and iterative interactions among stakeholders that lead to collaborative outcomes; this involve communication, the generation of commitment and shared understanding. The interaction of these elements is important during all the stages of collaboration (Ansell & Gash, 2008). At the time of data collection, WoSA processes in Saldanha Bay had been underway for only two years and face-to-face engagement processes amongst participants were still in their early stages. This section therefore draws on early insights of the collaboration process among participants.

WoSA engagement processes consisted of face-to-face meetings between actors in the newly established multi-level governance structures (Figure 9). Participants in these meetings represented a range of government sectors including the municipality, private sector actors and civil society. It was evident through the observation of WoSA meetings that there was a considerable overlap of actors who attended meetings at various levels of governance.

One of the topics that arose in the WoSA engagement meetings was the need for similar forms of engagement with private sector actors in order to identify points of connection or mutual understanding. While having a significant impact on economic activities, private sector organisations were implementing a number of social responsibility projects that were often duplicated by their counterparts and which were rarely linked to addressing community needs. The need to engage with private sector organisations remained an outstanding challenge for WoSA, however, as private sector actors were mainly concerned with profits and did not share the goal of addressing community needs that government actors were mandated to address. This made it difficult to consider how government sectors could work towards common goals with private sector organisations.

Key informants viewed WoSA engagement processes as a necessary first step to collaborative process to enable an understanding of the various sectoral roles and responsibilities. Learning about sector mandates was vital, especially as previous cross-sector engagements such as the PSG 3 fora had involved limited co-operation of specific sectors as

opposed to wide-spread collaboration. Understanding each other's roles and identifying points of mutual connection between sectors was mentioned as crucial in supporting the response of government sectors to community needs.

Actors who were involved in WoSA meetings expressed that frequent face-to-face engagement spaces enabled the building of trust and relationships between stakeholders. Relationship building, learning and adapting were principles that featured in the design principles of the WoSA approach defined by the Saldanha Bay WoSA team (Western Cape Government, 2018b) and re-iterated in WoSA learning events (Western Cape Economic Development Partnership, 2019).

The relationships that developed between actors meant that meeting spaces gradually became safe platforms for discussing complexity such as implementation challenges facing frontline teams. This was valuable for interviewees who felt that the usual bureaucratic government spaces rarely provided these kinds of opportunities to reflect and understand the complex realities at service delivery level:

> *"The other thing that WoSA has managed to do that is often taken for granted is to create that safe space for people.. to say honestly "I feel I failed here and this is why but help me". And so that kind of discussion is not often tolerated in provincial government. We have no appetite for failure."* (Interviewee 44, Department of Transport and Public Works)

The ability to express frustration and engage with others in open and safe spaces was energising and stimulated commitment to the process for a number of interviewees. Some identified the shift from feeling obliged to attend WoSA meetings in the beginning to enthusiasm at the prospect of an upcoming WoSA event.

Key informants identified a number of outcomes of the collaboration that were attributed to valuable relationships and the creation of safe engagement spaces. The WoSA network and relationships enabled rapid decision-making that would have taken longer in the past. An example of this was the ease of finding a temporary venue allocated by the local municipality after one of the clinics got burnt during a protest:

"During (a) protest (at the) end of last year... they burned down the clinic in Diazville in Saldanha Bay and we ... decided to get the site back in Diazville … And only [one] phone call and [an] email later, [the] municipality allocated a site… So in the past I could guarantee you it will not happen [but] because of us working now so closely together via the WoSA approach and we know each other and they do understand our situation now. It was as easy as pie to get a piece of land that we can now temporarily build our structures on. It was as easy as that." (Interviewee 43, health sector)

One of the other resulting outcomes linked to understanding each other's mandates included reducing duplication of interventions targeting similar communities. In addition, WoSA relationships provided the 'currency' that allowed collaborative spin-off activities outside of primary WoSA activities. School visits, which were previously conducted by individual sectors, became a combined endeavour between the departments of Education, Social Development, and Cultural Affairs and Sport. Moreover, because of the network stakeholders also felt comfortable in going beyond their primary mandates to assist their fellow team members.

Evidence of shared understanding among WoSA actors was seen in the similarity of terminology and language used across interviewees – such as the reference to WoSA as a philosophy, which was echoed by many of the interviewees. This understanding was coupled with sentiments that avoided defining WoSA as a project or a vertical initiative demonstrating common values between stakeholders. Moreover, the FTD and the Carol and Lindi story featured in a number of meetings and WoSA events and these became anchoring ideas used to support the necessity of collaboration and the value of preventative action.

On the other hand, challenges that faced engagement processes included stakeholders feeling protective over their individual government sector mandates at early stages:

"In the start there is some egos involved, and when you deal with senior managers and it is egos and sometimes you move out of your boundary – and there is, like, the things you get sometimes, like you [are] stepping on my toes and this is my area. But that was in the start and it happened a few examples of that" (Interviewee 37, Department of Community Safety)

Similarly, there were divergent views about how quickly the WoSA network would progress to actionable objectives. Some interviewees expressed the feeling that relationship building

activities took a significant period of time as opposed to working on tangible activities. This was associated with the fear that it would discourage stakeholders if the network failed to achieve the set objectives, while others thought ascertaining tangible objectives would be a good test for how effective the WoSA network was.

> *"What initially happened for two years.,. we've worked on building relationships which is great but ... I think many of the members have articulated that ... we had to start doing something. We also needed to understand, although we have good relationships we also need to challenge each other. We mustn't now say "You know I don't want to say this is not working because we must have good relationships". When you have good relationships you will be able to talk to each other and say "Listen, this is not working" – but also be open to people saying to you this is not working. But I think it was a bit of a frustration because it took long for us to come and start doing things."* (Interviewee 38, Department of Social Development)

7.3.5 Intermediate outcomes: re-emerging intersectoral FTD goals within the WoSA approach

In summary, one of the main outcomes of the WoSA approach and specifically the social cluster group was the set of intersectoral FTD activities that have been highlighted in 7.1 above. Although intersectoral FTD processes were in early stages of development, this effort demonstrates the social cluster group's significant commitment by to working intersectorally. The social cluster group was cited as the most developed team out of all the five clusters. Some of the informants linked its successes to the wide reach of sectors involved in community spaces and service delivery at the frontline (i.e. departments of Health, Education and Social Development). Actors in these sectors were better positioned to work together due to the proximity in community spaces. Future WoSA plans involved a better integration of social cluster activities with the other clusters.

Similarly, earlier sections demonstrated that the commitment to intersectoral approaches for the FTD initiative was enabled by favourable starting conditions, positively influenced by past collaborative endeavours. Moreover, leaders of WoSA ensured valuable engagement spaces assisted by boundary spanning actors and the use of appropriate problem framing and definitions. These factors coupled with clear governance structures and procedural processes offered legitimacy to the WoSA engagements which significantly shaped the collaboration process.

Lastly, face-to-face meetings over a period of time ensured relationships, trust and shared understanding amongst actors were built which sustained momentum in the processes.

7.4 CHAPTER SUMMARY

This chapter has described the intersection of the FTD initiative with Better Spaces and the WoSA. It has explored elements within these spaces that allowed for the wide acceptance of intersectoral processes for the FTD initiative among bureaucratic actors. Similarly, I draw attention to the formulation of intersectoral FTD processes within the social cluster WoSA group led by the social development sector. Further, the development of tangible interventions such as referral networks for at-risk mothers and the ECD conference signal beginning of a much wider intersectoral focus and goal than vertical health-based interventions shown in Chapter 6.

This chapter showed the beginning of intersectoral commitment to the FTD in a sub district experimenting with the WoSA where the FTD was only one activity amongst a broad range of other intersectoral agendas. The findings in the chapter are limited as they did not outline core activities regarding the success of the FTD initiative or specific ECD activities undertaken other than the formation of a referral network and the ECD conference. This is due to the data collection period that took place two years after the WoSA process had began and the same year the FTD initiative was launched in Saldanha Bay. Therefore, the findings reflect an early commitment to collaboration and could not explore whether significant outcomes of the FTD had been met or not. Despite this, the value of early bureaucratic commitment to intersectoral action provides early considerations for what can enable intersectoral agendas in health systems.

Through collaborative governance propositions, this chapter outlines the value of adequate starting conditions, facilitative leadership, and appropriate institutional design elements on facilitating collaborative processes (Table 12). However, the FTD initiative in WoSA processes also offers complexities that intersectoral processes need to consider which include the time and effort to manage engagement processes, remaining debates regarding engagements with the private sector as well as how to navigate resistance of collaborative processes within bureaucratic spaces.

The next cycle of the PSP – 2019-2024 – shows the adoption of the WoSA approach by the provincial government as a way of addressing a number of focus areas. This includes the

FTD, which remains a continuing provincial priority for the next five years. The new PSP acknowledges the necessity of long-term and holistic strategies to address the FTD (Western Cape Government, 2019b). It is yet to be seen whether this commitment to the FTD, along with collaborative approach of the WoSA as a way of addressing interventions, will enable sustained momentum to intersectoral FTD processes.

Table 12: Collaborative governance elements

Collaborative governance propositions	Factors from the FTD-WoSA process
1. Starting conditions of collaborative process	- Existing policy frameworks stressed the need for collaboration. - Previous collaborative endeavours offered WoSA networks, lessons and incentives, especially the Better Spaces pilot and accompanying Drakenstein FTD group. - Involvement of heads of provincial departments and clear governance structures mandated the WoSA. This enabled equal engagements of government actors within WoSA thus reducing perceptions of power imbalances amongst actors from different government departments.
2. Facilitative leadership as a driver of intersectoral processes	- The brokerage role of leaders between different governance levels was a key facilitating role for WoSA leaders that required time, resources and particular skills, including using the FTD as an anchoring idea for the group. - The active and regular attendance of senior managers at WoSA meetings showed a consistent commitment to the WoSA process and included leading the social cluster group that formulated the FTD. - Access to senior managers within WoSA structures was viewed as different to previous collaborative efforts and legitimised the WoSA collaborative process. - Personality and enthusiasm of leaders valuable for WoSA engagements. - Facilitative role of key leaders was also enhanced by other supportive actors including boundary-spanning across WoSA regions and teams.
3. Institutional design	- Clear governance structures and accountability. - Value of learning and knowledge generated within WoSA governance teams was highlighted as one of successes of WoSA, aided by information sharing and relationships amongst actors. - WoSA reporting incorporated to day-to-day sector work which enabled the mandate to collaborate.

Collaborative governance propositions	Factors from the FTD-WoSA process
4. Collaborative process	- Valuable relationships and safe engagement spaces through consistent face-to-face meetings. - WoSA engagement processes viewed as a necessary first step to to enable an understanding of each other's sectoral roles and responsibilities. - The ability to express frustration and engage with others in open and safe spaces energised and stimulated commitment to the process. - Advantages of relationships included reduced duplication of services and spin-off collaborative activities beyond WoSA. - Evidence of shared understanding through similarity of language amongst interviewees and similar ways of viewing the FTD.
5. Intersectoral FTD processes as intermediate outcomes	FTD as one of the outcomes of the social cluster group and the FTD concept, including the Carol and Lindi story used to frame the need for collaboration within WoSA meetings.

CHAPTER 8:
DISCUSSION, CONCLUSIONS AND RECOMMENDATIONS

8.1 INTRODUCTION

In this final chapter, I discuss what the findings of this study offer for understanding the constraints of intersectoral collaboration and what can enable the creation of an environment that sustains intersectoral action. Based on the overall conclusions of the thesis, I provide recommendations for policy and future research and reflect on the limitations of this research.

There is still limited knowledge regarding how to develop and sustain intersectoral collaboration for health in settings across the world (Exworthy, 2008; Embrett & Randall, 2014). In this thesis, I posed the broad question of how an analysis of the FTD policy process might shed light on the dynamics of intersectoral collaboration. To understand the phenomenon of intersectoral collaboration I used a range of analytical approaches across various stages of the FTD policy process, from agenda setting to policy implementation over a five-year period (described in Chapter 4). I have shown how the political prioritisation of the FTD resulted from increasing global attention and a favourable provincial context that was grappling with how to address child safety. I describe how, despite this political prioritisation, attempts to operationalise the FTD in policies and practices were characterised by limited intersectoral processes and policy 'thinning' (Lehmann & Gilson, 2013) of intersectoral intentions for the FTD.

To understand what contributed to this policy thinning, I started by showing how policy documents had varied meanings and understandings of the FTD initiative. Chapter 5 highlighted the lack of agreement on interventions for the FTD in the text of policy, particularly the role of other sectors beyond health. After triangulating documentary sources, interviews and observation data, I then examined how the interaction of unclear ideas, vertical initiatives, institutional constraints and divergent interests between actors resulted in limited intersectoral efforts. Further, I described the re-emergence of intersectoral FTD ideas within the broad WoSA and explored collaborative governance factors that enabled the re-formulation of the FTD in later years.

Based on the key findings of this study, I have structured this chapter to focus on two sets of observations. The first section will discuss how the findings illuminate the challenges that face intersectoral collaborative endeavours and whether these insights align with experiences in the broader literature. In the second section, based on the empirical evidence in this study, I consider the factors and processes which might create an enabling environment for intersectoral collaboration.

8.2 CHALLENGES THAT FACE INTERSECTORAL COLLABORATION FOR HEALTH

Even for initiatives like the FTD that have widespread political attention and are supported by evidence, intersectoral collaboration cannot be taken for granted; a number of key obstacles may present themselves during the transitions in the policy process, from political prioritisation to implementation.

8.2.1 Agenda-setting processes of intersectoral initiatives

Policy studies on intersectoral collaboration have outlined agenda setting as a crucial stage in policy processes, and identified political attention as a key ingredient in facilitating attention to policy issues (Pelletier et al., 2012; Khayatzadeh-Mahani et al., 2017; Mauti et al., 2019). The initial FTD experience at early stages showed how intersectoral policies can receive political attention, through processes such as launches with top government officials, media attention and communication campaigns with the public; but that this level of attention does not guarantee success in subsequent phases of the policy process. As in the FTD experience, other case studies have shown how political attention to intersectoral action may be transient and can fade over time (Hoey & Pelletier, 2011; Khayatzadeh-Mahani *et al.*, 2016). Thus, although political attention is vital for ensuring that intersectoral reforms get onto the agenda, it is clear that political attention alone does not enable sustained action.

Based on the case of the FTD, it was also evident that what occurred in subsequent policy processes was determined by agenda-setting activities, including who was involved in the process or not, and how the policy issue was perceived by policy actors. The lack of involvement of all relevant actors across sectors and those tasked with implementation hindered the potential of the FTD. In particular, service delivery actors within the health system who were not involved in these early stages felt excluded and perceived the FTD initiative as an external agenda. As a result, they did not own the FTD initiative, creating a

barrier to further formulation and implementation. Similarly, when the health sector takes responsibility for an initiative, this may make it difficult for other sectors to get involved in policy processes, especially if these other sectors view the initiative as a health programme (Mahlangu, Vearey & Goudge, 2018).

8.2.2 Policy formulation

Although agenda setting can occur when solutions for the policy issue are not yet specified, the policy formulation stage of policy making requires operationalising the policy and agreement on specific policy solutions. Moreover, achieving the level of co-ordination required for intersectoral action rests on clear definitions of the policy problem in order to establish shared understanding amongst different partners (Percy-Smith, 2006; Emerson, 2018; Zaidi *et al.*, 2018). The quality and extent of policy problem definitions and solution specification can be an indicator of whether there is shared understanding of interventions or divergent goals amongst the relevant sectors who need to collaborate. A vague construction of the problem and solution, as shown within the provincial FTD experience, makes it difficult to establish the necessary partnerships and build consensus around shared goals, and slows policy momentum.

For policies requiring intersectoral action, identifying favourable policy solutions that can be implemented has been a well-documented challenge on account of differing interests and understandings of the policy problem among actors (Exworthy, 2008; Pelletier *et al.*, 2012; Bilodeau *et al.*, 2018). Consistent with findings elsewhere (Hoey & Pelletier, 2011; Pelletier *et al.*, 2012), the different understandings of the FTD were visible in both policy documents and in how actors perceived the issue. However, it was interesting that despite the range of possible interventions, actors ultimately chose to frame interventions as a binary choice between broad intersectoral interventions versus maternal and child health interventions. The tension between focusing on health-based interventions versus multisectoral efforts has also emerged in efforts that address nutrition (Pelletier *et al.*, 2012). The debate of 'health' versus 'other' also means that intersectoral action can be viewed by actors as the alternative or competitor to health interventions.

Debating broad versus narrow interventions can be a good opportunity to generate solutions if existing intersectoral forums allow for discussions and negotiations of possible intervention options (Pelletier *et al.*, 2012). However, in the absence of effective institutional mechanisms that allow the deliberation of available options, decisions are often made in ways that suit the

dominant organisation, which in the case of FTD was the health sector. Decisions regarding which interventions will predominate depends on the sector that controls the agenda and defines the policy problem as well as perceptions regarding the feasibility of interventions. This reduces the possibility of intersectoral action, as intersectoral approaches should ideally include interventions that encompass health and other sectors.

Another key hindrance to intersectoral collaboration is the prioritisation and policy framing of intersectoral policy issues as vertical, stand-alone projects, rather than tackling the core problems of siloed sectoral functioning. Verticalisation of policy mandates reflects how bureaucracies approach policy-making and is difficult to change or challenge (van Eyk *et al.*, 2017). Experiences in Australia and Iran (Baum *et al.*, 2017; Khayatzadeh-Mahani *et al.*, 2017) highlight how attempts to transition from vertical projects to institutionalised approaches can hinder intersectoral action. This may explain why despite the push for whole of government approaches within the Western Cape's PSP (Western Cape Government, 2014), the verticalisation of initiatives or projects within intersectoral planning processes was still the norm, making it difficult to think differently about new policy issues such as the FTD.

8.2.3 Policy implementation

Implementation of intersectoral action remains a challenging process that has affected a number of policy issues (Khayatzadeh-Mahani *et al.*, 2016; Sumner, Lund & Petersen, 2016; Kim *et al.*, 2017; Mauti *et al.*, 2019). Experiences elsewhere have shown how, despite prioritisation and political attention to intersectoral policy, intentions can end up in inactive planning committees (Hoey & Pelletier, 2011; Mauti *et al.*, 2019), poor implementation or even collapse after a few years (Hoey & Pelletier, 2011). The FTD experience prompts the reflection that initial political attention cannot on its own sustain collaborative action without bureaucratic commitment to action at multiple levels. Bureaucratic commitment requires the allocation of resources and the development of the necessary systems or platforms for integrated planning, as well as ensuring accountability for the implementation of set plans (Pelletier *et al.*, 2012; Burgess *et al.*, 2017; Kim *et al.*, 2017; Zaidi *et al.*, 2018). Without the necessary supportive resources, systems and structures, the FTD initiative experienced several setbacks that hindered implementation.

Policy implementation literature describes implementation processes as complex and messy and that it requires clear objectives and adequate resources (Orgill & Gilson, 2018). Implementation processes also engage a wide range of actors at the service delivery level where unclear policy objectives are interpreted in multiple ways. The lack of clear problem definitions of, and interventions for the FTD had consequences during implementation, resulting in versions of the FTD initiative that were different from the original intersectoral intentions. Unclear policy directives also affected NGO partners at service delivery level who struggled to identify how the provincial FTD initiative was different to their existing mandates.

Where there are unclear problem definitions, a framing of the policy issue in familiar terms, such as a biomedical or clinical intervention, provides a tangible and concrete way for actors to respond, even if it limits intersectoral action (Van Eyk et al., 2017). This was especially the case with FTD when the new policy issue was assimilated as an extension of health interventions such as immunisation or prenatal clinical services. This can occur when new ideas are introduced in the policy domain that actors find hard to understand. The potential for policy action to take a different course is limited when such frames become institutionalised as the assumed direction for policy (Van Eyk et al., 2017).

Bolivia's experiences in the implementation of nutrition programmes demonstrated how at local levels, national directives for action were difficult to implement in sectors where there was limited infrastructure or where local actors were burdened by unskilled staff, inappropriate policies for their contexts and other priorities demanding action (Hoey & Pelletier, 2011). Similarly, in India efforts to implement joint planning and co-ordination of health and nutrition programmes had limited success, due to the demands of sector priorities and heavy workloads (Kim et al., 2017). These echo the FTD experience, where the institutional constraints of the health sector influenced the actions of actors involved in the FTD initiative. The combination of large patient numbers, ineffective referral systems and inadequate skills for empathetic care, along with competing priorities of the health sector contributed to the ways in which service delivery actors prioritised collaboration. In addition, given the ambiguity surrounding FTD, implementation actors perceived interventions based on health sector mandates as the most feasible to implement and so supported ideas that were linked to the health sector. This led to a preference for health interventions over multi-sector efforts.

In summary, considering the available well-documented evidence on the various intersectoral approaches for the FTD (Chapter 5), the findings in this study confirm that intersectoral action is not hindered by the lack of solutions but rather the combination of ideological positions that actors and institutions hold, a lack of capacity amongst service providers, limited supportive structures including finances and human resources, and the lack of the necessary engagement spaces for negotiating differing interests. These factors made it difficult for the provincial FTD process to gain traction as an intersectoral mandate.

8.3 FACTORS THAT CREATE A FAVOURABLE ENVIRONMENT FOR INTERSECTORAL COLLABORATION

In the case of the FTD, despite the thinning of intersectoral agendas, the initiative re-emerged within the WoSA which was an experiment in joined-up government in four sub-districts of the Western Cape Province. The re-formulation of the FTD in the WoSA therefore offers some insights into factors that can enable intersectoral action, which I discuss below.

8.3.1 Initial conditions at the start of collaborative processes

The previous section in this chapter highlighted the value of negotiating common problem definitions and solutions for intersectoral action. Theories of collaborative governance also emphasise the significance of starting conditions that trigger collaboration (Ansell & Gash, 2008; Emerson, 2018). When considering the key starting conditions for the WoSA-FTD collaboration, the results confirm what others have found (Bryson, Crosby & Stone, 2015), namely that perceived socio-economic challenges provided the drive to collaborate. However, there were other factors that were key in the early stages of the WoSA process.

In addition to the need to address 'wicked problems', the FTD case showed that prior relationships and existing networks (such as the PSG 3 Committee) played crucial roles from early on in the WoSA collaboration. Collaborative governance propositions state that prior relationships and efforts to collaborate determine the levels of trust amongst collaborative partners (Bryson, Crosby & Stone, 2015). In this case, the evolution of the FTD initiative from early health-specific interventions to a later intersectoral version occurred within the PSG 3 Committee, while it was rethinking its approach to cross-sector work more generally. The ability of the same network to adopt an intersectoral approach showed an ability for learning within networks based on previous experiences. Moreover, new collaborative

relationships in the WoSA leveraged off the existing PSG 3 network, confirming the crucial role that existing networks can play at the start of new efforts to collaborate.

Similarly, one of the recommendations to sustain cross-sector collaborations is to ensure that these are institutionalised in existing systems and supported by clear governance structures, so that efforts to collaborate are not dependent on particular individuals or on structures that are outside the system (Rasanathan *et al.*, 2017). Institutionalising intersectoral action within systems can also support actors already committed to cross-sector working, while mandating those who are less committed to collaborate (Baum *et al.*, 2017). Besides ensuring that collaborative initiatives are institutionalised, the structure or forum under which the initiative is embedded needs to be committed to collaboration. Otherwise, as indicated earlier, such structures or platforms can be inactive or become a substitute for the lack of collaborative action (Hoey & Pelletier, 2011).

A number of collaborative governance frameworks consider formal agreements, mandates and governance structures as contributing factors to collaborative capacity (Ansell & Gash, 2008; Bryson, Crosby & Stone, 2015; Emerson, 2018). Formal agreements can include the purpose, mandates, designation of leaders and decision-making structures of the collaborative endeavour (Bryson, Crosby & Stone, 2015). In the WoSA case study, formal agreements and mandates were particularly influential in the early stages of the collaborative endeavour. Interviewees reflected on the role that these could play in collaborative processes that occur within broader institutional environments that are structured for siloed working and which have strict accountability processes for vertical mandates. Referred to as 'hard authorising' the presence of formal mandates to collaborate was considered an enabling factor for participation by mid-level officials, especially if collaboration was integrated within routine reporting systems and performance agreements.

Formal agreements were also important for ensuring the presence of high-level government officials in governance processes, a factor which set the WoSA apart from previous efforts to collaborate. The role of high-level government officials also appears to be influential in several other experiences such as the HiAP initiative (Baum *et al.*, 2013; Mauti *et al.*, 2019). Their involvement impacts whether or not political attention and commitment towards the intersectoral process is sustained (Mauti *et al.*, 2019). In the case of the WoSA, high-level government actors were influential in motivating the commitment of other officials, especially mid-level government actors, and ensured accountability for the collaborative

process. This aligns to recent literature which argues that the support from the high levels of the bureaucratic spheres is particularly important for intersectoral action, especially at the initiation stages (Rasanathan *et al.*, 2017).

8.3.2 Agreement on common goals of the collaborative process and framing of the problem

As extensively argued in this thesis, having an initial agreement on problem definitions is at the core of intersectoral collaboration and is an essential starting point (Bryson, Crosby & Stone, 2006; Ansell & Gash, 2008; Corbin, Jones & Barry, 2018). Ansell and Gash (2008) refer to a range of terms such as a shared understanding, common mission and shared vision, all of which imply that collaborative partners have to jointly articulate what they can achieve together. In the interviews documented in Chapter 7, actors often made reference to the WoSA as an approach to engaging the life course and not a specific project. The FTD was located within this broader idea, with interviewees frequently referencing the Carol and Lindi narrative, showing how cross-sector actors in this collaborative process had established common views of the collaborative process and of the FTD initiative.

The re-formulation of the FTD within the WoSA in a way that embraced collective interests of various sectors signals how framing of policy problems can be particularly useful for drawing other sectors into the collaborative process. Framing the FTD as part of a life course approach enabled its relevance in the wider space of collaborative action. Actors from various sectors were able to identify their roles within, and consider the impact of, the FTD period throughout the life course and where each of their sectors could contribute. This shows how frames can trigger the buy-in of various sectors by helping stakeholders identify the benefits of the collaborative process and where each partner can contribute to the desired goal. Framing problems and solutions in this way circumvented the challenge of unclear roles and responsibilities that has faced a number of collaborative endeavours (Sumner, Lund & Petersen, 2016; Mahlangu, Vearey & Goudge, 2018).

Successful intersectoral action rests on framings of the policy issue that are inclusive and embrace the collective interests of all partners. This implies that there is a need for spaces where negotiation of frames can occur. As framing contributes to the establishment of shared goals, the level of acceptability or shared vision amongst collaborative partners does not mean a complete agreement on issues but rather that partners should feel their interests are embraced to a sufficient extent in the shared goal (Bilodeau *et al.*, 2018).

Leaders have a particular role in facilitating processes that can generate shared goals within collaborative endeavours. The leadership roles that have been described for ensuring effective collaborative governance include framing the agenda, convening stakeholders, and structuring deliberations (Bryson, Crosby & Stone, 2015). In the FTD-WoSA case, the ability of leaders to draw attention to the goals of the collaborative process and to integrate the Carol and Lindi narrative within engagement spaces helped in shaping a common view of the policy problem. The WoSA experience also corresponds to findings elsewhere, namely that sustained negotiation, persuasion and mobilisation skills are key leadership capacities that enhance collaborations (Ansell & Gash, 2008; Nisbett et al., 2015; Rasanathan et al., 2017). Such skills seem to have been particularly useful for sustaining the commitment of stakeholders and enhancing communication and open spaces of engagement, thus stimulating shared understandings amongst collaborative partners.

8.3.3 Relationships amongst cross-sector actors and supportive spaces of engagement

Relationships emerged as a crucial currency for the collaborative action and were considered one of the key achievements of the WoSA process. These relationships were fostered through regular face-to-face meetings and deliberations over time, and were increasingly characterised by mutual understanding and respect and acts of reciprocity. These experiences draw attention to the value of the quality of relationships within collaborations. To sustain the collaborative process, a number of studies place relationships and trust at the centre of partnerships which are enabled by consistent engagements over long periods (Bryson, Crosby & Stone, 2006; Ansell & Gash, 2008; Manandhar et al., 2009; Emerson, 2018).

As a result of the formal governance arrangements described earlier, relationships amongst stakeholders within horizontal forms of networking provided the space to negotiate different perspectives of the policy issue between various actors. A number of policy experiences recommend the need for such cross-sector structures that promote dialogue and the negotiation of different views. These have been referred to as interdisciplinary committees, working groups (Stead, 2008) or policy networks (Zheng, De Jong & Koppenjan, 2010; Shearer *et al.*, 2016). Baum et al refer to ‘supportive bureaucratic policy networks’ that include senior and mid-level staff across sectors as a powerful way to facilitate cross-sector engagements and to bring about action on the SDH (Baum *et al.*, 2017). The ability of collaborative participants to form such relationships was enabled by what was termed ‘soft authorising’ which referred to informal agreements between managers and their subordinates

that supported collaborative partners to form ad hoc, informal and horizontal forms of networking across sectoral players.

Collaborative networks can also be valuable spaces for implementation actors at service delivery level. The initial provincial FTD process revealed the risks of implementing actors having limited spaces and opportunities to voice opinions on policy processes. This can lead to frontline actors interpreting and adapting policy in ways that can result in unexpected outcomes. Networks that include both bureaucratic actors and actors outside the government can also be advantageous for policy entrepreneurs in cases such as the FTD, as it avoids external actors being seen as outsiders and having limited decision-making power on proposed interventions. These networks could have benefitted actors such as the PICH in the early years of the FTD initiative. Spaces for negotiating different understandings with implementation actors from different sectors can take various forms, depending on the needs and the groups of actors involved; they could also exist at different levels of the system.

Supportive networks and spaces of engagement enable mutual learning amongst collaborative partners, necessary when knowledge gaps exist on how to address 'wicked problems' as well as how to sustain intersectoral action (Rasanathan et al., 2017). Thus, maintaining avenues of mutual learning and documenting such lessons within collaborative endeavours can strengthen implementation processes.

The facilitative role of leaders, brokers and champions within the WoSA process was key to ensuring that spaces of engagement remained open and safe to ensure continuous communication and to build valuable relationships among actors. This is similar to other experiences where boundary spanning actors were valuable in managing the communication, negotiation and planning elements of collaborative endeavours that maintained spaces of engagement (Pelletier et al., 2011, 2017).

In summary, the FTD in the WoSA represented a unique collaborative approach, because it was created within (geographical) spaces of exception to bureaucratic rules and norms of functioning. This ensured clear governance structures, attention to formal agreements and mandates early in the process, as well as agreements on problem definitions and solutions and adequate spaces of engagement amongst cross-sector partners.

8.4 THE ROLE OF HEALTH SECTORS IN COLLABORATIVE PROCESSES

The discussion on the collaborative processes of the FTD also draws attention to the position of the health sector or health systems within intersectoral collaboration.

It was evident from this case that health systems are not monolithic and consist of a range of actors with different positions and interests on one policy issue, as shown in Table 10 in Chapter 6. To advance intersectoral action for health, the health sector must learn to work with other sectors as well as manage various actors' interests within the health system itself. This requires that health sectors should approach intersectoral action open to other sectors and equipped with the necessary knowledge and skills to manage collaborative relationships. This also means supporting champions both within the health sector and in other sectors (Kickbusch & Gleicher, 2012). In cross-sector experiences from Australia, Baum et al (2017) detail how bureaucratic actors from non-health sectors relied on the presence, support and encouragement from supportive actors within the health sector.

In an effort to identify how health sectors may be best positioned for collaboration, some authors recommend that assessing institutional hierarchies, and the location of health ministries within them, may be key to allocating leadership roles on a health issue (Rasanathan et al., 2017). Others suggest that health sectors can play various roles in intersectoral collaboration including leading initiatives, research and education, advocating for health equity and monitoring and evaluating the impact on health outcomes (Barr et al., 2008).

In the case of the FTD, the health sector's role in maternal and child health services ensured that it was a central player in intersectoral collaboration. However, not all intersectoral policy issues share these features. An analysis of 18 case studies of intersectoral action highlights three main levels through which the health sector can participate in intersectoral collaboration. The first level involves issues where the health sector has the greatest knowledge, experience and control over implementation, where health sectors can lead the policy mandate. In issues where the health sector has the necessary knowledge but lacks control over implementing the initiative – such as health promotion in schools – the health sector may take the lead but has to ensure other relevant sectors own and participate in addressing the issue. The last level involves initiatives that address determinants of health such as poverty which are out of the scope of the health system; in this case the health sector can only act as a partner during development and implementation (Barr et al., 2008).

Deciding on the role for the health sector needs to consider the nature of the policy issue and it should ideally be done after mapping the profile, incentives and relationships of all the sectors involved (Rasanathan *et al.*, 2017); only then can the level of involvement of the health sector be established. This of course requires the necessary spaces for deliberation within networks across sectors and is enhanced by relationships and facilitative leadership skills, as detailed above.

8.5 SUMMARY

In summary, the factors highlighted in the previous three sections allow for a comparison of factors that shaped the overall FTD process, drawing on both the 3I's and collaborative governance propositions. These key factors are summarised in Table 13 below, drawing attention to the lessons for ensuring commitment to collaborative processes during the stages of the policy process.

Table 13: A comparison of constraints and enablers of intersectoral action for the FTD

Lessons for intersectoral collaboration	The FTD in early years (policy thinning and the loss of intersectoral goals)	The FTD in later years within the Whole of Society Approach
	Agenda setting	
Starting conditions trigger the collaborative process	- Political attention without bureaucratic commitment to intersectoral action including limited financial and human resources.	- Political attention accompanied by bureaucratic commitment through the involvement of high-level government officials. - Collaborative process leverages off previous networks and efforts to collaborate.

Lessons for intersectoral collaboration	The FTD in early years (policy thinning and the loss of intersectoral goals)	The FTD in later years within the Whole of Society Approach
Policy formulation and implementation		
Shared understanding of policy problems and solutions help establish ownership amongst partners aided by framing of the policy issue	- Vague and unclear policy solutions for the FTD. - FTD interventions viewed as 'health' versus 'intersectoral action'. - Varied interests amongst policy actors.	- Initial agreements and a shared understanding of the collaborative process and of the FTD amongst cross-sector partners. - Framing of the FTD as part of the life course draws in multi-sector actors. - Facilitative leadership enables partners to develop shared understandings and negotiate divergent interests.
Institutional mechanisms and clear governance structures for the collaborative process	- Absence of institutional structures and mechanisms to facilitate the negotiation and deliberation of possible solutions for the FTD. - Interventions selected are based on the health sector which owns the mandate for formulating the FTD. - Prioritisation of intersectoral policy issues as vertical projects within intersectoral forums.	- The FTD embedded within the WoSA with clear governance structures that enable negotiation of solutions to address challenges within the life course. - Formal mandates to collaborate enable mid-level officials to participate in the collaborative process as the collaborative endeavour is integrated into routine accountability and performance measures
Collaborative processes that prioritise safe engagement spaces and relationships amongst partners	- Institutional constraints of the health sector drives implementation actors towards biomedical framing of the FTD. - Service delivery actors in charge of implementation not involved in agenda-setting process and do not own the collaborative process.	- Involvement of all relevant cross-sector players and engagement with frontline providers. - Relationships amongst cross-sector actors and spaces of engagement provide an avenue for frontline providers to speak about challenges at implementation level. - Engagement spaces allow collaborative partners to learn over time.

8.6 CONCLUSIONS

This thesis set out to understand the phenomenon of intersectoral collaboration by examining the policy process of the FTD initiative. Applying the combination of policy analysis theory and collaborative governance constructs, my findings showed the trajectory of an intersectoral initiative within an LMIC setting at sub-national level. Based on the findings of this study, a number of conclusions can be drawn.

Firstly, my research suggests that policies requiring intersectoral action, like other policy issues, achieve political prioritisation due to the growing international evidence and the role of policy entrepreneurs in linking international evidence to local problems. Existing literature on intersectoral action argues that it is difficult to sustain political attention to intersectoral initiatives and to achieve commitment to action. My research agrees with this. In addition to this, my findings demonstrate that while intersectoral initiatives might have well-documented evidence, differing understandings of the policy issue hinders agreement on a way forward. My study further expanded the understanding of the levels of differing interests within intersectoral initiatives by showing that divergent interests can exist within the health sector between advocates of the policy issue and actors involved in service delivery mandates.

Moreover, I show that what hinders intersectoral action is the interaction of a number of key issues. These are unclear mandates for the policy issue and differing understandings on the way forward; verticalisation of the intersectoral initiative at early stages; the perception of actors involved at service delivery level that collaboration is unclear and impossible, leading to a preference for biomedical interventions; overwhelmed and complex implementation environments that affect actors' views on the necessity for collaboration. Taken together, the combination of these factors reveals what policy makers have to juggle in efforts to formulate and implement intersectoral action.

In addition to what has been suggested regarding the need to ensure that intersectoral efforts are institutionalised in existing systems (Baum *et al.*, 2017; Rasanathan *et al.*, 2017), this study was able to document how a provincial structure and network was able to learn from past experiences to create institutional forms that enabled successful intersectoral action on the FTD initiative to emerge in later years.

Similarly, based on the WoSA experience, it is worth noting that even though intersectoral initiatives have fluctuating courses, multiple policy windows offer a way to address policies in different ways over time. A failed intersectoral policy could be successful in another time and place, especially if the necessary enablers are in place. The FTD within the WoSA offered useful insights into the enabling factors for collaborative processes. These align with many of the propositions put forward in collaborative governance theories, and show the value of a governance lens on intersectoral action for health.

The findings of this FTD experience need to be considered in the light of the current focus on the SDGs which offers the platform to advance intersectoral collaboration through the interlinkages between goals. Several policy experiences suggest the need to examine challenges that can threaten the advancement of these global goals, however (Baum *et al.*, 2017; Khayatzadeh-Mahani *et al.*, 2017; Mauti *et al.*, 2019). A particular risk is the adoption of vertical approaches for each goal, especially as the allocation of resources often falls across several sectors. Efforts to address the SDGs therefore need to consider a number of factors: the value of building common understandings between relevant sectors; ensuring that actors have appropriate spaces that allow for policy dialogue and the negotiation of different perspectives; and paying attention to the principles of effective collaborative governance that allow for meaningful cross-sectoral engagements. However, such collaborative processes are not self-sustaining and require investment of time and effort and adequate resources.

8.7 LIMITATIONS AND RECOMMENDATIONS FOR FUTURE RESEARCH AND PRACTICE

The FTD was selected as a case because it represented efforts to address intersectoral collaboration. However, the FTD initiative was only one of the collaborative initiatives in the Western Cape Province that was underway at the start of 2016 and which was prioritised by the PSG 3 Committee. Including a range of cases might have provided a comparative experience of collaboration, thus illuminating additional factors that can influence intersectoral action. On the other hand, the strength of selecting the FTD as a single case was that I could track all the dimensions on the phenomena as it unfolded over time. This research also took place within a specific provincial context and within two sub-districts and cannot claim to be exhaustive in identifying all facets of intersectoral action. In addition, the FTD as a case reveals how intersectoral collaboration unfolds where there is a predominant role for health and social sectors. Therefore, findings from the FTD experience did not reveal

complexities that could emerge in intersectoral processes that involve other sectors particularly in cases where health interests contrast with commercial interests such as the regulation of tobacco. As such, claims made in this thesis are not necessarily generalisable to all other intersectoral experiences. However, a contextualised understanding of what occurs during intersectoral policy processes could be considered as theoretically generalisable from this research.

There is a need for more evidence on intersectoral action for health and greater clarity regarding what types of research designs and methods can best generate that evidence (Glandon *et al.*, 2019). Especially needed is research that includes conceptual frameworks and theories that embrace the complexities of collaboration. Based on this, one of the main recommendations for future research is the development of typologies of collaboration in order to facilitate comparison of different collaborative approaches and cases. In addition, further research could consider the use of mixed methods, including quantitative assessments of intersectoral implementation outcomes, as the current existing research is largely case studies and qualitative approaches.

During the course of this study, I realised that there was a range of informal collaborative, as well as intersectoral, relationships among frontline providers within the social development sector that were not related to the FTD. Apart from describing this range of intersectoral workings, it was not possible to consider these relationships in depth, which limits the findings of this thesis. Examining how these relationships were negotiated, especially within sectors other than health, would have enhanced the understanding of how intersectorality plays out at the frontline. In light of this, further research should examine how frontline providers sustain informal cross-sector arrangements.

It is also worth noting that the majority of the respondents in this study were actors within the health sector with very few respondents from non-health sectors. This meant that the findings did not fully embrace experiences from other sectors and is a major limitation in the study. While the WoSA experiences in Chapter 7 included a range of actors which, to a certain extent, allowed me to consider experiences from other sectors, they were only involved in the last phase of the whole PhD study. There has been a call to learn from experiences that do not directly involve the health sector (Rasanathan *et al.*, 2017).

For the FTD, building on this analysis of the Western Cape experience, additional research could usefully seek to understand the perspectives of other sectoral players, and their

respective institutional barriers and opportunities in similar initiatives. This of course means that researchers within this field should consider developing interdisciplinary relationships in networks with researchers outside of the health field. Academic institutions and research centres could facilitate this type of interdisciplinary learning.

While experiences from the WoSA in Chapter 7 provide valuable considerations for collaborative governance, these insights are limited as the lessons learnt relate only to the period of this study, which began when the WoSA had been underway for two years. Further studies could explore how such collaborative networks evolve further and focus on the costs of maintaining such networks, as well as how these engage existing vertical hierarchies within government sectors. Related to this, future studies could focus on how to develop the necessary facilitative skills of leaders within collaborative networks that emerged as a valuable asset within the WoSA teams.

Generally, more empirical work of this nature is needed to promote an understanding among stakeholders both within and outside of the health sector regarding the conditions under which intersectoral action outperforms single sector approaches. Although it was still in its early stages, the WoSA has shown how relationships between actors of various sectors assisted not only the FTD but other sector-specific mandates and how government officials were willing to step out of their mandates to assists their counterparts. Therefore, demonstrating how intersectoral collaboration has multiplier effects that assist both the collaborative goal and other sector-specific work would be helpful in making the case for intersectoral collaboration.

To complement the recommendations for further research, recommendations for practice are as follows:

- Maximising windows of opportunity for intersectoral action means that policy entrepreneurs should frame policy problems in ways that offer incentives for other sectors and contribute to shared ownership of the issue once policy formulation begins. An alternative would be to allow shared understandings of policy problems to emerge after deliberations or negotiations within networks or teams such as in the WoSA process. How this happens depends on the context, or on whether platforms that can facilitate the necessary negotiations exist. The framing of the policy issue also needs to have resonance with high-level political agendas and fit with the context in which the collaborative process is taking place. Policy entrepreneurs could also consider promoting a

comprehensive set of action steps for senior politicians and senior ministry officials including the need to send appropriate signals and incentives to managers and implementers who influence outcomes during implementation. However, the buy-in by managers may only emerge over time and may need continuous negotiations.

- Due to the existing range of informal intersectoral relationships, more effort should be made by policy makers to leverage off existing collaborations and networks when new initiatives are being considered. Similarly, more effort should also be placed on institutionalising these existing forms of collaboration, especially at frontline service delivery level as this may legitimise existing relationships.

- To enable the negotiation of differing understandings of the policy issue amongst actors, networks or teams have proved to be an effective way to work across sectors. Efforts to collaborate should therefore consider building networks that include the necessary stakeholders. These could prioritise repeated communication and dialogue regarding interventions and could start by allocating time to learn about each other's mandates and interests. Ensuring that such networks have clear governance structures and roles and responsibilities for all stakeholders, including NGOs, is beneficial for collaborative endeavours.

- There is also a general need within policy communities addressing 'wicked problems' to strengthen the capacity to broker agreements, navigate differing interests, resolve conflicts, build cross-sector relationships and respond to recurring challenges and opportunities in a collaborative way. As such, interventions proposed to address 'wicked problems' should integrate continual learning, and mechanisms for adjusting policies where necessary as policy interventions in one area can have unintended consequences in another. Ensuring that continual learning is part of policy development processes of such interventions can be stimulated by the capacity and willingness of organisations to integrate and institutionalise such learning experiences. Moreover, the ability of such policy communities and health systems to embed learning into aspects of decision-making will rely on the continuity of the relevant policy actors including leaders and managers who can facilitate such learning processes by transferring lessons learnt across policy spaces. Ensuring continuity of policy makers, leaders and managers can strengthen

institutional memory and prevent the loss of important tacit knowledge and learning that benefits decision-making spaces for intersectoral action.

- Horizontal collaboration does not happen effortlessly and requires the necessary investment in human resources, distinct co-ordination platforms or forums (such as networks described earlier) and integrated systems for planning, resources and performance tracking over time. These factors should be prioritised at early stages of collaborative efforts and ideally maintained during the duration of the process although this may be difficult to sustain over time.

- The need for champions for intersectoral work is necessary both within the health sector and in non-health sectors. This means that actors from other sectors should be involved in early planning stages of collaborative efforts.

- Incentives and disincentives for co-ordination need to be recognised and addressed during the course of collaboration as this affects how actors view the intersectoral policy issue. Networks could serve as an appropriate platform for considering how actors view the incentives to collaborate and how to make incentives clear or frame the collaboration in a way that offers incentives for non-health sectors.

- For the implementation of intersectoral initiatives, there is a need to strengthen operational capacities for basic programme planning and improving referral systems between sectors. It is also worth noting that collaboration is difficult to implement when actors at service delivery level are overwhelmed by realities at the frontline. These realities need to be considered during formulation processes to avoid implementation actors feeling excluded and policy issues being formulated in ways that do not reflect the experiences at the frontline.

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Appendix 1:

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INFORMATION SHEET

Project Title: Intersectoral collaboration during policy formulation and early implementation: the case of the First 1000 Days Initiative in the Western Cape Province

What is this study about?
My name is Ida Okeyo from the School of Public Health at the University of the Western Cape. I am doing a research project to understand the policy development process of the First 1000 Days (FTD) Initiative. We are inviting you to participate in this research process because your experience as a key stakeholder in the FTD will provide insights to improve our understanding of how the initiative developed as well as future challenges and opportunities. The aim of the study is to generate lessons which will strengthen the future implementation of the FTD.

This information sheet will tell you a few things about the study. If there are any words that you don't understand as you read it, please let me know so that I can explain. You may ask questions at any time. If you wish to take part in the study, you will be asked to sign the consent form.

What will I be asked to do if I agree to participate?
If you agree to participate, you will be approached for an interview where you will be asked questions regarding your understanding of the FTD initiative, the actors shaping its development and your perceptions of enablers and challenges of intersectoral collaboration. A summary of the questions that you will be asked is attached to this form. The interviews will last for about an hour and will be conducted in a location that is convenient for you.

Would my participation in this study be kept confidential?
The researchers undertake to protect your identity and the nature of your contribution. This study will involve the use of audio recordings during the interviews to assist in capturing all the information correctly. To ensure your anonymity, a code will be used instead of your name on interviews and audio files. Only the researchers will have access to the identification key for the codes. All interview transcripts will be kept in a secured storage area and password-protected computer files. The answers obtained from the interviews will be kept confidential,

so no-one will know how you answered the questions. Personal information and your name will not be used in any report or results generated from this study.

Do I have to be in this research and may I stop participating at any time?
Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. You may also choose not to have the interview audio-taped. If you feel uncomfortable discussing topics or answering any questions you do not have to answer them and don't have to explain why. You may stop at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalized**.**

What are the risks of this research?
All human interactions and talking about self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?
This research is not designed to help you personally, but the responses you provide will help inform our understanding of how to improve the process of intersectoral collaboration during policy development. This will benefit other policy processes intending to use intersectoral collaboration as a means to reduce health inequalities.

What if I have questions?
This research is being conducted by **Ida Okeyo** from the School of Public Health at the University of the Western Cape. If you have any questions about the research study itself, please contact **Ida Okeyo** at: **+27797577883** or by email at **idaokeyo@gmail.com**

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

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This research has been approved by the University of the Western Cape's Research Ethics Committee. (Reference Number: *to be inserted on receipt thereof*)

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION

Research Office

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Appendix 2: Key informant interview guide – policy formulation actors

Date:_____	**Interview site:** _____
Interviewer: _____	**Participant:** _____
Participant number:_____	**Participant contact number:** _____

Section	Questions
1. Evolution of the First 1000 Days Initiative	I would like to start the interview with what motivated the attention towards the First 1000 Days Initiative (FTD) I'm interested in where the idea of the FTD started. Where did the idea originate from? What do you think motivated the idea behind this initiative? Could you explain to me how the FTD initiative being conceptualised? What are the main goals of the initiative? What are the interventions being prioritised and why? Have these goals or priorities changed since the FTD gained attention and why? (*from 2014 to 2018/ through various years prompt for any shift from the intervention framework*) Since the FTD gained attention, are there any specific moments, events, meetings or workshops which you think have influenced how the initiative is today? *(CBS co-coordinators meeting, TOC process, prompt for how this has happened)* Are there any particular documents that you feel have shaped the development of this initiative and why? What do you think about the Whole of Society approach which is gaining attention and its relation to the FTD? (*Prompt for how? Will there be a change in governance*) Although it's still in the early days of the initiative what do you believe are some of the expected outcomes of implementing this policy? Has there already been some implementation activity going on at the service-delivery level for this initiative? Can you tell me about some of the early plans being conceptualised for the implementation process of the FTD?

	What do you think is influencing these early planning stages? What are some of the priorities during this early stages of implementation? How do you think the initiative will play out at the service-delivery level? (*implementation*) What factors do you consider are likely to hinder the success of the FTD being implemented?
2. Context/policy environment	I'm interested in understanding how other policy contexts happening at both the Provincial and National level are influencing the initiative such as the other Provincial Strategic Goals and other policies e.g. the National Integrated Early Childhood Development Policy. In what ways has the FTD been shaped by other process happening at the Provincial level such as the Provincial Strategic Goals? What about other policies happening Nationally such as the education policy and any others policy processes that you can think of?
3. Framing	I would like to talk about some of the language/symbols or slogans that I have come across within some of the document such as the FTD unique identifier – Grow, love play and relationships matter most. What do you understand as the role of these slogans in this policy process?
4. Actors (roles, relationships)	Let's talk about some of the people involved in this initiative. Can you tell me about how you came to be involved in this initiative? (*role or function within this policy initiative*) What are some of the key people/organisations/groups you can think of that have played a role in how the FTD has evolved till now?(*both individuals and groups within the government and outside*) Why do you consider them influential? How do you think these actors influence how the First 1000 Days initiative has evolved? (*how it got attention and is being shaped currently*) Can you tell me whether the people/institutions involved in shaping the initiative are linked or related in any way? Since the FTD gained attention, has there been a change in the main key players till now?

	Where are decisions made/who are the key decision-makers in deciding on FTD policy and strategies? Do you think this could be different or more effective Do you feel that the policy process is successfully engaging all the relevant stakeholders? (*at all levels*) How? Any key players that have been left out? The situational analysis report talks about a number of players involved in various aspects of the FTD – What do you think about the number of people involved within this policy? Does this impact the policy process in any way? What are some of the governance processes that enable the organisation of the FTD such as the lines of reporting – who does the FTD EXCO report to for example? How do you view the role of NGOs within this initiative?
5. Intersectoral collaboration processes	What is your view of collaboration between sectors to meet the goals of the FTD? What opportunities do you think exist for the health sector to work with others to achieve the goals of this initiative? Have there been any processes to date to engage other sectors while designing this policy? (*both within and outside government sectors*) In your opinion what factors do you think would enable effective intersectoral collaboration processes during policy formulation and early stages of implementation?
6. Conclusion *(Check unclear points and wrap up)*	I have now come to the end of the interview and would like to ask the last two remaining questions. Is there an aspect of the FTD that you feel we have not discussed? Are there any other key players that you think I should talk to get a much better understanding of the FTD?

Appendix 3:

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CONSENT FORM

Title: Intersectoral collaboration during policy formulation and early implementation: the case of the First 1000 Days Initiative in the Western Cape Province

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone. I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

☐ I agree to be audiotaped during my participation in this study

☐ I do not agree to be audiotaped during my participation in this study

Participant's name……..

Participant's signature…….

Date……

BIOMEDICAL RESEARCH ETHICS ADMINISTRATION
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Appendix 4: Interview guide – policy implementation/front-line actors

Date:_____	**Interview site:** _____
Interviewer: _____	**Participant:** _____
Participant number:_____	**Sector/organisation:** _____
Participant contact number:_____	

Section	Questions
1. Actors (roles, experiences)	I would like to start the interview by hearing what your role is in your organisation/the facility/ field of maternal and child health? What has been your experience in this role/field? (why, prompt for examples) Are you familiar with any programmes/initiatives/policies that target pregnant women and children during the FTD period? (from government or other organisations) If yes, what is your perception of these programmes/initiatives? Based on your experience in working with pregnant women and/children, what are some of the priorities that you feel should be central/ should receive attention in this field? (Prompt for why) Which people/departments/organisations do you feel should be the main actors in these priorities? What are their main roles?
2. Knowledge regarding the Initiative **(*Only ask if participants have heard of the provincial FTD initiative*)**	Have you heard of the FTD initiative? If yes, What do you think about the FTD initiative? What do you think motivated the idea behind this initiative? What do you think is different about FTD versus other Maternal and Child Health initiatives? What do you think are some of the main goals of the initiative? Which are some of the interventions being prioritised that you are aware of? Since the FTD initiative has gained attention, which interventions/priorities do you think represent the vision of the programme?

	Have you interacted with any other actors/people/organisations regarding the FTD? If yes, who do you feel are some of the key people/organisations you can think of that have played a role in how the FTD has evolved till now? Why do you consider them influential? Do you feel that the policy process is successfully engaging all the relevant stakeholders? (at all levels) How? Any key players that have been left out?
3. Collaborative working/experiences	Are there/do you work with other partners/individuals/organisations as part of the work you are involved in? If yes, how? (Arrangements, governance, how does it work?) Who are some of the key people/organisations that you work with? (try and get a list) What are their roles? What do you understand as collaboration? What has been some of your experience of working with other partners? (prompt for challenges/ enablers of collaboration) What do you think are some of the challenges of working with others in this field? What do you feel can help improve working with others to improve child outcomes? (prompt for why and how) Are there any key stakeholders that you are not connected to that you would like to involve? What are some of the experiences of partnerships or collaboration for child health that you feel have worked well? (could be within your organisation/facility and outside) (Prompt for why, examples)
4. WOSA players ***(only for WOSA interviews)***	I'm interested in where the idea of WOSA started. Where did the idea originate from? What do you think motivated the idea behind this initiative Who do you perceive are the initiators of the WOSA processes? Do you feel that there are any particular factors that have sustained the momentum for WOSA till date? Do you think there is a link between WOSA and the FTD? (why/how)

	Let's talk about some of the people involved within the WOSA process Can you tell me about how you came to be involved in WOSA? (role or function) What are some of the key people/organisations/groups you can think of that have played a role in how the WOSA has evolved till now?(both individuals and groups within the government and outside) Why do you consider them influential? How do you think these stakeholders have influenced how WOSA has evolved? (how it got attention and is being shaped currently) Can you tell me whether the people/institutions involved are linked or related in any way? What has been your experience since you have been involved in WOSA? What has been done differently from your day to day roles or tasks? What has been achieved/what are some of the key achievements that you feel have occurred to date? What have been some of the challenges you have faced during the process? (prompt for why, sectoral processes and mandates) Have there been any ways that you have navigated the challenges? (how)
5. Context/policy environment	Are there any other programs or initiatives happening that have shaped/influenced how you do your work/your organisation?

Appendix 5: Observation tool for Whole of Society Approach and the First 1000 Days in Saldanha Bay

Elements from (Emerson, 2018; Emerson et al., 2012) and (Ansell and Gash, 2008)	**Details**	**Key elements for data collection**
System Context *May influence dynamics and performance of collaboration at any time*	Resources/power Policy History Politics Trust/conflicts Cultural factors Constraints	**Documents** - Policy and legal frameworks - Socio economic profiles - Map key actors **Observations** - How do stakeholders speak about historical relationships with each other (Pre-existing conflict, levels of trust)? - Actor power?
Drivers *Provide impetus for collaboration*	Uncertainty about problem Participatory inclusiveness Process transparency Interdependence Initiating leadership Incentives	**Documents** - Outline of ground rules, transparent processes, clarity of purpose **Observations** - Who leads, who speaks? - How do stakeholders speak about the need for each other (interdependence) ? - Stakeholders view of the importance of their roles or co-operation in the process? - What reasons are given for the need to collaborate? - What ensures legibility of the process?
Principled engagement *Ensures quality of the process*	Discovery Definition Deliberations Determination	**Documents** - Procedural decisions: clear but flexible ground rules, investigation and resolution of problems - Evidence of common goals - Joint decision making - Basic protocols; clear definitions of roles, governance structures - Timelines of face to face engagement - Changes in framings, new language **Observations** - Who is in, who is out, inclusivity and openness? - Safe space to deliberate between various options?

		- Ability to listen to other perspectives and communicate? - Joint problem diagnosis, new common understandings? - Common understanding of the process?
Shared motivation *Provides social capital, reinforces engagement processes*	Trust and understanding Shared commitment Internal legitimacy	**Documents** - Common values and goals - Commitment to processes/ shared agreements **Observe** - How do partners percieve each other or speak about each other? - Is there mutual understanding of each other's positions and interests?
Capacity for joint action *Sustains process*	Procedural and institutional arrangements Facilitative leadership Knowledge Resources	**Documents** - Decision-making processes and structures - Generation and sharing of formal and informal (tacit, experiential) knowledge - Shared and leveraging of resources - Deployment of resources - Evidence of common goals - Joint decision making **Observe** - Information or knowledge sharing?
Actions/ intermediate outcomes *Encourage ongoing processes*	Small wins Strategic plans Joint fact-finding	**Observations** - What has been done differently? - What has been achieved? - Perceived collaborative advantage/views of the relationship between their participation and effective outcomes

Appendix 6: Interview guide – Whole of Society Approach and the First 1,000 Days in Saldanha Bay

Date:_____ **Interview site:** _____

Interviewer: _____ **Participant:** _____

Participant number:_____ **Sector/organisation:** _____

Participant contact number:_____

Section	Questions
System context	I would like to start the interview by hearing what your role is in your sector/organisation? I'm interested in where the idea of WOSA started. Where did the idea originate from? What do you think motivated the idea behind this initiative? What created the need to collaborate? What are some of the expectations you have of the process? (interests) How have you engaged with stakeholders from various sectors in the past before the WOSA process? How do you view other stakeholders based on past engagements? (trust vs suspicion/stereotypes)
Knowledge regarding the Initiative **(Only ask if participants have heard of the FTD initiative or are involved in the FTD/social cluster)**	Have you heard of the FTD initiative? If yes, What do you think about the FTD initiative? What do you think motivated the idea behind this initiative? When did you first engage with the FTD concepts? What do you think are some of the main goals of the initiative? Do you think there is a link between WOSA and the FTD? (why/how) What are some of the main activities that the FTD has embarked on as part of WOSA? How have they been organised? Have you interacted with any other actors/people/organisations regarding the FTD? If yes, who do you feel are some of the key people/organisations you can think of that have played a role in how the FTD has evolved till now? Why do you consider them influential? How do you see the FTD unfolding in future?

Drivers	Let's talk about some of the people involved within the WOSA process. Can you tell me about how you came to be involved in WOSA? (role or function) What are some of the key activities that you have been engaged with as part of this process? Or … What do you understand as your role within WOSA? (ownership) What do you think is the role of other sectors/stakeholders within this process? (understanding of other sectors' roles) Who do you perceive are the initiators of the WOSA processes? (formal and informal) Who are some of the key people/sectors/groups you can think of that have played a role in how the WOSA has evolved till now?(both individuals and groups within the government and outside) Why do you consider them influential? How do you think these stakeholders have influenced how WOSA has evolved? Can you tell me whether the people/institutions involved are linked or related in any way? **If they are, how are they linked or related?** What do you think has sustained the momentum for WOSA during this process? / has kept people going on this journey? **What are the advantages of working collaboratively within WOSA? (shared motivation)**
Principled engagement process	How do the various stakeholders within WOSA relate to each other? How are the relationships maintained between various partners? (What specific processes?) What is your understanding about how the WOSA process if organised? Or governed? (what does it involve?) What happens if there are any conflicts between stakeholders? How have they been negotiated?
Capacity for joint action	What are some of the decision-making processes and structures that support WOSA? How are the decisions made within WOSA? Is there sharing or leveraging of knowledge and resources/budget support?

Actions	What has been your experience since you have been involved in WOSA? What has been done differently from your day-to-day roles or tasks? What has been achieved/what are some of the key achievements that you feel have occurred to date? **What have been some of the challenges you have faced during the process? (prompt for why, sectoral processes and mandates)** Have there been any ways that you have navigated the challenges? (how)

Appendix 7:

UNIVERSITY of the WESTERN CAPE

OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

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07 December 2017

Ms I Okeyo
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM17/10/9

Project Title: Intersectoral collaboration during policy formulation and early implementation: the case of the first 1000 days initiative in the Western Cape Province.

Approval Period: 07 December 2017 – 07 December 2018

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report in good time for annual renewal.

The permission from the Provincial Health Department must be submitted for record keeping purposes.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

PROVISIONAL REC NUMBER -130416-050

UNIVERSITY of the WESTERN CAPE

60 YEARS of hope, action & knowledge

27 March 2020

Ms I Okeyo
School of Public Health
Faculty of Community and Health Sciences

Ethics Reference Number: BM17/10/9

Project Title: Intersectoral collaboration during policy formulation and early implementation: The case of the first 1000 days initiative in the Western Cape Province.

Approval Period: 13 March 2020 – 13 March 2023

I hereby certify that the Biomedical Science Research Ethics Committee of the University of the Western Cape approved the scientific methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

Please remember to submit a progress report annually by 30 November for the duration of the project.

Permission to conduct the study must be submitted to BMREC for record-keeping.

The Committee must be informed of any serious adverse event and/or termination of the study.

Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape

Director: Research Development
University of the Western Cape
Private Bag X 17
Bellville 7535
Republic of South Africa
Tel: +27 21 959 4111
Email: research-ethics@uwc.ac.za

NHREC Registration Number: BMREC-130416-050

Appendix 8:

Western Cape Government
Health

Health Impact Assessment
Health Research Sub-Directorate
Health.Research@westerncape.gov.za
Tel: +27 21 483 0866: fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za)

REFERENCE: WC_201712_026
ENQUIRIES: Dr Sabela Petros

University of Western Cape

Robert Sobukwe Road

Bellville

Cape Town

7535

For attention: Ms Ida Okeyo, Prof Helen Schneider, Prof Uta Lehmann

Re: Intersectoral collaboration during policy formulation and early implementation: the case of the First 1000 Days Initiative in the Western Cape Province.

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research. Please contact following people to assist you with any further enquiries in accessing the following:

Western Cape First1000 Days	**Hilary Goeiman**	**021 483 5663**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. In the event where the research project goes beyond the *estimated completion* date which was submitted, researchers are expected to complete and submit a progress report

(**Annexure 8**) to the provincial Research Co-ordinator

(Health.Research@westerncape.gov.za).

4. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR J EVANS

ACTING DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 02/05/18